UNDERSTANDING THE MEANING OF MENTORING OF NEWLY GRADUATED REGISTERED NURSES FOR GOOD WORK IN HONG KONG

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CERTIFICATE OF ORIGINALITY

I hereby declare that this thesis entitles ‘Understanding the meaning of mentoring of newly graduated registered nurses for good work in Hong Kong’ is my own work and that, to the best of my knowledge and belief, it reproduces no material previously published or written, nor material that has been accepted for the award of any other degree or diploma, except where due acknowledgement has been made in the text.

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ABSTRACT OF DISSERTATION ENTITLED

‘Understanding the meaning of mentoring of newly graduated registered nurses for good work in Hong Kong’

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Background

Nursing in a complex and dynamic health care landscape resembles sailing in stormy seas and rainy weather, while good work is akin to a distant beacon that seems beyond reach, yet must not be ignored. Mentoring has been one of the most frequently suggested strategies for facilitating both the transition of new graduates and good work, as if it were a panacea. Nevertheless, the concept of mentoring in nursing practice remains ambiguous and confused, and the term is often used interchangeably with preceptoring, a related concept in the literature. Mentoring as a way of promoting good work among newly graduated nurses has to date been underexplored.

Aim

The aim of this study is to understand the meaning of mentoring newly graduated registered nurses (NGRNs) in the transition and in the pursuit of good work through different stories of experiences that are lived, told, relived, and retold in a complex health care landscape.

Design

The research methodology that was adopted was based on Clandinin and Connelly’s narrative inquiry. Four methods were employed to collect field texts from four sources of data in eight participating public hospitals in Hong Kong. Eighteen NGRN participants were recruited to participate in the one-year enquiry process through repeated interviews and email conversations. Focus group interviews were also

conducted with 11 preceptors and 10 stakeholders (senior nurses, ward managers, and doctors). Relevant hospital documents relating to the participants' stories of their experiences were also reviewed. The research texts were composed from the field texts through the iterative process of narrative and paradigmatic analyses.

Findings

Thinking narratively of the participants' stories of their experiences along the three dimensions – temporal, personal-social interactions, and the place of the narrative inquiry space – revealed the complexity of mentoring NGRNs for the transition and the pursuit of good work. NGRNs are in need of ongoing mentoring throughout their first two years of clinical practice in their transition and in the effort to sustain good work in the midst of educative and miseducative experiences. Four interrelated narrative threads are discerned from the NGRN, preceptor, and stakeholder participants' stories of their experiences, hospital documents, and the integration of the findings with the relevant literature. They are: 1) Contrasting stories of the preceptorship programme, 2) Knotmentoring for good work with self, opportunistic, and peer mentoring, 3) Understanding not-mentoring through assumptions about practice readiness and scolding, and 4) Disempowering by sacred hospital or unit stories.

Conclusion

This narrative inquiry has served as a springboard to generate insights into how NGRNs are mentored by themselves and others in the midst of ongoing experiences, to sustain their stories of good work in nursing. New possibilities are imagined in the narrative inquiry space to support NGRNs in persisting to sail towards the beacon in stormy seas and rainy weather. Mentoring them to perform good work will benefit patients and their families now and in the future by helping to retain nurses who are committed patient advocates to mentor future generations.

PUBLICATIONS ARISING FROM THE THESIS

Publications and Conference Presentations

Pang, M. C. S., & **Law, B. Y. S.** (2010, February 9). *Good work in nursing and mentorship scheme.* Paper presented at the Hospital Authority General Manager of Nursing Meeting, Kowloon Hospital, Hong Kong.

Chan, E. A., & **Law, B. Y. S.** (2011, July 29). *Narrative inquiry.* Invited paper presented at the 2011 National Nursing Research Conference Jointly Organized by the Pi Iota Chapter, Honor Society of Nursing, Sigma Theta Tau International and the School of Nursing Guangzhou Medical University, Guangzhou Medical University, Guangzhou, China.

Law, B. Y. S., & Chan, E. A. (2012, February 23). *Making good: Understanding the meaning of mentoring newly graduated registered nurses in Hong Kong.* Paper presented at the 15th East Asian Forum of Nursing Scholars, Singapore.

Law, B. Y. S., & Chan, E. A. (2013, May 18). *Telling and retelling of stories of good work by newly-graduated registered nurses in Hong Kong.* Paper presented at the 9th International Congress of Qualitative Inquiry (QI2013), University of Illinois, Urbana-Champaign, USA.

Law, B. Y. S., & Chan, E. A. (2014, June 27). *Learning and sustaining to be a patient advocate as a newly graduated registered nurse: Speaking up and being heard.* Paper presented at the panel presentation of the Conference on Communication, Medicine and Ethics, The Universita della Svizzera Italiana, Lugano, Switzerland.

Law, B. Y. S., & Chan, E. A. (2015). The experience of learning to speak up: A narrative inquiry on newly graduated registered nurses. *Journal of Clinical Nursing, 24*(13-14), 1837-1848.

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ABBREVIATIONS

A-Line	Arterial Line
AED	Accident and Emergency Department
AI	Appreciative Inquiry
APN	Advanced Practice Nurse
BBA	Born Before Arrival
BLS	Basic Life Support
BP	Blood Pressure
COS	Chief of Service
CPAP	Continuous Positive Airway Pressure
CRM	Crew Resource Management
CT	Computer Tomography
DAW	Drug Allergy Warning
DDA	Dangerous Drug Administration
DNR	Do Not Resuscitate
DOM	Department Operation Manager
DSA	Digital Subtraction Angiography
EBP	Evidence Based Practice
EN	Enroled Nurse
ETT	Endotracheal Tube
FiO_2	Fractional Concentration of Inspired Oxygen
FG	Focus Group
GCS	Glasgow Coma Scale
GERO	Gerontology Unit
GMN	General Manager of Nursing
GYNAE	Gynaecology Unit
HA	Hospital Authority
HCA	Health Care Assistant
HK	Hong Kong
HO	House Officer
IAD	Incontinence-associated Dermatitis
ICU	Intensive Care Unit
IRB	Institutional Review Broad
ISBAR	Identify, Situation, Background, Assessment, & Recommendation
IVIG	Intravenous Immunoglobulin
MED	Medical Unit
MEWS	Modified Early Warning Signs
MO	Medical Officer
MRI	Magnetic Resonance Imaging
MSF	Medecins Sans Frontieres
N/PICU	Neonatal and Paediatric Intensive Care Unit
NEATS	Non-Emergency Ambulance Transfer Service
NEURO	Neuroscience Unit
NGRN	Newly Graduated Registered Nurse
NO	Nursing Officer
NRP	Nurse Residency Programme
OGD	Oesophago-duodenoscopy
ORTH	Orthopaedic Unit
OSH	Occupation Safety and Health

PAED	Paediatric Unit
PALS	Paediatric Advanced Life Support
PAN	Afternoon, Morning and Night shifts
PET	Partial Exchange Transfusion
PRO	Patient Relations Office
RDMS	Red Dot Mobility System
RN	Registered Nurse
SaO_2	Arterial Oxygen Concentration
SARS	Severe Acute Respiratory Syndrome
SCBU	Special Care Baby Unit
SDR	Staff Development Review
SURG	Surgical Unit
TPN	Total Parental Nutrition
TUNS	Temporary Undergraduate Nursing Student
WM	Ward manager

PART ONE

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This narrative inquiry, which seeks to understand the meanings of mentoring newly graduated registered nurses (NGRNs) who are in transition and in pursuit of good work in nursing, was inspired and shaped by my own past experience. This chapter provides an overview of my own narrative history in transitioning from a baccalaureate undergraduate nursing student to an NGRN. Through telling (writing) my own story, my autobiography, as it was, my personal justifications for conducting this narrative inquiry are articulated. It is my own experiences that brought me to my research questions or narratively research puzzles of what other NGRNs and stakeholders in the complex health care landscape experienced and felt. My further research also looks the relevant literature to understand the significance for conducting this narrative inquiry. Looking at who I was, who I am now and who I am becoming is also important in a narrative inquiry as these could shape how I pay attention to the experiences of my research participants (Clandinin & Connelly, 2000; Clandinin, 2013). This chapter closes with an outline of this dissertation.

1.2 My story of transition: An image of sailing without a rudder

As a sailing enthusiast, when I reflect on my own transitional experience, an image of me sailing without a rudder comes to mind. Normally, when sailing a dinghy, a rudder is used for steering. Sailing without a rudder is rather challenging, as the sail setting, centreboard, and the positioning of the weight of my body have to be used in combination for steering instead. If the sea is calm and the wind is gentle and constant, coming from one direction, an expert helmsman can sail without a rudder. However, if the sea is rough and the wind is strong and blowing erratically, sailing without a rudder is a great challenge even for an expert helmsman. For me, as a registered nurse newly graduated from a four-year baccalaureate nursing programme,

I was able to manage sailing the type of dinghy that I was familiar with from my years of practice in a well-surrounded pond where the wind and water currents were very steady and I was under the observation of a sailing instructor. You may wonder why I had to sail without a rudder as a novice helmsman. Although I was assigned a preceptor after graduation, I did not have the chance to work with her. Instead, I had to sail alone, with only the distant observation of other sailing instructors or the lifeguard (that is, other nurses and the shift in-charge nurse) who only helped when I had capsized. There were times when the rudder had been pushed out of the water by the water current, causing the dinghy to malfunction. As a novice helmsman, I did not even realise the rudder was up and was struggling and improvising to sail in rough and unpredictable weather conditions. My head hit repeatedly by the dinghy's boom because the sail setting was wrong. Sometimes, I even capsized because I had lost balance or because the wind had shifted. Kind and helpful sailing instructors and lifeguards sometimes alerted me to the situation of the rudder, and gradually, through these challenging experiences, my awareness of the issue of the rudder grew.

In addition to this unintentional situation of ‘sailing without a rudder’, there were also times when my preceptor forced me to sail alone in windy conditions and rough seas without using the rudder. Though my sailing skills had improved dramatically by then, this learning experience was too challenging, painful and discouraging. Many times I cried before, during and after sailing. Many times I was consumed by doubt and felt ready to give up.

1.3 Beginning my story of an NGRN at a highly specialised unit

My story of being an NGRN began in 2007 in the large hospital where I had done almost half of my clinical practicum. I was assigned to work in the neuroscience unit, which specialises in the care of both neurosurgical and neuromedical patients. I had a three-month module in nursing therapeutic in my third year that covered the neurological system and some of the neuroscience diseases. While some of my university classmates had the opportunity to have clinical practicum at some neuroscience units, I did not. It was difficult for me to imagine what a neuroscience unit was like.

> *27 August 2007: Although it's been many years, I still remember the exact date of my appointment as a registered nurse (RN). On that day, I had put on the uniform of an RN. I paused in front of the door with the sign proclaiming neuroscience unit - a specialty filled with mystery, possibly shaped by the television drama that usually use a neurosurgeon as the protagonist. I admired my best friend who had the precious opportunity to have her clinical placement at the neuroscience unit in year two. Now, here comes my turn with a chance to work as an RN. Everything was NEW and UNFAMILIAR – the setting, people, diseases, equipments and procedures. I was both excited and nervous.*

My experience of being assigned to a highly specialised unit was not unusual. For their first RN positions, many of my university classmates and other NGRNs were also assigned specialised units, such as the accident and emergency department (AED), intensive care unit (ICU) and special care baby unit (SCBU). As NGRNs, we had acquired a general foundation from our nursing programmes, but our exposure to these highly specialised areas ranged from none at all to as little as two weeks of clinical exposure only. Were we expected to transfer our entry-level competencies across such diverse practice settings and client populations? Or, put another way, what kind of support or 'mentoring' should be provided to NGRNs in these highly specialised areas?

1.4 My story of being 'taught' by a preceptor

Generally, all NGRNs employed by public hospitals under the Hong Kong Hospital Authority (HA) are in a two-year preceptorship programme. This includes a hospital orientation, with a unit-based nurse as a preceptor (at least two years of clinical experience), and clinical rotations to another specialty after their initial assigned unit (HA, 2010a; 2011a).

> *'Your mentor is Annie. She is on leave for these two weeks.'* [The term mentor has been used interchangeably with the related term preceptor by health care professionals in their daily clinical practice, who have no awareness of their differences reported in the literature. A more detailed discussion is provided in the later section. In short, mentoring refers to the process by which a person is guided, taught, and influenced in important ways by people, events, situations and circumstances (Angelini, 1995; Darling, 1985a). Preceptoring can be viewed as a prescriptive, functional and enabling relationship that has an organizational dimension and that functions within a structured framework. The new staff is formally assigned to or matched with a qualified and experienced employee to provide a form of staff orientation via structured learning support for achieving externally set

objectives that is confined to a short and limited period of time when compared with the process of mentoring. Mentoring is a broad term that might encompass preceptor, not vice versa. A preceptor can evolve into a mentor if the relationship continues to grow with the addition of the missing psychosocial component (Billay & Yonge, 2004; Hodgson & Scanlan, 2013; McCloughen, O'Brien & Jackson, 2006; Meier, 2013; Mills, Francis & Bonner, 2005; Morton-Cooper & Palmer 2000; Stewart & Krueger, 1996; Yoder, 1990).]

That's what I was told (that my mentor Annie is on leave for two weeks) on my first day of work by the shift in-charge! He then gave me a very general ward orientation and ward routine. In the absence of my preceptor, I worked as ward runner in finishing all the ward routines. Different senior nurses taught me bits and pieces at different times on an as-needed basis. I was on information overload and ended each shift exhausted. My mind was filled with questions but I did not know whom to ask nor where to start. The training was not systematic but rather was improvised and fragmented. Sometimes the teaching of different nurses was conflicting, leaving me in a state of confusion.

Meanwhile, I periodically heard stories about Annie from others when they asked who my preceptor was. They said things like, 'She is very strict and has a high standard of nursing care. She is very experienced and knowledgeable.' When my preceptor returned to work, she was surprised and angry with the limited knowledge I had gained in the two weeks that she had been away.

Whenever my university classmates and teachers ask about my transition, tears threaten to well up in my eyes. I can still recall the time, a year after my professional registration, when I participated in a qualitative study conducted by a group of final year nursing students As I recounted my experience of this transition period, I uncontrollably burst into tears as I flashed back to the scolding and humiliation to which my preceptor subjected me. The scene that comes to mind most often was the day that she threw a suture set at my chest in the treatment room.

*My preceptor had just returned from her annual leave. She was asking what procedure set I would use when removing scalp stitches from a patient. 'Suture set', I said. My preceptor was so furious with this answer that she threw the suture set at me. She scolded me loudly in a belittling tone. 'Are you planning to see any gap wounds and re-suture them immediately by yourself with the suture set? [*Suturing is generally not performed by nurses but by doctors, except at the AED]' *She left the treatment room angrily, leaving me wondering what my mistake was and what procedure set I should be using. In fact, the use of a suture set was what a nursing officer had taught me in the first two weeks while my preceptor was on leave. Also, from my perspective, I think a pair of scissors and forceps are essential for the procedure of stitches removal. I felt very helpless, not knowing what my preceptor wanted and feeling confused because of the conflicting teaching by*

different senior nurses.

It had taken me some time to become familiar with the various types of procedure sets, which are comprised of different stainless steel implements. Upon further reflection about that horrible scene, I can *guess* what answer my preceptor had expected. A suture set contains four pairs of forceps, a pair of scissors and a pair of needle holders. Honestly speaking, a suture set cannot be regarded as the wrong procedure set for removing stitches because it contains all the essential implements. However, it might not be the best possible choice as it contains some implements that are not used for stitches removal, such as the needle holders and an extra pair of forceps. By contrast, a simple procedure set that contains three pairs of forceps is the more appropriate choice. The procedure of stitches removal can be easily performed by adding a pair of scissors, thus leaving no implement opened but unused. I might have been thinking too straightforwardly by focusing on a procedure set that contains the necessary pair of scissors but overlooking the possibility of adding a pair of scissors to a different procedure set. That is, I might have given an unsatisfactory answer, but it was not an absolutely wrong answer. The more important point of this incident was that I did not learn effectively from that kind of 'teaching', scolding and disruptive behaviour of my preceptor. Initially, I had expected a preceptor to be someone who offers help, advice and support. However, working with my preceptor left me feeling very discouraged and helpless. My preceptor became an additional stressor in an already stressful and overwhelming workplace environment. This incident was just one of many examples when I was scolded in transition, the result of which was that no immediate or effective learning came of the experience.

As mentioned earlier, my neuroscience unit cared for neurosurgical and neuromedical patients. Two different teams of doctors with contrasting practices, preferences and routines headed up the unit. For the nursing professionals and other allied health professionals, such as the physiotherapists and speech therapists, we had to accommodate the totally different styles of the neurosurgical and neuromedical teams. When the patients' conditions stabilized, they would be transferred from my acute hospital to another hospital for rehabilitation. At the beginning of my transition, I was assigned to patients who were more stable and were pending transfer and discharge from the hospital. Most of my patients suffered from ischemic stroke and

were under the care of the neuromedical team, and I was familiar with procedures for transferring patients to the stroke unit of the rehabilitation hospital.

One day, I was assigned to a patient of the neurosurgical team who was fit to transfer to the rehabilitation hospital. This was my first time transferring a neurosurgical patient. Wondering if there were any differences in the management, I took the initiative to ask my preceptor, who was also the shift in-charge. My preceptor was furious with me again. ‘It is impossible that you don’t know how to manage the transfer! I have taught you!’ She shouted loudly at me at the nursing station. The noisy workplace suddenly quieted as those around us listened in stunned silence. I could feel the eyes of our colleagues on us. The situation was very embarrassing. Yet I was quite certain that she had not taught me anything about the transfer before. I tried to explain that this was my first time transferring a neurosurgical patient. During Annie's two-week absence, other senior nurses had taught me the operational knowledge for transferring neuromedical patients, but none had highlighted the potential differences when the caring for a neurosurgical patient. Annie continued shouting, saying ‘Use your brain to think!’ She warned the other nursing colleagues not to teach me. I felt so helpless, embarrassed and overwhelmed and I could feel my face flush and redden. Tears started to stream down my cheeks. With a heavy heart, I walked to the washroom to calm myself. I desperately wondered how I was supposed to come up with the appropriate way to handle situations like this when I was not taught any of the operational knowledge nor were any guidelines provided in a documented way that could be easily searched and retrieved. On my way back to the nursing station, feeling like I was walking to my execution, I saw another senior nurse in the injection room. We had to hide ourselves in a corner of the room while she explained to me in whispered tones that I had to call the neurosurgical unit of the rehabilitation hospital directly to make a reservation, and they would call us back if a bed was available.

Reflecting and writing my own story now, I still wonder why such a simple procedure - just make a phone call - had to be ‘taught’ in such a horrendous way. Although I was assigned a preceptor, I was not taught or supported by her at the very beginning of my role transition. She expected a level of competence from me based merely on the length of time I had worked as an NGRN, that is, two weeks, but not

based on the kind of support and teaching I received from the other nursing colleagues in our busy and complex neuroscience unit. In fact, I was confident in my own nursing skills and knowledge. My preceptor's frequent dissatisfaction and scolding were related to the operational knowledge that I could not and should not have been expected to gain through thinking. Honestly speaking, I was scared to work with my preceptor in any sense. Even when I was not working with her on the same shift, I could be scolded by her when I was either delivering to or receiving from her a handover of patient care. I soon developed 'preceptor-phobia'! That is also why the image of sailing without a rudder emerged when I reflected on my transitional experience. By not providing me with the needed teaching, my preceptor seemed to have forced me to sail without a rudder and I had to ask others for help or improvise dangerously.

1.5 Situating in the 'villain village'

In the absence of the necessary guidance from my preceptor, I had to seek advice and ask for help from the other senior nursing colleagues. Through all these interactions, I gradually realised that some seniors were less approachable, unsupportive and reluctant to teach. Other seniors might have offered me advice but their advice often did not conform with what other seniors and especially my preceptor expected. If I was working with those seniors who were more supportive and their teaching was 'reliable' in the sense that it was likely to be accepted by the others in the unit, I tended to approach them when they were available. However, there were many times when I had to work with my preceptor and other less approachable colleagues, and therefore I risked being scolded when I wanted to ask a question or clarify something.

I also heard how my neuroscience unit was notorious among the nursing professionals in the other units in my hospital, who called it the 'villain village'. The villain village was famous for having very senior and experienced nurses with high expectations of the new graduates or other nurses who were newly rotated in and who tended to scold whenever their expectations were not met. During this period in the villain village, I worked extremely hard to double check everything I did, not only to ensure that I made no mistake that might harm the patients but also to minimize my chances of being scolded. I always stayed overtime to study the kardex

(flip chart folders in which patient notes are recorded by different health care professionals), making a conscious effort to make sure that I could answer the questions that I anticipated being raised by the seniors related to my team of patients. Reflecting on all of this later, after I had successfully adapted, I attempted to restory or recast the story of their scolding culture, which might have been shaped by the nature of the neuroscience unit and their educational background.

Many of the patients were vulnerable, had difficulty communicating and were less able to protect themselves due to their neurological diseases. Therefore, good nursing observation and assessment were needed. Apart from the need for advanced and highly specialised knowledge and skills, the need for various types of basic nursing care was also intense as many of the patients were partially or even totally dependent on such care, which included assisting patients to turn on their side every two hours to prevent pressure sores from developing, sitting them out of bed, napkin changing, feeding and tube feeding, wound dressing, all of which are very labour intensive. The number of assessments and documentation forms seemed to be larger due to the complexity and dependency of care needed in the unit. The complex nature of such a highly specialised unit might have shaped many of the senior nurses, including my preceptor, to be extremely cautious and meticulous when nursing their patients and teaching the younger nurses. They tended to scold whenever the care by the young nurses deviated from their expectations or stories of competence.

In fact, most of these senior nurses had graduated from nursing schools, and were treated as part of the nursing workforce in training and learning in the clinical setting. By contrast, their clinical practicum hours were more than triple my limited 1560 hours of clinical placement hours as a baccalaureate nursing student, although I had gained extra hours through an overseas clinical placement in Melbourne, Australia. They might not have been able to understand the kind of university education that many of the new graduates received. Shaped by the nursing school's apprenticeship model, they might have repeated the same use of scolding of the younger nurses whenever their expectations were not met. The scolding nature of the villain village contributed to my great sense of sailing without a rudder. However, there was another layer to my complex story of transition.

1.6 The water current continues to push up the rudder

In such a highly specialised neuroscience unit, former new graduates usually worked for one year or even longer as ward runner, working only on ward routine, before they were given the chance to work as team leader with their own patient assignment. However, my experience was different and I only worked as a ward runner for three weeks in this new and complex environment before being immediately assigned to be a team leader in charge of the care of 8 to 12 patients. This occurred because several senior nurses resigned or moved to other workplaces and other nurses reported sick. Normally, we had one shift in-charge nurse, four team leaders and one ward runner. When someone reported sick, there were generally two ways to deal with the situation. Either the responsibilities of the ward runner were shared by the four team leaders, or a nurse continued to work as a ward runner, while the patients were divided among the remaining three team leaders who shared the responsibility of a larger number of patient assignments. That was how I came to be assigned to be a team leader. Because we were so understaffed, close supervision continued to be absent. Some shift in-charge nurses might double check my team of patients and their documentation before the end of shift to ensure that I had not made any mistakes or missed anything, while others did not, merely answer any questions I raised when I was aware of a problem or a learning need. That was why most of what I learnt depended on my work experience, which was neither systematic nor built on previous teaching and was highly dependent on my own awareness of any problems or knowledge deficit. Another way I learnt was when my mistakes were discovered by my seniors or after being scolded. That was why every shift was very stressful, especially when all beds were fully occupied and any bed that was newly vacant after a patient was discharged was reoccupied by a new patient admission during the same shift. I can still recall how disorganised my handovers were at the beginning, as I could not relate yet the patient diagnosis, medical histories, laboratory results, and prescribed investigation and treatment. It took me three months of struggling to be a team leader before I began to have a sense that I had adapted to this new role.

However, the challenges did not subside as the nursing shortage problem in our unit continued. The neuroscience unit had a central cubicle that was similar to a high dependency unit, with physiological monitoring machines that were connected to the central monitors in the nursing station. This central cubicle was reserved for the most

critical and acute patients, such as those transferred out of the intensive care unit (ICU) with various types of drains still in their heads after the neurosurgeries, or those who have breathing problems and were connected to the ventilators. On the two sides of this central cubicle were two cubicles which were also reserved for the more unstable and critical neuroscience patients. I had been taking care of patients in the remaining cubicles that were further away from the nursing station, who were relatively more stable. However, I was assigned to work at the central cubicles to care for critically ill and unstable patients at a time when I had had only three months of clinical experience in working as an NGRN. This was due to poor skills mix. In fact, there were several enroled nurses (EN) who had many more years of clinical experience than me, but as ENs, they were not allowed to take care of patients at the central cubicle. The nursing shortage, especially the problem of an insufficient number of RNs to care for the patients in the highly specialised areas, was like erratic and unpredictable water current that continued to push up my rudder, adding difficulty to the sail.

1.7 Labeled as ‘the black one’ and usually struggling alone

After being assigned to work at the central cubicles, my colleagues began to call me ‘the black one’, as I was regarded as the one with bad luck or misfortune. I was usually the most busy team leader of the shift, juggling multiple happenings. For instance, I might have two patients with tracheostomies who needed frequent suctioning. After the doctor completed his rounds, I might be tied up in a case conference with the neuromedical doctors and other allied health care professionals in the meeting room because two of my patients who suffered from acute stroke had been chosen for discussion of how to improve their discharge planning. After the case conference, it was not uncommon for me to detect during the routine vital sign observation that the level of consciousness of two other patients had suddenly dropped, requiring an urgent computer tomography of their brain, or that they had experienced a sudden onset of tachycardia that required cardiac monitoring, medication infusion and the urgent consultation of the medical team. Meanwhile, the bed that was newly vacant after a relatively stable patient was transferred and handed over to another team leader was immediately re-occupied by a new patient who transferred from the ICU. In addition to settling the new patient, usually with

intravenous infusion, oxygen supply and tube feeding and even a drain in the head, I would also be busy with the thick pile of ICU printed documentation. Because the ICU used an electronic documentation system instead of a written one, I had to check them over to make sure that all required prescriptions, such as the medication, infusion and tube feeding, were correctly transferred to our written documentation. While I was finding the patient's intake and output to calculate the daily intake-output balance and to prepare to file the thick pile of printed documentation into the patient's kardex, the telephone might ring again. 'Bernice, you will have a new patient, who was intubated and transferring out by the helicopter from the Cheung Chau Island. Pick her up directly at the computer tomography suite and see if the patient needs a neurosurgery immediately or can wait after pre-operative tests are done.' Given this description of a typical day for me, the 'black one', it should not be difficult to imagine how chaotic my team was and how stressed-out I felt as an NGRN with only a few months of experience.

Thus, my transitional experience was like sailing alone without a rudder in a roaring stormy sea and in rainy and windy weather. Although some supportive nursing colleagues offered help as I was admitting an intubated patient in the already chaotic team, what my preceptor and other unsupportive ones said was, 'Leave her alone! She has to handle all this on her own!'. Their view was that I should learn independently and through my own experience. Nursing colleagues who tried to be supportive to me were usually called to leave me alone, forcing me to working on my own. My unit was located on the top floor of the hospital, just below the roof where the helipad for emergency transfers of patients from rural parts of Hong Kong was located. For quite a long time, it seemed that I had developed another phobia in addition to my preceptor-phobia: phobia associated with the noise of a helicopter. I felt frustrated and discouraged whenever I heard that noise, as it signalled another emergency admission that I had to handle all on my own! There were times when I would wake up from my dreams by a flashback of something being missed or the alarms of ventilators and monitors or the noise of the helicopter. As I write and rewrite my own stories on my learning and development, and issues with patient safety, they were found to be shaped not only by my assigned preceptor, but also other senior nurses whom I have encountered. Preceptoring seems to provide a rather narrow perspective. I kept wondering what did the term 'mentoring' mean to

frontline senior nurses and NGRNs for the latter's transition and pursuit of good work.

1.8 Persistently sailing towards the beacon in a stormy or foggy weather

Despite these chaotic circumstances, I persisted to live my story of nursing, like sailing towards the beacon in a stormy or foggy weather. I could not afford to spend much time sitting side by side with my patients, but I valued the short and intermittent periods of time that I could communicate with each of my patients to understand their needs, conditions, feelings and even their families. These usually happened when I was checking the kardex or writing the documentation and checking all paperwork before the end of shift, or while I was performing some basic nursing care for them, such as turning and wound dressing. Though this might reveal many problems, such as the need to change their diet on the computer system, or the need for a referral to a medical social worker, I empathized with my patients who were suffering from neurological diseases, which not only affected them physically but holistically, including their psychosocial, spiritual and financial dimensions. I valued the time when I could really understand my patients holistically and attend to their individualized needs. I always took the initiative to update the families with the patient's latest condition, and it was easy for me to establish close and trusting relationships with both the patients and their families, even those who had been labelled by other colleagues as difficult. I insisted on providing the best possible care within my scope, even if I had to work overtime. I enjoyed the interpersonal aspect of my nursing care. That was important to me, as I think a nurse should be nursing and caring for the patient and their families, rather than the paperwork. It was their smiles, their understanding and their appreciation that contributed greatly to my sense of satisfaction and sustained my stories of nursing or good work.

1.9 Supported by different mentors

My stories of nursing were consistent with those of some senior nursing colleagues. Paradoxically, one of them was my preceptor, Annie, although with some differences. As mentioned earlier, my preceptor had a high standard of nursing care, and was very proper, experienced and knowledgeable. In terms of patient care, we shared

many similarities in our nursing approach. Annie soon recognised my dedication to good work in nursing, such that our tense preceptor-preceptee relationship gradually developed into long-term, trusting mentoring relationship or friendship before she requested to rotate to work at another hospital nearer to her home. However, I have to admit that we have quite different stories of how to support, precept, or mentor NGRNs, and even our stories of nursing are different, as mine includes not only patients and their families, but also our nursing colleagues and others in the health care team. Nevertheless, with the same overriding goal in striving to provide best possible quality care for patients and their families, we developed mutual respect and continued to support each other in living our stories of nursing or good work. I gradually regard Annie as my mentor in both of my professional and personal lives.

Another was a nursing officer whose ongoing support and reassurance were very important to me. She was very supportive to new graduates and young nurses and is a role model of good work in nursing. Despite her leadership and management rank, she did not simply delegate but took the initiative to care for both patients and colleagues, even working overtime on the frontlines on busy and chaotic days. She supported and taught me a lot during my one-and-a-half year experience at the neuroscience unit, not only about neurosurgical knowledge and skills but in reaffirming the importance of upholding the values and ideals of nursing. When I experienced unhappy incidents like being scolded by my preceptor or being treated rudely during a handover at the ICU, she took the initiative to offer support, a listening ear and reassurance. She was very concerned about my situation, both professionally and personally. At other times, when she heard from others stories about what was happening to me, she took the initiative to discuss matters with me and debrief me. Before I had to rotate to another department, not by choice but as part of the preceptorship programme for all NGRNs, she made special arrangements for me and another colleague to observe some common neurosurgeries in the operating theatre. That was a valuable experience to me. Although she was not my assigned preceptor, we connected and established a close and trusting relationship. One time, she overheard me and another RN discover to our surprise that we shared the same birth date, and this nursing officer gave me a birthday gift because recognised me as one of the junior nurses who had a caring heart and she encouraged me not to give up my passion. In retrospect, my relationship with her can be seen as

informal mentoring or classic mentoring (Bennetts, 2002), and it was vital in supporting me through the overwhelmingly stressful transition period and sustaining my stories of nursing.

Looking back at my experiences before nursing, I can easily see many other important adults who supported me and influenced my life considerably, which is called mentor bonding (Darling, 1985c). For instance, two English teachers in primary school and three Chinese teachers in secondary school with whom I have maintained close contact and shared my personal life and reflections through letters, a very knowledgeable uncle and two university teachers whom I seek out for advice whenever I encountered difficulties. According to the temporal dimension of the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000), as well as the mentor bonding paradigm (Darling, 1985c), the experiences of mentor bonding and informal mentoring in my upbringing could have shaped my experience of mentoring as a nurse, as well as my understanding and interpretations of the meaning of mentoring and the meaning to my research participants. An awareness of the potential shaping effect of my narrative history is important throughout the narrative inquiry. In the same vein, I hope that my stories and those of my research participant resonate with you (my reader). An awareness of your narrative history is also important as they might shape how you interpret our stories and this narrative inquiry.

1.10 Questioning whether sailing towards the beacon is unrealistic

Although some supportive senior nurses and I continued to live out and tell our own stories of nursing, there were times when our stories bumped into the competing and even conflicting stories of nursing or patient care told by others. I used to sacrifice my break time on both the morning and afternoon shifts and worked overtime to meet my patients' needs, while ensuring that nothing was missing from any of the documentation and that no mistake had been committed. It was impressive that a frank, influential and experienced health care assistant (HCA) said to me more than once, 'Bernice, you are too passionate! You can't get all things done!' Even with the availability of a hoist to lift patients, getting a patient out of bed is a labour intensive task in an already busy and labour intensive workplace. Nonetheless, sitting a patient up has been shown to be beneficial to hospitalized patients. While other caring

nurses and I advocated getting patients out of bed and participated in the process actively, the story told by the unsupportive nurses and HCAs was that we were the 'troublemakers'. Furthermore, it was not uncommon for me to observe that some senior nurses were task- and paper-oriented and 'efficient', as they simply followed doctor's prescriptions and focused on getting all routine care done while ignoring the gurgling sounds of a patient who was desperately in need of frequent suctioning. Some even cut corners. There were medical colleagues who simply labelled patients and their families as 'problematic' and refused meet them to explain the patient's condition despite their repeated requests.

Though I had been sustaining my stories of nursing, I could not deny that other peoples' stories of nursing had an effect in shaping me. There were times when I questioned myself, especially when I was exhausted by the complex and busy health care landscape.

What is GOOD WORK IN NURSING?
How does it vary depending on the perspectives of different people?
Is GOOD WORK too much of an ideal in the current health care landscape?

My personal justification is not confined to my own personal experience that began with an extraordinarily negative transitional experience at the neuroscience unit to a relatively positive transitional experience at the surgical unit and AED in my subsequent clinical rotation. In fact, my experience was not uncommon, and many of my classmates experienced similarly challenging and overwhelming transitional experiences. Many of my university classmates and some ex-colleagues left the public hospitals under the Hong Kong HA in their first few years of clinical practice and shifted to work in the private sector. Throughout my years of practice, I have witnessed good nurses gradually giving up their 'ideal' stories of nursing under the multiple tensions in the complex health care landscape. My research interest was confirmed by my ongoing observation at the AED that NGRNs' transitional experience remained stressful and chaotic in the complex health care landscape. My brief observation of other units when I participated in emergency transfers of my patients at my hospital, as well as listening to the stories of other NGRNs served as further confirmation. In fact, the high expectations others, the negative workplace environment and the scolding culture were not limited to NGRNs but was also felt by

other new staff, ranging from newly employed HCAs, newly graduated ENs, newly rotated-in nurses and doctors. All these stories, told and lived in the complex health care landscape, served as personal justification for me to gain an in-depth understanding of NGRNs and their contexts through narrative inquiry to better understand the following research puzzles and to retell the stories of NGRNs.

- What are the experiences in the first two years of other NGRNs in transition and in pursuit of good work in nursing?
- What is their perception of their 'mentoring' experiences during their transition and in their pursuit of good work in nursing?
- How their stories of experience and meanings of 'mentoring' may help us to see new possibilities and address 'mentoring' in the support of NGRNs' learning in transition and their sustenance of good work?

1.11 Study purposes

The purpose of this study is two-fold. First, it aims to understand the first two year of experience of NGRNs in transition and in pursuit of good work in nursing, and what the 'mentoring' experience means to them through their stories of experiences lived and told in the complex health care landscape. Second, it examines the possibilities to address 'mentoring' in the support of NGRNs' learning in transition and their sustenance of good work.

1.12 Definition of terms

1.12.1 Newly graduated registered nurse

'Newly graduated registered nurses (NGRNs)' refers to general registered nurses newly graduated from undergraduate nursing programmes and newly registered at the Nursing Council of Hong Kong who are in their first two years of clinical experience. There are two main reasons for setting the two-year boundary. First, previous studies have identified that the practice readiness of new nurse graduates might take two years to fully develop (Wolff, Pesut & Regan, 2010; Wolff, Regan, Pesut & Black, 2010), and novice nurses may take at least two year to become competent nurses (Benner, 1984). Second, the two-year duration aligns with the two year-preceptorship programme provided by the Hong Kong HA for each newly employed nurse graduate (HA, 2010a).

1.12.2 Mentoring

Mentoring, in this study, is used tentatively to refer to the process by which a person is guided, taught, and influenced in important ways by people, events, situations and circumstances (Angelini, 1995; Darling, 1985a). This term was tentatively used as the understanding of this concept as part of a larger phenomenon will only be revealed from the field texts. Meanwhile, a two-year preceptorship programme is provided for each NGRN employed by the public hospitals under the Hong Kong HA with an assigned preceptor in the unit and a clinical rotation to another specialty after their initial unit (HA, 2006). Preceptoring can be viewed as a prescriptive, functional and enabling relationship that has an organizational dimension and that functions within a structured framework. The new staff is formally assigned to or matched with a qualified and experienced employee to provide a structured learning support for achieving externally set objectives.

I brought the broader operational definition of mentoring with me into the field for two main reasons. First, mentoring is chosen to be the research focus as the study aim is to explore new possibilities to improve the 'mentoring' experience of NGRNs for not only better transition, but also sustenance of good work in nursing. With the rather broad operational definition of mentoring, it encourages a more holistic understanding of how an NGRN in transition and sustenance of good work is guided, taught, and influenced in important ways by not only their assigned preceptor, but also other senior nurses, people or events in the health care landscape. In contrast, preceptoring or preceptorship is a form of staff orientation that is confined to a short and limited period of time when compared with the process of mentoring. Preceptoring aims at preparing and facilitating transition, however, might have limitations to support NGRNs in sustenance of good work throughout their first two years of practice. Under the shaping of the short duration and nature, preceptoring also differs from mentoring in that, if there is any psychosocial component at all, it is quite small. A preceptor can evolve into a mentor if the relationship continues to grow with the addition of the missing psychosocial component (Billay & Yonge, 2004; Hodgson & Scanlan, 2013; McCloughen, O'Brien & Jackson, 2006; Meier, 2013; Mills, Francis & Bonner, 2005; Morton-Cooper & Palmer 2000; Stewart & Krueger, 1996; Yoder, 1990). Second, although a 'two-year' preceptorship

programme is provided for NGRNs, the duration that NGRNs were assigned by the ward managers to work with their preceptors was often limited to the first few weeks or even less like my past experience. Many of the NGRNs did not have the chance to work with their assigned preceptors and being influenced in important ways under various factors. The 'two-year' seems to refer only to the period for NGRNs to have a clinical rotation to a second specialty after their initial unit.

It is important to highlight that mentoring is different from the related term of preceptoring and using the two terms interchangeably could lead to conceptual confusion and hinder conceptual development. Therefore, in this dissertation, the concept of mentoring and preceptorship, and the terms mentor and preceptor, are distinguished from each other and are not being used interchangeably, with the hope of enhancing conceptual clarity. Meanwhile, in the participants' quotations, their use of term mentor interchangeably with preceptor is retained to reveal the confusion at the operation level. Nevertheless, increasing the possible conceptual clarity of mentoring and preceptoring might also eliminate misalignments of expectations among different stakeholders in the health care landscape.

1.12.3 Mentor

Mentor, in this study, refers to any person who leads guides, and advises an NGRN in important ways. Along with the encompassing definition of mentoring, a mentor is therefore, not confined to those interactions with a particular person who is formally assigned to each NGRN under the structure of an organization, such as the preceptor, but could refer to other people in the NGRNs' professional and even personal life, such as other senior nursing colleagues, other NGRNs (peers), ward managers, patients, families and even the NGRNs themselves.

1.12.4 Preceptorship

Preceptorship, in this dissertation, refers to the prescriptive relationship between an NGRN and the preceptor assigned by the institution. According to a hospital document of the HA in guiding the public hospitals to plan and implement the preceptorship programme, preceptorship is expected to be an individualized teaching/learning arrangement in which the preceptor is immediately available in the clinical setting to act as a role model and to provide guidance to the NGRN (HA,

2006). It is worth noting that this expectation may not be met at the operational level in daily practice.

1.12.5 Preceptor

A preceptor, in this dissertation, refers to an experienced and competent unit-based nurse who is formally assigned to the NGRNs by the institution. According to the hospital guideline, a preceptor is expected to carry out one-to-one orientation and act as a role model within the clinical setting to facilitate the NGRN's socialisation and development of nursing skills. It is also recommended that a preceptor be a registered nurse for a minimum of two years and preferably have a minimum of 12 to18 months in the unit (HA, 2006).

1.12.6 Good work in nursing

Good work is defined as work that is excellent, engaging and ethical (Gardner, 2010). It is shaped by four major sets of forces: cultural control in a profession, social control in a professional context, the personal standard of an individual professional, and the outcome control. Good work is likely to be actualized when the four sets of forces are in alignment or when the professional standards, peer behaviours, internal values and social values are all pointing in the same direction (Barendsen et al., 2011).

Good work in nursing is defined as work that is technically and scientifically effective, as well as morally and socially responsible, or simply refers to quality patient care that is in the best interests of the patient (Miller, 2006).

1.13 Organization of dissertation

The study is presented in five main parts. The first part includes this introduction and the following three chapters which delineate both my personal justifications for and the social significance of conducting this narrative inquiry. This chapter provides an overview of my own narrative history in transitioning to become an NGRN and my reflections in articulating my personal justifications.

As a novice researcher learning to be a narrative inquirer, the entire inquiry process shared many similarities with the challenging experience of my NGRN participants, which was filled with various tensions. One of these tensions was whether or not to have the conventional or statutory literature review chapters. The tension to avoid the conventional extensive literature review was in line with the underpinning of narrative inquiry, with the particular concern about thinking narratively instead of thinking formalistically that devalued the experience and practical knowledge of participants and limited the development of new understanding and knowledge (Clandinin & Connelly, 2000). This is not unique to narrative inquiry, but is also found in other qualitative methodologies such as the grounded theory, phenomenology and ethnography (that all three methodologies inform the narrative inquiry is further discussed in chapter 5). In all of these methodologies extensive reading of the literature often is delayed until after the conversations with the participants takes place, so as to maintain an open mind and avoid beginning the study with pre-conceived ideas (Glaser, 1992; Munhall, 2012; Wolcott, 1990). Also, imposing a structured step-by-step description and appraisal of my literature retrospectively would have separated and disconnected the review chapters from the remaining ones in the dissertation, in addition to failing to authentically capture the inquiry process, which repeatedly moved back and forth and was at times chaotic (Silverman, 2010).

In order to balance the above with the expectation of a statutory review chapter, the following three chapters provide a scan of the relevant literature about good work, experiences of NGRNs and mentoring. The literature search was conducted by searching the Medline, Cumulative Index to Nursing & Allied Health Literature (CINAHL), PsychoINFO and Scopus databases, covering English-language sources published from 1985 to 2015. The search terms used include the following: good work, mentoring, mentorship, mentor, mentee, protégé, neophyte, field education, transition, transition to practice, socialisation, entry to practice, transition programme, orientation programme, residency, internship, externship, novice nurse, new staff, new nurse, new nurse graduate, new graduate nurse, newly graduated nurse, newly graduated registered nurse, newly hired nurse, newly-licenced registered nurse, newly qualified nurse and entry-level nurse. However, in view of the conceptual confusion and the use of the terms preceptor interchangeably with mentor in the

literature (Stewart & Krueger, 1996; Yoder, 1990; Yonge, Billay, Myrick & Luhanga, 2007), the search terms preceptor, preceptee, preceptorship, preceptoring and precepting were also used in the search of the relevant literature. In addition to the electronic databases, the reference lists of studies retrieved in the databases were reviewed to identify other relevant references that contributed to the theory and research of the four research areas. Seminal works published decade ago were also included.

The main purpose of the three chapters is to demonstrate the social significance and to justify this research study. I chose to tell the story of my narrative inquiry by representing literature that give me a vicarious experience of both good and bad impressions, which prompted me to reflect and ask more questions. The questions raised are not confined to what is there, but include what is not there, which might be the gold nuggets that had been taken-for-granted (Clandinin & Connelly, 2000; Munhall, 2012). The scanning of literature attempted to be broad rather than restrictive, for the sake of the development of theoretical sensitivity (Glaser, 1978; Glaser & Strauss, 1967). The use of 'scanning literature' as the chapter title is to remind readers that the literature review process is an ongoing one and not confined to these three particular chapters. Insight s and influences of other theoretical literature are interwoven at relevant points throughout the later chapters along with the iterative process in writing the field texts into the final research texts.

The second part provides an account of the methodology adopted in the study, including my own eye-opening experience of narrative inquiry, justifications for using narrative inquiry as the research methodology, explanations of some of the key narrative terms for the reading of the subsequent parts of the dissertation, and the detailed process from gaining access into the field to writing the field texts into the research texts.

The third part of the dissertation contains chapters with the interpretive accounts of six of my NGRN participants. The fourth part illustrates the four narrative threads and their relationships, interweaving the stories lived and told by my NGRN, preceptor, and stakeholder participants and myself as a nurse in the complex health care landscape, as well as the narrative inquirer. As mentioned earlier, relevant

literature are integrated in these two parts while presenting and discussing the findings from the narrative and paradigmatic analyses. The final part addresses the limitations of the study, provides a summary of the research findings, reiterates the contributions of the narrative inquiry, and concludes by providing an account of the implications and recommendation for nursing education, practice, policy and further research.

CHAPTER TWO

SCANNING LITERATURE OF GOOD WORK IN NURSING

2.1 Introduction

This chapter examines the concept of good work in nursing in the rapidly changing health care landscape. Beginning with my own narrative history of being attracted to good work, I will delineate the conceptualization of the good work and scan the relevant research studies.

2.2 Attracted by the beacon of hope in the darkness

Ever since childhood, I have had an especially strong interest in the health care field. I became a nursing student after graduating from secondary school in 2003, which was also the year Hong Kong was significantly impacted by the outbreak of Severe Acute Respiratory Syndrome (SARS). This painful history reminds me that health care professionals experience anxiety and stress when faced with daily exposure at work to emerging infectious diseases. It also reminds me not to take things for granted, but to stay alert to the dynamic, uncertain and unpredictable nature of the health care landscape.

Hong Kong is no different from overseas countries in facing a nursing shortage and an aging nursing workforce, as well as an aging population. Although the Hospital Authority (HA) can depend on the nursing schools to supply nursing students, and despite the 2012 increase of local university nursing programmes to 1800, this is still insufficient to meet the need for 1700 new nurses each year, in competition with the private sector for additional new nurse graduates (HA, 2012). Furthermore, the number of nurses reaching retirement age will drastically increase beginning in 2018, when about 320 nurses will retire double the 161 who retired in 2014 (Hong Kong Information Service Department, 2013a). Thus, the current low nurse-to-patient ratios in the public hospitals is unlikely to improve (the current average nurse-to-patient ratio for the three shifts of morning, afternoon and night are 1:11, 1:12 and 1:24 respectively) (Hong Kong Information Service Department, 2013b). This is in

great contrast to the statutory ratio of 1:4 to 1: 6 in the State of Victoria in Australia and in California in the United States (International Council of Nurses, 2009). Nurses in Hong Kong public hospitals report high stress levels at work and strong intentions to leave and only moderate job satisfaction, owing to their heavy patient load in the busy and complex health care landscape (Lam, 2013; Wang, Kong & Chair, 2011). While an older study indicated that one-third of Hong Kong nurses had poor mental health (Wong, Leung, So & Lam, 2001), it is alarming to note that in recent years some nurses, ranging from nursing students to newly promoted advanced practice nurses, were unable to cope with their work stress and committed suicide (Apple Daily, 2005, March 4; Apple Daily, 2012, May 27; Apple Daily, 2012, June 6).

Furthermore, a growing body of literature suggests that a nursing shortage, nurse burnout and quality of patient care are closely related (Currie, Harvey, West, McKenna & Keeney, 2005; Poghosyan, Clarke, Finlayson & Aiken, 2010). Unfortunately and alarmingly, a long list of serious medical errors related to nursing professionals in Hong Kong public hospitals is readily available in the annual report on sentinel and serious untoward events (HA, 2015a). To name just a few, they include giving a wrong blood transfusion to a newborn (HA, 2009), injecting oral syrup morphine into a patient's vein (Apple Daily, 2009, August 29), mixing up two infants and discharging them to the wrong families (Apple Daily, 2009, August 17), injecting newborn babies with expired vaccinations (Apple Daily, 2009, August 26), scalding a baby boy with hot bath water, resulting in a second-degree burns over the perineum, buttock and bilateral lower limbs (Apple Daily, 2010, April 10), causing the death of a patient suffering from motor neuron disease when his oxygen supply was suspended after he had been transported to another cubicle in the same unit (HA, 2014a), and transplanting a heart of the wrong blood type (Apple Daily, 2013, May 22). It is important for us to learn from all these painful and negative experiences and rethink how we can provide quality patient care in spite of all the challenges in the health care landscape. In addition to finding strategies to overcome each new obstacle to quality of care, it might be high time for a paradigm shift. We need to explore from a positive perspective how nurses sustain their professional values and commitment to excellence and passion in nursing. Good work is the beacon of hope in the darkness.

2.3 The GoodWork ™ Project

In the mid-1990s, Harvard University psychologists Howard Gardner, Mihaly Csikszentmihalyi and William Damon began exploring the concept of good work in the United States. They chose genetics and journalism as the first two distinct professions in which well-known figures were nominated by experts in those fields to undergo semi-structured in-depth interviews to understand how they sustain both excellence and ethics at work in the face of powerful political, cultural, social and economic forces (Gardner, Csikszentmihalyi & Damon, 2001). This was how the GoodWork ™ Project began. The inquiry soon extended to high-achieving students and young professionals in journalism, genetics, and theatre (Fischman, Soloman, Greenspan & Gardner, 2004). The GoodWork ™ Project soon resonated with many other researchers in various other professions, including business and social entrepreneurs, law, education, digital media, philanthropy, and medicine, and grew into an enormous undertaking. Young entry-level professionals and experienced professionals who had achieved distinction in their respective professions were identified and interviewed about the strategies they used to maintain their commitment to good work in an era that emphasizes productivity and profitability, often at the expense of quality work. The GoodWork ™ Project hoped to increase the prevalence of good work in society (The Good Project, 2015).

Good work is defined as work that is excellent, engaging and ethical (Gardner, 2010). These three attributes are essential and indispensable. Excellence refers to work that is technically proficient and supported by the latest knowledge. Engagement refers to work that is personally meaningful, satisfying and fulfilling. Ethics refers to work that is responsible to the broader society even when it goes against the immediate interests of the worker (Gardner, 2010; Barendsen et al., 2011). Empathy is the fourth attribute that also starts with an E. It might not be applicable to some professionals, such as journalists and scientists, but it is paramount in the caring professions, such as nursing (Gardner, 2010). Unfortunately, the pursuit of good work is often challenging in contemporary society, which is dominated by the three Ms – money (money and profit), markets (market forces), and me (self-centredness). Instead of good work, the result can be compromised work, which is work that is

legal but undermines and deviates from the core values of the profession. Gardner (2010) suggests that society needs to change by rotating the three ‘M’s on their side to yield the three ‘E’s mnemonic: excellence, engagement and ethics, the three essential attributes of good work. The E can be rotated once more to yield a ‘W’ that stands for ‘We’, for a better society.

Good work is shaped by four major sets of forces, namely, cultural control in a profession, social control in a professional context, the personal standard of an individual professional, and outcome control. Cultural control refers to the core values and beliefs of a profession. Social control in a professional context refers to the group of people working in the domain who influence the regulations of the profession; for instance, the nursing councils and associations, deans and faculty of the nursing schools, influential figures of the profession, hospitals and even individual units. Personal standard refers to the internal force or internal values of individual professionals. This is often shaped by social and cultural controls and past experiences and values, as well as the personality and temperament of the individual. A professional usually internalizes perceived requirements into his/her self-image or professional identity or in narrative term stories to live by (Connelly & Clandinin, 1999). The fourth set of forces, outcome control, refers to the external forces from the larger domain of society, which establishes rewards and sanctions that affect the entire profession. Therefore, good work is likely to be actualized when the four sets of forces are in alignment or when professional standards, peer behaviours, internal values and social values all point in the same direction. Otherwise, confusion could result when conflicts arise between the different forces, which might lead to compromised work that does not make sense to the individual professional (Barendsen et al., 2011; Gardner, 2005). In fact, none of the four sets of forces is static, but can change over time. Therefore, all alignments and misalignments are temporary and subjected to change according to the development of the four sets of forces (Barendsen et al., 2011; Gardner et al., 2001). Correspondingly, six factors were identified that determine the likelihood of an individual to perform good work. They include personal beliefs and values, role models and mentors, peers, previous pivotal experiences, norms of the institutional milieu, and ongoing support from others in the same field and domain. When these six factors all point in a positive direction, good work is highly likely to occur (Fischman et al., 2004).

The above conception of good work concluded that ideal good work for journalists, geneticists, theatre performers and other professionals may have crucial differences from that of nursing professionals. This may arise from the unique nature, histories and related work structures of the nursing profession. Further examination of the concept of good work in nursing is needed to understand how nurses perceive good work, and to identify the opportunities and obstacles, as well as strategies to sustain a commitment to good work, which would benefit not only the nursing professionals themselves, but also the patients and their families under their care.

2.4 Good work in nursing

Good work from the perspective of nurses has been only briefly explored. There is paucity of literature on the concept of good work in nursing, with the few studies that do exist having been conducted in the United States, Norway, Sweden, and Australia. Joan Miller (2006) was the first nursing scholar to adopt the research methodology of the GoodWork ^{TM} Project (The Good Project, 2015) to understand the meaning of good work in the nursing profession in the United States, using semi-structured interviews and prioritising 30 given values. Participants included eight young nurses with less than five years experience who were nominated by supervisors, former faculty members and peers for their commitment to excellent nursing, and 16 more experienced nurses in administrative positions in their hospitals or universities who were selected based on their national or international distinction held (Miller, 2006). Despite the varying levels of professional experience, both young and experienced nurses shared many similarities in their perceptions of good work. Quality care was recognised as their overriding goal in nursing. ‘Honesty and integrity’ and ‘quality of work’ were two of the 30 values that both young and experienced nurses ranked in the top four most important values. Possibly due to the influence of their different roles and generations, ‘understanding and helping others’ and ‘faith’ were the other two values ranked first and third most important by the young nurses, while the experienced nurses ranked ‘teaching and mentoring’ and ‘hard work’ third and fourth most important. Positive formative influences from role models including parents and mentors, as well as a supportive work environment characterized by teamwork, cohesiveness and shared values, were identified as opportunities for good work in

nursing. Young nurses emphasized expressions of gratitude as a motivation to perform good work. Unsurprisingly, nursing shortage, demands on time, conflicting values, lack of autonomy and market forces that emphasized productivity were among the obstacles listed as impediments to good work in nursing. In order to overcome these obstacles, both groups of nurses adopted strategies such as prioritisation, team building, contemplation and reflection. While experienced nurses tended to use value alignment when there were conflicting values in the health care team, young nurses tended to avoid conflict altogether (Miller, 2006). The use of avoidance among young nurses at the lower echelon of hospital hierarchy requires special attention, as failure to speak up within the interdisciplinary team for their patients in a vulnerable state might jeopardize patient safety (Law & Chan, 2015; Okuyama, Wagner & Bijnen, 2014). Miller (2006) defined good work in nursing as work that is technically and scientifically effective, as well as morally and socially responsible, which is a definition adopted by subsequent nursing researchers examining the concept of good work (Welk, 2013).

Welk (2013) conducted a very similar qualitative descriptive study in the United States. It was a longitudinal study that focused on how newly-licenced nurses understood the concept of good work in nursing when they had just graduated from their baccalaureate nursing programmes and again one year later (Alichnie & Miller, 2012). Only the findings of phase one of the studies can be retrieved, and they are similar to the findings reported by Miller (2006). The new nurses in the first three months after obtaining their licences perceived their primary responsibility to be duty to patients. While positive role modelling and support, cohesion and teamwork were once again regarded as opportunities for good work, negative role models, who over delegated their work to the others, were reported as an obstacle to good work.

The study of good work in nursing soon spread to the other parts of the world. Christiansen (2008) also conducted a qualitative study in Norway by conducting semi-structured in-depth interviews with ten young nurses with less than two years experience to understand how they recognise themselves in doing good work. The study assumes that recognition of good work may serve as a source of consciousness-raising of professional and ethical guidelines in the working environment. Three themes were identified which revealed that good work in nursing is dependent on

context. Good work is confirmed when the needs of the patient and their families are fulfilled. When the condition of the patients improved or patient education was assimilated, nurses developed a sense of satisfaction. In contrast, when patients deteriorated, nurses experienced dissatisfaction and even emotional strain. This finding was consistent with one of the attributes of good work, engagement (Gardner, 2010). The second theme is managing the flow of responsibilities, which is more than getting the work done, but rather, emphasizes the importance of getting the overall picture of ongoing daily activities. If time permits, good work means that care is implemented according to their plans; otherwise the list of tasks has to be prioritised according to importance. The third theme is positive feedback, which means that good work is being confirmed by peers, doctors, management and most importantly their patients. Young nurses in Norway (Christiansen, 2008) and the United States (Miller, 2006) shared similar views of the meaning of good work. Their view of nursing care was more internalized and focused on an individual rather than a team approach to care, and they required others' feedback for reassurance. In contrast to the young nurses, the veteran nurses' concept of good work revealed a broader perspective. They mentioned not only caring, but empowering and advocating for patients, as well as teaching and mentoring, and cultivating a learning environment to increase the prevalence of good work among their younger colleagues. Therefore, the perception of good work can change based on context, as well as temporally along with the personal and professional development of nurses.

In the same vein as Christiansen's (2008) work, Cleary, Horsfall, O'Hara-Aarons, Jackson and Hunt (2012) recognised the dearth of knowledge on optimism or positive thinking in nursing, and the limited acknowledgement of good work in nursing in honouring nurses' achievements despite the challenging health care landscapes and their setting role models for others to emulate. Using a qualitative interpretive approach and conducting interviews as the data collection method, they explored good work in nursing from the perspectives of 40 mental health nurses in Australia. Establishing positive and trusting relationships with patients, especially those who were aggressive, depressive and even suicidal, and providing practical and holistic support, as well as observing the improvement of patients in terms of their mental health, were recognised as good work in nursing which were patient-related. While participants were invited to describe their achievement of good work on an

individual basis, participants also reported teamwork with good communication, professionalism, morale, fluid transfer of leadership and initiative. Though the authors did not indicate how many years of experience the mental health nurses had, the nurses' level of seniority was revealed through their leadership, teaching and mentoring roles. Their recognition that good work occurs when teamwork is achieved revealed the importance they placed on a team approach when caring for mental health patients, work which usually involves aggressive patients and other safety issues. This contrasted with the perception of good work among young nurses, which tends to be individually focused. More than half of the participants indicated their sense of optimism-pessimism was determined by their work environment, other colleagues and management, and patients (Cleary, Horsfall, O'Hara-Aarons, Jackson & Hunt, 2012).

While most of the studies in exploring the perceptions of good work were conducted using qualitative methodology, Josefsson, Åling and Östin (2011) adopted a quantitative descriptive design. The perception of good work among 213 registered nurses working in Swedish municipal elderly care was investigated using a structured questionnaire modified from two Swedish questionnaires, with a theoretical underpinning of action and social theory, systems theory and the Karasek and Theorell's demand-control-support model. Shaped by the theoretical underpinning of the original Swedish questionnaires, the findings reflect not only the work values, degree of independence, and future perspectives of the nurses, but also issues in the work environment and condition. From the perspective of the registered nurses working in municipal elderly care, good work has multiple dimensions. Personally, work has to be intellectually stimulating without resulting in guilty feelings, must provide freedom and autonomy with the possibility to influence important decisions, be beneficial to others, and not conflict with personal values. Socially, the nurses considered fellow workers who are appreciative and pleasant, as well as a manager who is fair and understanding to be very important. They expected innovative thinking and believed that initiative should be highly valued. Spatially, the work environment has to be safe, free of violence, and provided with adequate equipment. Financially, the work has to be secure and provide a steady income, which can be increased by putting in greater effort.

Despite the potential demographical, cultural and contextual differences, the views of good work among nurses with varying years of clinical experience from different countries, hospital systems, hospitals, specialties and units are highly consistent with one another (Christiansen, 2008; Cleary, Horsfall, O'Hara-Aarons, Jackson & Hunt, 2012; Josefsson, Åling & Östin, 2011; Miller, 2006; Welk, 2003). On one hand, the studies seem to imply that nurses across different countries share very similar concepts of good work. On the other hand, it might be possible that good work in nursing situated on the complex and rapidly changing health care landscape has been oversimplified. In the following section, the oversimplification is explored and how Clandinin and Connelly's (2000) narrative inquiry might contribute to better understand the concept of good work in practice is highlighted, while details of the methodology will be presented in chapter 5.

2.5 Is good work in nursing being oversimplified?

This oversimplification of the concept of good work in nursing seems to have three dimensions. First, the oversimplification might be related to methodological issues in these studies, resulting in findings that are timeless or decontextualized. It is important to note that all of the published research studies examined above explore nurses' perceptions of good work only at a single point in time, like a snapshot of a single moment that does not take into consideration what happened before or after the snapshot was taken. Without extending the data collection beyond a single point in time, any changes or developments cannot be tracked. The need for longitudinal studies about good work and educational intervention was supported by Miller (2013). It is also unknown whether this perception of good work can be sustained over time or through difficult times and continued to represent the practice of nurses taking care of patients and their families. Nevertheless, understanding the forces leading to these changes or developments is paramount to facilitate the preservation and sustainability of good work in nursing. Narrative inquiry with the emphasis on temporality could address how the present can be shaped by the past and re-shape the past as well as inform the future.

Furthermore, the findings seem to be oversimplified into decontextualized themes. This might be influenced by the reductionist thinking and the word limits of journal

articles. However, even when the decontextualized themes were presented as interrelated, they seem unable to capture the complexity of the multi-layered health care landscape and appeared to be a list of ideals or dreams that were unreachable and unrealistic to practitioners, who are always being pulled by different and even conflicting influences. Without providing information about the context and the nuances of the nurses' experiences, the findings might not be useful as a source of consciousness-raising of professional and ethical guidance as expected by Christiansen (2008). They might seem too abstract and limit the degree to which other nurses, especially novice nurses, can emulate the examples given. These problems expose a need for a paradigm shift in further research.

The second dimension is that oversimplification might be related to dichotomous thinking. Barendsen et al. (2011) reemphasized that good work is more likely to be actualized when the four sets of forces are in alignment. However, previous studies of good work in nursing seem to paint an exquisite picture of nursing as though all sets of forces are well aligned, when in fact they usually are not in the complex and dynamic health care landscape. Therefore, the concept of good work seems incomplete. This might be related to the design of previous studies, which merely elicited perceptions of good work from a single perspective. Misalignments among the four sets of forces might become more prominent when the experiences and perceived meanings of different stakeholders in the health care landscape are scrutinized. The personal-social interaction dimension of the narrative inquiry space (Clandinin & Connelly, 2000) could contribute to a better understanding of the misalignments. It is important for nursing practitioners, management, leaders, policy makers, educators and researchers to understand where there are misalignments that impede good work in nursing. Otherwise, unrelieved misalignments might increase the likelihood that nurses experience both physical and emotional exhaustion, negativity, and loss of confidence, all predisposing nurses who are struggling to perform good work despite adversity to experience burnout (Miller, 2011). Also, it is imperative to gain understanding about how nurses sustain good work despite misalignments in the health care context.

The third dimension of oversimplification is related to mentoring, role modelling and a supportive work environment, which were recognised as opportunities for good

work in nursing (Miller, 2006; Miller, 2011; Welk, 2013). In fact, negative mentoring and role modelling, an unsupportive work environment, for example, where over-delegation and cliques exist, have also been reported as obstacles to good work (Welk, 2013). The relationship between good work and mentoring has not been specifically explored in nursing. Whether mentoring, role modelling and supportive work environment have been used as solution is unknown. How and to what extent mentoring, role modelling and supportive work environment collectively are shaping nurses in pursuing good work in nursing in the complex health care landscape is worth further research and study.

2.6 Summary

Good work in nursing seems to be a distant and dim beacon in the midst of foggy or stormy weather. How can we assist nurses, especially young nurses, in sailing toward the beacon in a roaring sea that represents the complexity and dynamism of the health care landscape? Shaped by my past experience, as well as the literature on good work, I saw both personal and social significance to understanding the meaning of mentoring to newly graduated nurses in transition and in pursuing good work. Despite the frequent responses of 'impossible!', 'unrealistic', 'too ideal', 'already a time and nursing shortage' when insiders in the nursing profession as well as outsiders heard about my research interest, I saw the importance of sustaining good work among newly graduated registered nurses (NGRNs). Failure to sustain good work among these young nurses could potentially jeopardize patient safety at three levels. First, passionate nurses might feel dissatisfied, exhausted, and burnt out due to the misalignment of the different sets of forces, which may lead them to make the decision to leave the institution and the nursing profession. Second, nurses who experience misalignments may stay in the nursing field but distance themselves from their patients and the patients' families, to minimize their moral distress, and focus only on getting all their assigned work done. Third, dispassionate nurses may become negative role models or mentors of the younger generation of nurses and the unit culture, which could potentially influence the quality of care. Further scanning of literature investigating the transitional and mentoring experience of NGRNs is paramount, which is presented in the following two chapters.

CHAPTER THREE

SCANNING LITERATURE OF TRANSITIONAL EXPERIENCES OF NEWLY GRADUATED NURSES

'… With ageing population, Government will continue to increase resources on healthcare. In 2015-16, Government's recurrent allocation to the Hospital Authority (HA) will be $49 billion, up by nearly 50 per cent over five years ago…

… To cater for the long-term demand for healthcare services, we shall carry out a number of hospital projects. Projects already under construction or planning include the development of an acute general hospital in the Kai Tak Development Area (Phase 1), Tin Shui Wai Hospital and Hong Kong Children's Hospital; the redevelopment of Kwong Wah Hospital and Queen Mary Hospital; and the expansion of United Christian Hospital. A total of 2 800 additional beds will be provided. The works expenditure is estimated at $81 billion…

… From the 2015/16 academic year onwards, Government will subsidise on a pilot basis 1 000 students per cohort to pursue undergraduate programmes for meeting the manpower needs of Hong Kong. For the first cohort, there will be 13 programmes, covering health care and other professions. This scheme will cost $960 million…' (Tsang, 2015, pp. 31, 37, 38).

3.1 Introduction

The above was part of the budget speech by Hong Kong Financial Secretary, John C. Tsang. His budget press conference caught my attention as I was watching the news on television on my lunch break. In response to the aging population and increasing demand on health care, three new hospitals will be developed and an existing hospital will be expanded to provide additional beds. This means that an even larger number of nurses and other health care workers will be needed in the near future. Two huge questions immediately came to my mind: 'What will the transitional experiences of the newly graduated nurses in the future be?' and 'To what extent will their experiences be similar to mine?' This chapter provides an overview of the experiences in the past of newly graduated nurses transitioning to professional nurses in the clinical setting, which have the potential to help predict what will happen in the near future.

van Gennep (1960), an anthropologist, suggests that transition is a rite of passage, like the drastic changes individuals experience in different stages of life, from Birth, Puberty, and Marriage to Death. Not only does it cut off old ways of life, but it also orients the individual to an unknown future. It involves the various aspects of an individual, namely biological, psychological and social, leading to stress, uncertainty and changes of self-identity.

In a similar vein, Bridges (1980) also described transition as a process of adapting to life changes. The differences between change and transition were underscored. While change is defined as what is done differently, transition is defined as the psychological reorientation needed to adapt successfully to the change. Transition is referred to as the state of confusion in the 'in-between ness', between what was and what is. Transition can be viewed as occurring in three phases, namely the ending, the neutral zone and the new beginning. Ending refers to the phase when the person realises the losses inherent in making the change, such as the loss of immediate support from educators and faculty that is experienced by newly graduated nurses, when they often experience disbelief, anger, anxiety and even depression. In the neutral zone or state of in-between ness, the new graduates find that the rules of being a nursing student no longer apply to their practice, while at the same time they do not know the rules of the health care setting and often fail to cope with the challenges at work. This frequently leads new nurses to develop distress and anger, but can also lead to a new understanding of nursing. The new beginning refers to the final phase in which new nurses successfully transition to their new role with a sense of relief (Bridges, 1980). In this dissertation, the transition of newly graduated registered nurses (NGRNs) refers to the transition from a nurse newly graduated from the undergraduate nursing programme to a professional nurse practicing in the complex health care setting.

A scan of the literature shows the body of literature on the transitional and socialisation experiences of newly graduated nurses is vast. Though the literature repeatedly and consistently reports that their experiences are overwhelmingly stressful, the problem remains widespread and unresolved. The significance in conducting this narrative inquiry will be unveiled by examining the relevant

literature along three dimensions of the narrative inquiry: the personal-social interaction dimension, the temporal dimension, and the place dimension.

3.2 Personal-social interaction dimension

Besides the term transition, socialisation is another term commonly used when studying the experience of newly graduated nurses. Professional socialisation is the process of moving from one social role to another by acquiring knowledge, skills, behaviours, values, roles, attitudes and norms to participate in a group and achieving a professional identity (Saarmann, Freitas, Rapps & Riegel, 1992; Tradewell, 1996). In the socialisation process, a person changes from being an outsider of an organization to a newcomer entering the organization, and later becomes an insider or a member of the group. Socialisation has its root in social learning theory, in which the social learning process involves identification processes and observational learning through modelling and imitation (Dominguez & Hager, 2013; Saarmann, Freitas, Rapps & Riegel, 1992). This socialisation process can be viewed as consisting of three stages, namely a Stage of separation, Stage of transition, and Stage of integration (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013; Öhlén & Segesten, 1998; Tradewell, 1996; Trice & Morand, 1989). In the stage of separation, newcomers detach from their old roles as nursing students and separate from academia. This stage of separation is characterized by the theme of ‘knowing’. In the stage of transition, newcomers are in a state of between-ness in which nurse graduates leave their student role to enter the role of professional nurse, with the theme of ‘becoming’. The final integration stage involves formation of the professional identity along with integration into professional roles and communities, with the theme of ‘affirming’. Reading about this socialisation process led me to question the differences as well as the relationship between the terms socialisation and transition, which both involve three stages or phases. Socialisation can be viewed as a concept that emphasizes the social dimension, while transition can be viewed as a concept that emphasizes the personal, particularly the psychological, dimension. With my research interest in understanding how NGRNs sustain good work in nursing through mentoring in mind, this literature shed light on the importance of involving not only the stage of transition but also the stage of integration.

Scanning the literature revealed that the experiences of new nurse graduates, even tracked over years of research, remain stressful and horrendous. The bad experiences seem to be related to the nurses' unpreparedness for the complexity of nursing and others' expectations that they will hit the ground running, pervasive and detrimental negative workplace interactions, which even include bullying, and having their established professional identities shaken by others in their situated context. All of these factors are discussed in the following three subsections.

3.2.1 Unprepared for the complexity of the healthcare system but expected to hit the ground running

Clark and Holmes (2007) conducted a qualitative explorative study in the United Kingdom exploring factors that influence the development of competence among newly qualified nurses and looking at the question from multiple perspectives, including those of newly qualified nurses, preceptors, practice development nurses and ward managers. Though the various stakeholders had different views on other aspects, such as the clinical rotation, they formed a consensus that newly qualified nurses are not ready for practice at the point of registration and need six months to develop their sense of readiness and confidence. Ironically, the amount of time provided to consolidate their previous learning was limited (Clark & Holmes, 2007). The findings resonated with me as I recalled my own past experience of being pushed to take care of a team of neuromedical and neurosurgical patients on my own beyond my practice readiness, for which I received inadequate support labeled as 'preceptoring'.

Though the findings of another study can be categorized into three themes, the perceptions of the new nurses and nurse managers were not well aligned with each other. Chernomas et al. (2010) interviewed the counterparts using focus groups in Canada. The study identified the first theme as 'Knowing who I am', indicating that new nurses want to be known as beginning practitioners who are in transition and therefore in need of time and further guidance and supervision, and as individuals with unique learning and transition needs. Paradoxically, nurse managers also emphasized knowing new nurses, but using the nursing students' final clinical practicums to identify potential employees who could fit in with the culture. To nurse

managers, the first theme of ‘knowing who I am’ also meant knowing the work ethics and generational differences of new nurses, such as commitment to unit and receptiveness of feedback, especially negative feedback. In the second theme, ‘knowing what I need’, new nurses identified support, feedback and encouragement from their preceptor, other nursing colleagues and nurse manager as important facilitators of their transition to professional practice. Though nurse managers seemed to understand well the needs of new nurses, managers acknowledged that systematic and structural factors such as an imbalance of senior and junior staff limited their capacity to meet the needs of new nurses. In the third theme, new nurses reported feeling ‘prepared’, but preferred more clinical learning, particularly about more complex psychomotor skills such as managing intravenous therapy and chest drains. They further identified an issue in which they had an ethical obligation to recognise their limitations and ask for help, but would encounter another ethical dilemma if other senior nurses were unwilling or too busy to provide assistance with their learning needs. Inadequate preparation of inter-professional collaboration, team leadership, and delegation and supervision of health care aides were also reported as being problematic. Nurse managers agreed that new nurses have a sound theoretical basis, but need further development of their critical thinking, prioritising and organizing skills. They also need to develop their capacity to manage complex social and family issues in order to meet these real-world demands and work within the health care system, especially when dealing with the dynamics and personalities particular to each unit. Some nurse managers also recognised new nurses’ fear and uncertainty, and shared their strategies of affirming a non-blame culture and using feedback and validation to alleviate their anxiety. The authors concluded by disagreeing with the expectation that new nurses can ‘hit the ground running’, while acknowledging that additional time for training beyond the initial orientation is needed for the professional development of new nurses (Chernomas, Care, McKenzie, Guse & Currie, 2010).

The findings of another qualitative exploratory study which explores the meaning in Canada of new graduate nurses’ practice readiness from multiple perspectives also challenged the expectation of ‘hitting the ground running’. The concept of practice readiness was much more complex than anticipated because different stakeholders possessed diverse interpretations, as identified through focus group interviews with

new graduate nurses and other nurses with varying years of experience in the practice, education and regulatory sectors. Only four common themes could be identified among different stakeholders regarding practice readiness. The first theme of readiness for practice was identified as the possession, by new graduate nurses, of a generalist foundation and some job-specific capabilities required meeting the needs of their immediate workforce. The second and third themes suggested that new graduates are recognised as ready to practice by different stakeholders when they can provide safe client care and adapt to the new and changing circumstances of the health care landscape. Last, readiness also means maintaining balance in doing, knowing and thinking, which means keeping up-to-date with practical and theoretical knowledge, as well as developing critical thinking. Meanwhile, different stakeholders had contrasting expectations. First, some participants, particularly practice nurses, expected the new graduates to be prepared by their nursing education with competencies that would be transferable across diverse practice settings, client populations of varying acuity and even in complex situations. In contrast, nurse educators perceived readiness as being able to function independently in stable and predictable situations. Second, there were mixed expectations of new nurses, ranging from an expectation that nurses performing at a beginning level should possess enough knowledge to recognise a situation and ask for help if necessary to, ironically, an expectation that they should 'hit the ground running' and perform at a level equivalent to their more experienced counterparts. Third, there was no general consensus about the expected types and amounts of theoretical and practical knowledge, except that all participants recognised that critical thinking was the key component of readiness (Wolff, Regan, Pesut & Black, 2010). Many participants in different sectors also identified that new nurses' self-confidence to act in an unfamiliar situation with unfamiliar client issues can only be developed through experience and not through formal education (Wolff et al., 2010). This is in line with the emphasis on experiential and situational learning for the development of contextual-dependent judgment and skills made by Benner, Sutphen, Leonard, Day and Shulman (2010).

Wolff et al. (2010) further identified potential forces shaping the diverging perspectives of the different stakeholders. First, the differences are closely related to having a different educational background, such as whether the participant was being

trained in a diploma or degree nursing programme. This sounds true to me, since most of my senior nurses received diploma hospital-based nursing training. The second shaping force is the expectation that new graduate nurses will be either professional or technical nurses, which is closely related to the first shaping force. The practice readiness of a professional nurse is viewed as a developmental process that evolves along the career trajectory and depends on the complexity of the work environment, previous learning experience and availability for support after registration. In contrast, if new graduates are expected to be technical nurses, then practice readiness is viewed as a tangible end product of nursing education, with the result that nurses are ready to 'hit the ground running' even possessing specific knowledge about organizational policies and procedures or social knowledge about physician preferences (Wolff, Pesut & Regan, 2010). The third shaping force is related to the different perceptions held by the education and practice sectors of their respective accountability and responsibility for the preparation of both nursing students and new graduates before and after professional registration in the health care landscape with a chronic nursing shortage. While the practice sector expects the education sector to be ultimately accountable for the preparation of new nurses, it is questionable whether the practice sector can provide adequate quality placements for the increasing numbers of nursing students in response to the nursing shortage issue to prepare NGRNs with the practice readiness expected. Furthermore, while NGRNs are prepared by the education sector to manage stable and predictable patient situations, this is contrary to the reality of practice. Because of the nursing shortage issue, these NGRNs have to take care of patients who are acutely ill, while patients who are more stable are often assigned to licenced practice nurses. The use of the metaphor 'flying 747s solo without having any training on smaller planes' by a new graduate participant probably best captures the stress and sense of uncertainty, powerlessness and helplessness felt by new nurses (Wolff, Pesut & Regan, 2010). I found this metaphor very striking in its similarity to my image of sailing without a rudder as a fresh graduate. Ironically, though different stakeholders, ranging from senior nurses, preceptors, nurse managers and nurse educators, perceived that the newly graduated nurses were not ready to practice in the complex health care landscape and are in great need of support from the others, nonetheless they seemed to expect new nurses to 'hit the ground running' against the backdrop of a shortage of nurses. Further research on the experience of newly graduated nurses to identify

appropriate strategies to alleviate their stress and to reverse the use of helpless and hopeless metaphors into more positive ones is socially significant.

3.2.2 Unsupportive workplace interactions and bullying

My experience in the 'villain village' of being scolded and not receiving needed support led me to wonder about the experience of other new nurse graduates. A review of the literature quickly showed that such workplace incivility, workplace bullying and lateral or horizontal violence experienced by new graduate nurses at the lower echelon of hospital hierarchy is pervasive (Duchscher & Myrick, 2008; Horsburgh & Ross, 2013; McKenna, Smith, Poole & Coverdale, 2003; Roberts, DeMarco & Griffin, 2009).

Smith, Andrusyszyn and Laschinger (2010) surveyed 117 new graduate nurses in Canada who had approximately two years of clinical experience to examine workplace incivility and empowerment. Workplace incivility is defined as 'a low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect' (Andersson & Pearson, 1999, p. 457). Despite the fact that zero tolerance for incivility was emphasized in the literature, it is important to note that the prevalence of workplace incivility remained high, with a majority of participants reporting some degree of co-worker incivility (90.4%) and supervisor incivility (77.8%). The authors concluded that newly graduated nurses with increased access to structural and psychological empowerment, combined with low levels of workplace incivility, are likely to demonstrate higher organizational commitment (Smith, Andrusyszyn & Laschinger, 2010).

Workplace bullying and horizontal or lateral violence are different from the aforementioned workplace incivility or other simple conflicts (Johnson, 2009). Workplace bullying has been referred to as nurse-on-nurse and inter-group conflict (Stanley, Martin, Michel, Welton & Nemeth, 2007), which is more severe, frequent, and lasting for a longer duration of time, with targets finding it difficult to defend against and stop the abuse (Lutgen-Sandvik, Tracy & Alberts, 2007). McKenna et al. (2003) reported findings from a national survey in New Zealand that focused on exploring the horizontal violence experiences of 551 registered nurses in their first year of practice. Many of the new graduates experienced horizontal violence in

various clinical settings, particularly direct verbal statements that were rude, abusive, humiliating or involved unjust criticism. More than half of the participants reported a perception of being undervalued by other nurses (58%), and experiencing a lack of supervision (46%) and a lack of support (17%); 38% felt distress about a particular conflict; 34% experienced blockage in their learning and felt emotionally neglected; and 20% felt the threat of possible repercussions if they reported incidents of horizontal violence. It is alarming to note that the persons involved in the most distressing incidents were not limited to charge nurse, unit manager, other senior nurses, the enroled nurses who were their subordinates though usually more experienced, but also their assigned preceptors. Nearly half of the most distressing events recalled were not reported (n = 170). As a result of an incident or serial incidents of horizontal violence, new graduates revealed having decreased confidence and self-esteem, experiencing fear, anxiety, sadness, depression, frustration, mistrust and nervousness, with one respondent reporting the need for antidepressant medication. Physical consequences were also reported, including weight loss, fatigue, headaches and incidents of hypertension and angina. Two respondents felt reassured by the support of other nursing staff. Two demonstrated self-resilience and indicated that the horizontal violence led them to 'stand up for myself' and 'feel strong in myself'. Only 12% of respondents received formal counselling or debriefing after the incident, while the majority of the new graduates reported that they received no formal training in managing horizontal violence. It is even more alarming that one-third of the 170 respondents who shared their most distressing incidents in the survey (34%) indicated that they had considered or intended to leave the nursing profession as a result of the incident (McKenna, Smith, Poole & Coverdale, 2003). This resonates with my experience, in which I was expecting my preceptor to assist my transition, but instead she became a major stressor, leading to many self-doubts, decreasing self-confidence and even thoughts of leaving.

Kelly and Ahern (2009) conducted a longitudinal phenomenology in Australia to gain a more in-depth understanding of horizontal violence experienced by new graduate nurses in their first six months of practice. Through interviews with 13 newly graduate nurses prior to their employment, it was revealed that all participants were unprepared for and had limited awareness of the cliques with all their secret and

hidden policies that would exclude them, along with the power hierarchy and 'bitchiness' in the workplace and nursing profession. As early as the first month of practice (second interview) or over the following six months of practice (third interview), the newly graduated nurses came to recognise both verbal and non-verbal communication that was used to show they were unwelcome within the work environment. This ranged from the use of sharp and blunt response – such as, 'Don't you know that?!' - when new nurses asked questions, to the use of the silent treatment by not talking with, acknowledging or even saying hello to new nurses. 'Eating their young' and 'thrown in at the deep end' were the two metaphors most frequently and spontaneously used by participants to describe their experiences of horizontal violence and lack of support after employment. The majority of the participants found that other senior nurses were not prepared to provide assistance in their learning and socialisation but expected them to learn on their own. Consequently, many of the new nurses depended on peer support from other new graduates, leading to the rather dangerous phenomenon of 'blind leading the blind', which can jeopardize patient safety. The existence of a 'power game' was an identified subtheme, as the participants perceived that the senior nurses believed that the use of humiliation was the best way to teach them. It was revealed that older nurses or those who were educated in hospital-based training were more difficult to work with and less likely to provide assistance and guidance to new nurses. 'Bitchness' was another identified subtheme to describe nurses being malicious, spiteful or nasty; for instance, being deliberately cruel by causing tension. Ironically, a gender issue was revealed to have some influence on the socialisation process, as the presence of male nurses made the ward environment more balanced and less 'bitchy'. Furthermore, the direct influence of ward managers on the work atmosphere as well as the indirect influence on the socialisation process was also acknowledged (Kelly & Ahern, 2009).

Horsburgh and Ross (2013) also conducted a study in Scotland using focus group interviews exploring the perceptions of compassionate care of 42 newly qualified nurses. Findings showed that the support they received was erratic rather than systematic, nicely captured by the statement 'the luck of the draw'. Sadly, metaphors such as 'thrown in at deep end' and 'left to swim or sink' were used to capture the sense of helplessness and to describe the inadequate support, which had also been

used repeatedly by participants in the previous studies. Participants generally perceived ‘compassionate care’ was a tautology or to be redundant, meaning that care would not be care in the absence of compassion. They believed that emotional engagement is not only desirable but a prerequisite for providing high quality patient care. It is important to note that these new nurses believed that compassionate care could not be actualized in the uncaring acts among nurses in the work environment (Horsburgh & Ross, 2013). This study sheds light on the concept of care in two ways. First, it is alarming if it is indeed true that the prevalence of uncaring acts including ‘eating the young’ or ‘throwing someone in at the deep end’ are at such a high level among nurses in the health care landscape. How are the NGRNs going to sustain their good work? Second, given that engagement is a pre-requisite in providing compassionate care (Horsburgh & Ross, 2013) or good work (Gardner, 2010), does this kind of engagement in the context of value conflicts accelerate the NGRNs’ experience of moral distress, job dissatisfaction, and burnout that results in nurses leaving the units and even the nursing profession (Miller, 2011)? Previous studies have also identified that newly graduated nurses are at higher risk of burnout than more experienced nurses, resulting in stronger intentions to leave (Lavoie-Tremblay, Wright, Desforges, Gélinas, Marchionni & Drevniok, 2008). This is another disturbing finding that needs special attention because newly graduated nurses who are engaged in their work or and persist in performing good work in nursing, and are situated in such a health care landscape might be at higher risk of burnout and attrition.

Hutchinson, Vickers, Jackson and Wilkes (2006) moved beyond this dominant discourse of horizontal violence between a bully and a victim to explore how bullies work together to control nursing team and practices in three ways. First, few of the bullies occupied formal positions of authority. Rather, they achieved extensive power by working cooperatively with other bullies in the form of long-lasting alliances. Bullying strategies including ignoring, denying and minimizing others, behaviours which have long been regarded as abusive but which are sometimes still ignored, tolerated, protected and/or condoned by more senior nurses, such as nurse managers and directors in the organization. It is alarming and disturbing to note that the prevalence of bullying has led to a high attrition rate among the victims, with some even committing suicide. Second, bullies defined ‘rules’ of work, which were

successfully maintained by enforcing a hierarchical division of labour with elements of militarism, public scrutiny and humiliation, and tactics of exclusion. These rules worked as powerful, often unspoken devices that legitimized and enabled bullies to sustain their influential positions in the unit. Special attention has to be given to the responses of the victims, who coped by changing practices, doing their own work and isolating themselves in their rooms to decrease their visibility and avoid being targeted. Third, it is even troubling to note that bullies legitimized their actions by framing the victims as 'too weak' to be good nurses, while the bullies were doing a favour by accepting and forgiving the 'weaknesses' of the targets - which was not true. Unfortunately, bullied nurses gradually internalized such images of themselves after repeated episodes of public humiliation and hostile behaviour. The findings revealed the profound detrimental effects in destroying the self-confidence and self-image of the victim, which must be addressed (Hutchinson, Vickers, Jackson & Wilkes, 2006).

Workplace incivility and violence reportedly can lead to decreased job satisfaction and organization commitment, increased burnout and intention to leave (Laschinger, Leiter, Day & Gilin, 2009; McKenna et al., 2003; Simons & Mawn, 2010). Burnout has further been identified to be related to higher chances of committing mistakes, which again would ultimately affect the quality of patient care (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). While the need for support among newly graduated nurses in transition has been discussed for decades in the nursing literature, ironically, the above studies reveal consistently negative findings in different continents and over different generations that further reveal the significance of conducting this narrative inquiry to understand the experience of working with NGRNs from the multiple perspectives of different stakeholders.

3.2.3 Upholding, shaken or giving up formative professional identity

In the previous chapter, the concept of good work in nursing was explored with an emphasis on learning from positive role models. In this section, alarming and disturbing findings about new nurse graduates struggling to maintain their professional identity and ideals under the various shaping forces in the health care landscape are discussed. More than four decades ago, Corwin (1961) in his earlier work identified that nursing students transitioning to be professional nurses working

in the practice setting would have experienced inherent conflicts between the professional and bureaucratic conceptions of their role. Also, the ideal perception of role and reality might lead to role discrepancy or modification of the original ideals cultivated by the nursing faculty in the undergraduate nursing programme. Corwin found that nurses who graduated from diploma and degree nursing programmes organised their bureaucratic-professional role conception differently and adjusted to role conflict differently. Furthermore, the discrepancy between the ideal roles and perceptions of reality increased after professional qualification, particularly for graduates of university-based nursing programmes. The degree-nursing students were likely to hold strong professional and weak bureaucratic conceptions. After graduation, these new nurses maintained their strong professional conception while strengthening their bureaucratic conception. As these new nurses did not modify their professional conception, they experienced a greater discrepancy throughout the transitional period. In contrast, diploma-nursing students affiliated with the hospitals held strong bureaucratic and weak professional conceptions. These new nurses said they experienced further weakening of their professional conceptions, while maintaining their bureaucratic conceptions. As these diploma graduate nurses modified their professional conceptions, they were less likely to experience role discrepancy (Corwin, 1961). It is important to note that though the study was conducted decades ago, Corwin's 1961 role conception scale has been used to measure the extent of transitional difficulties among new nurse graduates and to evaluate the effectiveness of various transitional programmes designed to alleviate such difficulties in the contemporary health care landscape (Beecroft, Kunzman & Krozek, 2001; Goldenberg & Iwasiw, 1993; Kramer, 1968; Young, Stuenkel & Bawel-Brinkley, 2008).

After graduation, newly graduated nurses soon found themselves immersed in a firmly entrenched, distinctively symbolic and hierarchical culture with dominant normative behaviours that are prescriptive, intellectually oppressive and cognitively restrictive. The health care institutions imposed social goals in emphasizing productivity, efficiency, and achievements, which was in striking contrast to the professional ideals that were emphasized in academia (Duchscher, 2001; Duchscher, 2009; Duchscher & Myrick, 2008). This resonated with the issues of role conflict and

role discrepancy identified by Corwin (1961) that often lead to job dissatisfaction and career disillusionment.

Maintaining standards has been portrayed as a ‘constant battle’ by nurses in the United Kingdom. Role stress was the core category that emerged from a grounded theory. While all nurses in the study identified their first year experience as overwhelmingly stressful, agreeing with the use of the metaphor ‘dropped in at deep end’, lack of support was not the only reason for their stress. Role anxiety was experienced when they perceived that their role as graduate nurses required them to be responsible for maintaining professional standards in spite of constraints. Inadequate staffing was identified as the primary obstacle to maintaining standards, together with other obstacles, including pressure to conform to the power structure, norms of the team, values of more senior nurses and ward routines, pressure to meet role expectations and lack of motivation required to uphold standards persistently. To overcome all these obstacles, nurses shared alarming examples of coping such as giving the needs and concerns of patients a relatively lower priority or failing to maintain standards and fulfilling the role of patient advocate through work delegation to nursing students without their adequate supervision. It is troubling to note that all ten nurse participants in their third or fourth year of clinical practice believed that ethical compromise was unavoidable (Kelly, 1996). It is questionable whether addressing their perceived main obstacles is feasible and whether inadequate human resources can facilitate their efforts to maintain the important standards of patient safety and quality care, as well as their professional identities and future mentoring of the younger generation. It is important to make an in-depth scrutiny of these nursing experiences, since the underlying cause of their shaken professional identity and the high rate of attrition might be related to the unit culture and hospital system. It is important to challenge the dominant discourse that there is inadequate staff and time for better quality of care, by thinking about aspects that we might have taken for granted, for instance, problems in the system itself and the design of care.

Preserving moral integrity was the core category identified in another grounded theory study that interviewed 22 baccalaureate nurses in the United States after they had been practicing for one year (Kelly, 1998). Preserving moral integrity can be recognised as a six-stage psycho-social process, in which new graduates used self-

protective strategies to maintain the kind of person they believed themselves to be. This is closely related to one's self-identity and professional identity. New nurses can be described as being in a stage of 'vulnerability' filled with fear and uncertainty, where the team's influences and expectations and their own self-expectations are the two greatest sources of stress (stage one). They were attempting to be good nurses in a context where efficiency is the main indicator of performance and completing housekeeping chores preceded patient interactions. In addition, they faced staffing shortages, limited support, and assignment to a large number of acutely ill patients. Under the hierarchical pressure, one new graduate nurse was asked to disregard an ethical obligation to suction a patient who was desperately in need, because a newly graduated nurse was not allowed to touch patients assigned to other nurses. These social pressures, together with a lack of confidence and fear of making mistakes, led new graduates to be predominately task-oriented. Nevertheless, they experienced a sense of guilt for not being present for anxious or even dying patients or failing to speak up for their patients who were being mistreated or disrespected. Special attention should be given to new graduates who perceived all dissatisfactions as temporary in attempting to alleviate their moral crises. They believed that they could do the currently neglected work for patients when they became more experienced or reassured themselves that they could protect their patients from mistreatment when they had more power (Kelly, 1998). This is in line with the alarming findings about young professionals in the GoodWork ^{TM} project, a minority of whom admitted that they would cut corners to preserve their lead in the race to the top of their professions (Fischman et al., 2004).

With this in mind, and in response to their own lack of confidence and self-doubt, new nurse graduates moved to the second stage, 'getting through the day', which was characterized by choosing to ignore certain aspects of nursing. Aspects of care that benefited patients were ignored, such as feeding, talking and changing wound dressings, in order to meet time pressures, and institutional and social norms. They covered up medical errors for fear of being punished, yet felt humiliated and heavy-laden for failing to meet their ethical obligation to protect the patient. Constant moral self-judgment resulted, which led to a sense of powerlessness and moral distress (Kelly, 1998).

New nurses attempted to cope with the moral distress in stage three by avoiding patient interactions, reducing their working hours, blaming the nursing administration and hospital system, leaving the unit that had conflicting values, or even leaving nursing altogether. However, such coping mechanisms seemed ineffective, because new graduates continued to experience deep emotional and moral crisis. In next stage, new graduates experienced alienation from themselves because of the persistent inconsistency between their behaviours and their own concepts of good work. They experienced a loss of ideals in various ways, including loss of their professional self-concept, ideal image of nursing, dream of working with other nurse colleagues as a team, aspiration to make a difference, and ideal of themselves. New graduates attempted to 'cope with lost ideals' in stage five through rationalization, which is a form of self-deception, in which nurses provided themselves with good rationales for their actions. This rationalization is crucial for resolving their moral distress and personal crisis. In contrasting the present self with the self of one year ago, nurses described themselves as more practical and flexible and less idealistic, and believed that the changes were for the better. In the final stage of the psycho-social process, new nurses began to gain control and be respected by the team. Under the reciprocal influences of the others, new nurses rebuilt their self-esteem and 'integrate[d] new professional self-concept[s]' (Kelly, 1998). This study once again revealed how the transitional and socialisation experience, as well as the professional identity of new nurses, can be shaped by others and their interactions in the situated context.

Similar findings were made in studies conducted in Australia and Canada (Duchscher, 2008). Another longitudinal study of new graduates in Australia also reported disillusionment among respondents after employment as registered nurses. They perceived themselves as the 'doctor's handmaiden' in rushing through the doctor's prescriptions but having no time to communicate with and educate patients. These all led to feelings of role conflict, questioning their own professional identity, and thoughts of leaving the nursing profession (Kelly & Ahern, 2009).

Conflict of care has been recognised as a critical passage point for nurses in their first three years of clinical practice, and is comprised of two layers. The first layer is the conflict between the caring theories cultivated in nursing education and the

difficulties carrying them out in the actual hospital setting, limited by the shift structure, daily patient assignment changes, lack of reinforcement, and lack of empowerment to spend time talking with patients. The second layer is the cultivation of an ideal maintenance of emotional distance from the patients, taught by their former nurse instructors in the nursing school, which kept participants from caring for their patients 'truly' (Deppoliti, 2008). Deppoliti (2008) further identified three overriding themes inherent to all identified passage points, which shaped the construct of their professional identity. The themes include responsibility, learning, perfecting the development of professionalism, negotiation for power and authority, principally with physicians and other system and professional issues, and fragmentation in nursing in relation to different educational backgrounds, working specialties, and lack of solidarity in the profession, as well as working with a diverse group of nurses with different values, characteristics and practices. The conflict of care issue echoed the findings of another study in Scotland. Newly qualified nurses used the metaphor 'ingrained in the woodwork' to describe more experienced nurses and nursing assistants who had entrenched views on care and demonstrated resistance to even minor changes for the benefit of patients. Such institutionalised negativity in the work environment has been recognised as an important factor inhibiting the delivery of compassionate care among newly qualified nurses (Horsburgh & Ross, 2013).

Maben, Latter and Clark (2007) conducted a longitudinal in-depth interpretive study in the United Kingdom examining the experience of newly qualified nurses implementing their ideals and values in their first three years of clinical practice. Upon graduation in the final week of their course, 72 final year nursing students completed a self-administered questionnaire (Phase 1). The findings indicated that they had a coherent and largely consistent set of nursing ideals and values around the delivery of high quality, patient-centred and holistic care which was evidence-based. These ideals and values were consistent with the UK nursing mandate which results in nursing students being heavily shaped by the teaching and socialisation of their pre-registration nursing programmes. Among these 72 nursing students, 49 volunteered to be further interviewed at 4-6 and 11-15 months post-qualification, and 26 of them were purposively sampled (Phase 2). The interview data indicated that their experiences of implementing values and ideals in practice were influenced by

both professional and organizational constraints. Professional constraints included a lack of positive attitudes, role models, and covert rules such as hurrying physical care, keeping an emotional distance from patients and fitting in rather than trying to change practice. Organizational constraints included time pressures, staffing shortages, poor skills mix, and the intensification and routinisation of nursing work to be much more task-oriented. There was also the reality of nursing role constraints in practice since qualified nurses were the only members who could administer medication and complete discharge forms and other paperwork, and thus were removed from the interpersonal aspects of care. Three years after graduation, a questionnaire with open questions together with the interview transcripts and questionnaire completed in phase 1 and 2, were mailed to the 26 nurse participants. The findings in phase 2 and 3 are relatively disturbing and alarming. Among 26 nurse participants, only 4 of them could be classified as sustained idealists, who were situated in conducive work environments with limited professional and organizational constraints. Fourteen participants could be classified as compromised idealists, who could only implement their ideals partially. They experienced frustration and were struggling. Their thwarted ideals led them to adjust their personal expectations and to compromise. Finally, four of them left the nursing profession. Sadly, eight participants were exposed to work environments filled with professional and organizational constraints. They demonstrated no sign of regaining any idealism over the first three years of clinical practice, but readjusted and lowered their expectations to merely getting 'basics' done. Many of these crushed idealists experienced severe stress and signs of burnout. In their conclusion, the authors raised the question of whether the nursing profession required a modernized mandate. They questioned whether the nursing mandate to provide bedside care that is high quality, patient-centred, holistic, and administered by registered nurses in a context of a nursing shortage and an aging population is overambitious and unrealistic, and is in fact a source of dissatisfaction and low morale. They suggested a change to a more fit-for-purpose mandate where qualified nurses are responsible for ensuring quality and ethical care through support, advice, clinical decision-making and supervising nursing assistants and lay caretakers (Maben, Latter & Clark, 2007). Though the response rate is rather low (50%), which might be due to the limitations of the study, the alarming findings revealed an important knowledge gap about how newly graduated nurses can be supported to sustain their ideals and values or good work in

nursing in spite of changing professional and organizational constraints, and particularly how such support might be given through role modelling and mentoring.

By contrast, Fagerberg and Kihlgren (2001) conducted a hermeneutic phenomenology in Sweden to understand the meanings of the professional identities of 19 registered nurses. The participants had taken part in a previous study that interviewed them each year during their three years of nursing education. This subsequent study interviewed them again two years after graduation. Four themes were identified, with one understood as the dominant perspective for each participant. They included having the patient in focus, being a team leader, preceptorship, and task orientation. These four themes emerged to form the phenomenon of identity as a nurse. The importance of preceptorship throughout the years of nursing education and initial period of role transition was emphasized, and yet the lack of support from preceptors or other more experienced nurses was portrayed as a nightmare. Two years after graduation, participants perceived themselves as nurses with a role of preceptor to other staff and nursing students, guiding them to provide better patient care. Positively, the authors concluded that the perspectives of nurses did not change throughout the five years, with only transitional elements observed. The authors concluded that the static perspective of nurses can be understood as a life paradigm. They further suggested that the occurrence of task orientation as the dominant perspective for some participants, even two years after graduation, might indicate that those participants are still at the advanced beginner stage identified by Benner (1984), characterized by tending to focus on tasks rather than having a holistic view (Fagerberg & Kihlgren, 2001). However, the findings have to be interpreted with caution. First, it is unclear whether the findings were limited by the use of a rather structured interview guide through the four data collection instances, as well as an analysis method that focused mainly on the commonalities across participants. Second, it is important to note that some of the registered nurse participants had a number of years of working experience as enroled nurses. This might have contributed to their rather static professional identity development over the five-year study period. Third, the study took place more than a decade ago in a different country with a different socio-economical, cultural, and educational background and a different health care system. This might lead to the rather positive and static professional identity.

New graduates are not prepared for the complexity of nursing, receiving inadequate support, possibly bullied, and being expected to hit the ground running. Their professional identity and ideals are at risk of being shaken or even suppressed, which can lead to leaving the workplace not to mention the nursing profession entirely. All these factors are associated with the alarming and relatively high rate of turnover intention and actual turnover. For example, 45.5% and 4.9% of participants (n = 348) in a study conducted in Canada expressed uncertainty about leaving and definite turnover intentions, respectively, after their first year of clinical practice (Rhéaume, Clément & LeBel, 2011). Similarly, an average of 34% in the United States, ranging from 25% to 46% of participants (n = 889), reported turnover intentions after 18 months of clinical practice at six hospitals with standard nurse residency programmes (Beecroft, Dorey & Wenten, 2008). An earlier study also conducted in the United States on the actual turnover of NGRNs showed that 30% and 57% left their job within their first and second year of practice, respectively (Bowles & Candela, 2005). This overwhelming loss of new nurses not only aggravates the already severe nursing shortage but also leaves a greater workload on the nurses who remain in service, perpetuating the vicious cycle of turnover in the midst of the aging nursing workforce. Furthermore, the turnover of newly graduated nurses is associated with high turnover cost and other losses (Aaron, 2011; Bratt, 2009; Halfer, 2007; Hatler, Stoffers, Kelly, Redding & Carr, 2011; Scott & Smith, 2008). Therefore, thinking along the personal-social interactions of NGRNs demonstrates the significance of further research to address the perpetuation of this stressful and horrendous experience.

3.3 Temporal dimension

As expected, the transitional and socialisation experiences of new nurse graduates both have a strong temporal dimension. Many studies conducted in various countries have identified process models in preparing new graduate nurses for the challenges ahead and in assisting senior nurses, nurse managers and administrators to better support the younger nurses. However, a scan of the literature shows that the majority of the studies focused on the experiences of new graduate nurses in their first 6 to 12 months of clinical practice, while a paucity of literature exists of study periods

extending beyond the first year of practice. Some important and relevant literature is presented in the following two sections to show the significance of further research about the first two years of clinical practice among NGRNs.

3.3.1 Abundant literature focusing on the first 12 months of clinical practice

Duchscher (2001) conducted a phenomenology with five new nurses in Canada. The study explored the first six months of transitional experience using repeated individual interviews in the second and eighth months combined with ongoing monthly journals. The 'journey' is the core process identified, which is the process of studying the new nurses as both professionals and individuals. This identification was derived from three major themes that emerged sequentially over time. 'Doing nursing' is the first theme, which can be seen as the initial stage of the transition, particularly of the first month when the new nurses focused mainly on doing or getting work done without killing the patients. In this stage, 'self-absorption' can be used to describe how the new nurses focused mainly on themselves and getting the work done under time pressure, rather than addressing individualized patient needs. The new nurses were highly dependent on others due to their limited knowledge, experience, familiarity with the work environment and confidence. They tended to trust the teaching and opinions of the others, all of whom were more experienced and they seldom questioned authority. New nurses demonstrated anxiety when interacting with physicians, who were universally described as verbally abusing them and others. They were trying to leave the nest, the well-protected learning environment created by their former nursing education. 'The meaning of nursing' is the second theme, referring to the period of time when new nurses began to let go of the familiar student role and began to grasp their professional nurse role. This took place at about the second and third months of employment. New nurses began to feel more comfort with fallibility and some level of uncertainty. Thus they gradually became less self-absorbed and shifted their focus to their patients and nursing care. With growing trust and confidence in themselves, they sought a more in-depth understanding of their practice and applied knowledge through reflection and becoming receptive to learning once again. They developed a broader perspective of nursing and performed their care duties from a more patient-centred and holistic perspective. 'Being a nurse' is the third theme, referring to the time after about five months of clinical practice when nurses resolve to stay in nursing. The author used

an in-vivo quote ‘puppet off a string’ as a subtheme in describing nurses who began to formulate opinions based on their experience and believe in themselves as competent beginning nurses. Their practices were supported by clear rationales and were critically analysed. Fortunately, the nurse participants reported that they were far less likely to compromise their care standards to maintain the status quo. Nurses also developed professional maturity and interdependence in this stage. They no longer focused on doing their tasks and personal issues, but also on practical knowledge, quality care and effectiveness. They shifted to a more interdependent relationship with other senior nursing and medical staff (Duchscher, 2001).

3.3.1.1 Transition shock (0-4 months)

Duchscher (2009) formulated another frequently cited theoretical framework – the concept of transition shock. Transition shock refers to the initial three to four months of professional role transition for newly graduated nurses, which is often the most acute and dramatic stage of transition. Transition shock is a non-linear and non-prescriptive process that involves adjustment in four interrelated aspects, namely, emotional, physical, socio-cultural and developmental, and intellectual. All four aspects are affected and altered by changing roles, responsibilities, relationships and levels of knowledge in the professional as well as personal lives of the newly graduated nurses. Duchscher (2009) suggested that both practice and academic institutions should focus on informing newly graduated nurses about professional role transition in the orientation and mentoring programme. However, it is doubtful whether preparing for transition shock through an orientation or mentorship programme alone is adequate. For instance, the experience of confusion and doubt during transition shock is often related to inadequate feedback from senior colleagues and ward managers, both positive and negative, as well as workplace interactions with senior physicians and nurses who are disapproving of, disrespectful to, intimidate, and devalue new nurses. On one hand, it might be important to better prepare newly graduated nurses for transition shock. On the other hand, it is important to address many of the underlying causes of transition shock, rather than accepting and even accommodating such an unsupportive and even intimating work environment (D'ambra & Andrews, 2014).

3.3.1.2 Process of becoming (0-12 months)

Duchscher (2008), using a similar approach, also developed a theory of transition, specifically defined as the as process of becoming for newly graduated nurses in their first 12 months of practice. There are three stages, namely, Doing, Being and Knowing, which are not in a linear, prescriptive or strictly progressive fashion, but are evolutionary and transformative. The Doing stage generally refers to the initial three to four months after orientation in which the new nurses initially felt excited about the transition but soon realised they were unprepared for their new role and responsibility, and experienced transition shock. The Doing stage encompasses learning, performing, concealing, adjusting and accommodating. While new nurses were usually comfortable in managing a patient load of fewer than 8 patients, they were often assigned to 8 to 16 patients who were clinically unstable, along with many other rigid and distracting non-nursing tasks. Meanwhile, quite a number of participants perceived themselves to be inadequately supported. They felt frustrated as they found themselves exposed to prescriptive and archaic ways of thinking. As in previous studies (Chernomas, Care, McKenzie, Guse & Currie, 2010; Kelly, 1996), graduates experienced difficulty in delegating work to other licenced and non-licenced staff, who were older and had more clinical experience. They felt uncertain about who could be trusted in the workplace to share the tremendous intensity, range and fluctuation of their own emotions, and so they tended to vent their feelings to their family members and friends outside the workplace. The functional learning curve was steep and led to overwhelmingly stress, anxiety, and self-doubt, sometimes even a fracturing the professional identity they had established through their years of nursing education. It was not uncommon for graduates to focus on every job detail, leading to anxiety about missing something or inadvertently and unintentionally doing harm to the patients under their care. It is interesting to note that the majority of participants at this stage tended to blame the discontinuity between the expectations of their superiors in reality and their anticipations about nursing learnt during their pre-registration nursing education. None of them at this stage considered that their affiliated institution should also be responsible for failing to prepare them or to gradually introduce them to a fully practicing nurse. Furthermore, it is important to note that the energy of new nurses was divided between the heavy demand of professional adjustment and the sociocultural and developmental changes in their personal lives (Duchscher, 2008).

The Being stage (4-8 months post-orientation) involved searching, examining, doubting, questioning and revealing, and can be further divided into two sub-stages. Early in this stage, new graduates demonstrated marked advancement in their professional development in terms of thinking, knowledge and skill competence. Their increasing sense of comfort created room for examining the underlying rationale, appropriateness and effectiveness of their care. However, it is alarming to note how frequently graduates were assigned to work beyond their clinical competence and cognitive and experiential comfort levels. Many of them were assigned to leadership positions such as the nurse in-charge or given responsibility for orienting new staff, assignments that the graduates consistently perceived as inappropriate and unsafe. Simultaneously, they developed self-doubt about their professional identities under the various constraints in the health care system. The self-doubt and struggle peaked at about five to seven months with a transition crisis, particularly regarding their confidence, competence, fear and sense of security. They attempted to cope by distancing and withdrawing themselves from their professional lives, with the hope of attaining better work-life balance and a better sense of control. Later in this stage (about six to eight months post-orientation), new nurses re-energized and felt ready to take on the challenges of working in other unfamiliar work environments and to plan long-term professional goals (Duchscher, 2008).

In the final stage of Knowing (about 9-12 months), these graduate nurses continued the recovery that had begun in the second stage. Separateness is the main characteristic of this stage, meaning that nurses were glad to move out of their learner role into a level of competence with greater expectations and a lower margin of error. Some shifted their primary supportive relationships from non-nursing friends and family to their nursing colleagues. It was in the latter half of this stage that these graduate nurses spent an increased amount of time exploring and critiquing their situated health care landscape as they realised its sociocultural and political constraints. Their stress levels decreased, though remained at a moderate high. It is important to note that the contributing stress factors shifted from an individual capacity to cope with given roles and responsibilities to the professional frustrations of managing the health care system, such as an ineffective or constraining hierarchy of authority and power. The professional achievement of the Knowing stage was

embodied in the reassurance nurses felt as they compared themselves positively to the newly arrived younger colleagues and were able to answer the questions they raised (Duchscher, 2008).

3.3.1.3 Perception of patient care quality (4, 8, and 12 months)

Apart from the above studies conducted in Canada and Australia, Kramer, Brewer and Maguire (2013) conducted a nation-wide research programme in the United States that also reported on the important temporal dimension of the professional socialisation experience of newly graduated nurses in their first year of practice, which intersected with the place dimension. Quantitative data were collected from 371 newly graduated nurses from 191 units of 17 magnet hospitals at 4, 8, and 12 months post-hire. The participants' units were further classified into three categories, namely Very Healthy Work Environment (VHWE), Healthy Work Environment (HWE) and Work Environment Needing Improvement (WENI) using the Essential of Magnetism II process instrument (EOMII). For all three HWE groups, there were significant differences in the degree of environmental reality shock experienced by newly graduated nurses at 4, 8, and 12 months post-hire. Newly graduated nurses working on WENI units reported the highest Environmental Reality Shock scores. This means that newly graduated nurses experienced the greatest fall from their initial high expectations of the environment. In contrast, those on VHWE units reported the lowest environmental reality shock scores (Kramer, Brewer & Maguire, 2013).

The newly graduated nurses' perceptions of the quality of patient care in their units were further investigated by using the nurse assessed quality of patient care rating scale. For all types of HWE units, a V-shape pattern was revealed. The quality of patient care ratings was high at 4 months, dipped at 8 months, and rocketed at 12 months. The scores of newly graduated nurses in VHWE units were significantly higher than those of their counterparts working in HWE or WENI units. Furthermore, the issues and concerns that constitute environmental reality shock experienced by newly graduated nurses at 4 and 8 months post-hire were also assessed. As expected, ten issues remained very high or high concerns at both 4 and 8 months post-hire, including getting work done, lack of self confidence and ambivalence, harming patients, delegating, prioritising, working with physicians, inadequate feedback, too

much responsibility, and 'floating' to other units. The following five issues, including experiencing work conceptions different from those taught in school, role expectations exceeding preparation, physical labour and mental fatigue, work-life imbalance, and bureaucratism followed a decreasing trend from being a high concern at 4 months to ranking at only some or no concern at 8 months post-hire (Kramer, Brewer & Maguire, 2013). For issues related to dying patients / families, this study was different from other studies (e.g. Casey, Fink, Krugman & Propst, 2004; Delaney, 2003; Qiao, Li & Hu, 2011; Yeh & Yu, 2009) in that newly graduated nurses demonstrated only some or even no concern at both 4 and 8 months (Kramer, Brewer & Maguire, 2013).

Importantly, two issues received only some or no concern at 4 months but increased to high concern at 8 months post-hire. They were having patients that did not receive needed care, friction, disagreement and conflict. New graduate nurses at earlier stages might be too self-absorbed and less aware of patient care quality as well as other factors that shape their practice in the social context. They may begin gaining awareness after eight months of practice (Kramer, Brewer & Maguire, 2013). This awareness may continue to increase beyond the first year of clinical practice that sheds important light on my research study about sustaining good work in nursing.

3.3.2 Paucity of literature study beyond the first 12 months

Limiting studies to the initial 12 months of role transition among newly graduated nurses carries the assumption that this period of time is the most stressful. However, the experience of further development and integration beyond the first year of clinical practice is not without stress (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013), and remains underexplored. Numerous alarming findings will be presented that demonstrate the significance of studying the period beyond the first year of clinical practice, particularly as my research puzzles are related to transition, sustaining good work, and mentoring.

3.3.2.1 Resolution of reality shock (0-18 months)

Kramer's (1974) seminal work on reality shock is imperative in the literature of new nurse graduates, which is one of the work most frequently cited by other researchers on this subject. Reality shock is defined as shock-like reactions when new nurse

graduates transition from the academic setting to their first job as professional nurses in hospitals. The shock-like reactions are closely related to the discrepancy between their role expectations and reality. They expected that their professional concept of nursing learnt during their years of study in an academic setting would be applicable to the hospital setting, but it was not. Reality shock can become a crisis of professional identity when a new graduate enters a workplace with a system of values and expectations by managers and the bureaucracy that is inconsistent with those learnt in school. New graduates go through four phases of reality shock. The Honeymoon phase comes first and is characterized by positive feelings such as excitement and euphoria about the real experience of working as a nurse and getting a salary for nursing work. This is similar to my own experience of initial excitement to be working in the neuroscience unit that I had been looking forward to joining. The second phase is the Shock phase. The new graduates enter this phase when they discover that they may not be able to achieve their goals because of their lack of clinical experience or the constrictive nature of the work environment. New graduates in the Shock phase demonstrate outrage, reject the values they learnt at school, and experience fatigue or even depression. Phase three is the Recovery phase, which is reached when the new graduates develop a sense of perspective toward their work. The final phase is known as the Resolution phase, in which the new graduates achieve competence and realise their ability to create an identity as a nursing professional. The Resolution phase is likely to be reached around 18 months after graduation, suggesting an 18-month adjustment period for new graduate nurses (Kramer, 1974). The four phases share some similarities with the three phases identified by Bridges (1980), particularly the involved psychological reorientation needed to adapt to the change (excepting the honeymoon phase).

More than three decades later, Halfer and Graf (2006) conducted a quantitative study by surveying 84 new graduate nurses at a children's hospital in the United States at 3, 6, 12, and 18 months of employment. All variables demonstrated a positive mean score by the end of 18 months of clinical practice. This is consistent with the length of time recognised by Kramer (1974) that is needed to resolve reality shock. The new nurses demonstrated significant improvement in the following variables: understanding of leadership expectations, ability to get work accomplished and manage job demands, and awareness of professional development opportunities. It is

interesting to note that U-shaped pattern emerged in the way some variables changed, meaning that respondents felt a lower satisfaction at a specific time interval, but that satisfaction later improved. These variables include having the knowledge and skills to perform the job, access to resources, and ability to participate in professional development opportunities. The authors used the Honeymoon phase described by Kramer (1974) to explain the initial feelings of higher satisfaction before the drop. Though significant improvement or changes occurred with other variables, these were affected by the participants' attrition rates, which ranged from 48% to 76%. Also, although the study analysed qualitative remarks, it revealed a limited in-depth understanding of the transitional experiences of new nurse graduates, particularly regarding experiences beyond the first year of clinical practice, and how and why satisfaction was achieved. The comments 'being able to continue to learn and grow here with all opportunities available' seemed to be the only qualitative comment that participants provided to shed some light on their overall satisfaction at the end of 18 months. It is uncertain whether further qualitative remarks were actually provided by the participants or whether the authors were constrained from writing more due to the word limits of the manuscript.

3.3.2.2 Development of professional competences (8-18 months)

Kramer et al. (2012) conducted a nation-wide research programme in the United States, using both qualitative and quantitative approaches and including participant observations, interviews and a short survey of 907 nurses. The majority of nursing participants were newly licenced registered nurses and experienced nurses or preceptors, and a minority of them was nurse managers and nurse educators. Participants identified seven critical challenges for newly licenced registered nurses trying to manage their professional roles and responsibilities. They included delegating to subordinates, prioritisation across different specialties and within the patient assignments per shift, managing patient care delivery under time pressure, clinical autonomy, collaboration with physicians, constructive conflict resolution, and utilizing feedback to restore self-confidence. The seven critical challenges identified by Kramer et al. (2012) are highly consistent with the difficulties identified by the other studies that explored the same subject from the individual perspectives of new graduate nurses (e.g. Kelly, 1996; Parker, Giles, Lantry & McMillan, 2014). Kramer et al. (2012) further invited the different stakeholders to estimate the

respective number of months needed to develop competence in the seven critical areas. Though the estimated number of months across different groups of stakeholder varied, it is important to note that the estimated duration for the seven critical areas ranged from 8 to 15 months. This once again supports my view that studying the experiences of NGRNs should not be limited to the first year of clinical practice (Kramer et al., 2012).

In a similar vein, McKenna and Newton (2008) conducted a phenomenology in the Australia by conducting focus group interviews with nine new graduates after their first year of clinical practice. They identified that the nurses' development did not stop after finishing the first year of practice and completing the one year transition support programme. The nurses in their 16^{th} to 18^{th} month of practice were still developing their sense of belonging, independence, and exploring opportunities for further professional development. The study was limited by its small sample size and the short durations of focus group interviews, which might have resulted in a superficial understanding. The authors concluded by recommending further studies about the experiences of new nurse graduates after their first year of practice (McKenna & Newton, 2008).

3.3.2.3 Development of practice readiness (3 to 24 months)

As mentioned earlier, stakeholders who had different expectations about whether newly graduated nurses should be professional nurses or technical nurses might also have different perceptions of practice readiness. The practice readiness of a professional nurse is viewed as a developmental process that evolves along the career trajectory, which may take 3 to 24 months. The duration of the transition depends on the complexity of the work environment, previous learning experience and availability for support after registration. In contrast, the practice readiness of a technical nurse is viewed as being more static and is expected as the tangible end product of nursing education (Wolff, Pesut & Regan, 2010). As my research interest is not in understanding the experience of NGRNs in general or technical nurses who merely emphasize getting work done and following instructions, but rather in nurses who persist in developing themselves and pursuing good work despite adversity, my focus is on the development of professional nurses. This helps confirm the

significance of planning a potential research duration that covers the first two years of clinical practice.

3.3.2.4 Skill acquisition from novice to competent (at least 2 years)

The transition of new nurse graduates can also be viewed as a process of skill acquisition while developing from novice to expert (Benner, 1984). Benner adopted the Dreyfus Model of skill acquisition which lists five ascending levels of proficiency in nursing and originated from research studying the performance of airline pilots during emergencies and chess players. The premise of the model is that context-dependent judgments and skills can only be acquired in real situations. The skills do not refer to psychomotor skills but to the applied skills of nursing in actual clinical situation. Three aspects of change in skilled performance were identified based on a Heidegerian phenomenology conducted in the United States using interviews, focus group interviews, and participant observations of more than 80 nursing professionals ranging from senior student nurses, newly graduated nurses and their preceptors, and experienced nurses. First, nursing judgments may shift from over reliance on abstract principles to applying previous concrete experiences adopted as paradigms. Second, nurses shift to making decisions based on certain relevant facts among the given set of information rather than wasting time searching or waiting for less relevant information. Third, nurses are no longer detached observers but are involved performers who are fully engaged in the situation. 'Novice' refers to nurses who are new to the environment or situation and the term is not determined merely by years of experience. Therefore, NGRNs are novices despite their hours of clinical practicum, because they have minimal or no previous experience in managing emergency situations, caring for dying patients, taking up the role of charge nurse and administering medication without supervision. Advanced beginner nurses regard patient care situations as a challenge to their skills and ability, and see themselves separate from the situation, not participating actively. They are task-focused, lack the ability to organise patient care, and lack the experience necessary to identify and respond to the important aspects of any given patient situation. Nurses who are 'Competent' have accumulated two to three years of experience in stable circumstances. They are more efficient, organised, and consistently apply critical thinking skills in identifying actual and potential problems and formulating appropriate plans of care (Benner, 1984). Therefore, NGRNs are

likely to be at the stage of a novice or advanced beginner. This once again confirms the need for potential research of longer duration in order to understand the transition to becoming a competent nurse. With my particular focus on sustaining good work, a minimum of the first two years of clinical experience ought to be scrutinized. Reflecting on my own experience, it was around the time I left the neuroscience unit, two years after graduation, that I had a sense of competence, confidence and efficiency about managing most of the situations I encountered, including being the second shift in-charge while the charge nurses left for meal breaks. In fact, Benner's seminal work has been frequently adopted as the theoretical framework used by many of the transition or mentoring programmes for newly graduated nurses, which is further discussed in the next chapter.

Schoessler and Waldo (2006) also constructed a process model for new graduate nurses in their first 18 months of practice, based on Benner's (1984) novice-to-expert skill acquisition model and Bridge's (1980) transition management. The authors conducted an interpretive phenomenology in the United States by having regular sharing and discussion sessions with new graduate nurses, known in whole as a narrative community. Four themes emerged from the narrative community, namely, relationship with the health care team, organization of patient care, relationship with patients and families, and experiencing marker events. In the first three months, new nurses focused narrowly on tasks. Learning to organise and prioritise those tasks left them with limited quality time for developing relationships with patients. They were dependent on other team members and valued their preceptor. They learnt to work with their nursing and medical colleagues and often took criticism from other team members personally, sometimes resulting in self-doubt. It was not until later in their practice that they realised some colleagues were less approachable than the others. Examples of marker events in this stage included various first experiences, the deaths of some of their own patients, making errors and developing new skills. During the fourth to ninth months, new nurses became more familiar with tasks and demonstrated improved shift organization. They expressed concerns about not being able to answer the questions raised by patients satisfactorily. Nevertheless, they became more confident when they realised that they were able to answer some of the questions raised by other team members. In the final stage (10-18 months), they were comfortable with procedural care and had a broadened perspective about patients.

This perspective included interacting with the patient's family, viewing relationships with the family as a challenge to overcome and regretting that they were unable to remember all their patients by name. Improvements in their shift organization were recognised by others. However, it is important to note that their interactions with physicians remained problematic. Marker events included beginning to precept younger nurses, completing shifts on time and assuming the responsibilities of a charge nurse (Schoessler & Waldo, 2006). The main limitation of this study was the absence of detail about the sampling, data collection and data analysis methods. Though it extended beyond the first year of clinical practice, I found the process model to be quite similar to Duchscher's (2008), but less detailed. Once again, the lack of detailed description may be related to the word limits of the journal.

3.3.2.5 Temporality of preceptoring (0-3 years)

Deppoliti (2008) in the United States interviewed 16 nurses who graduated and had been employed at a hospital within the past three years, and identified six passage points. They include orientation, conflict of care, fitting a niche, taking the licensure examination, becoming a charge nurse and moving on. One of the alarming findings was related to orientation. The success of orientation was determined by the nurses' relationship with the preceptors and a negative preceptoring experience outweighed that of a positive one. It is disturbing to note that a 'payback' system existed in the hospital setting, where nurses tended to repeat the negative experiences they had had as new graduates when they became preceptors of younger generation of nurses (Deppoliti, 2008). This further revealed the temporal dimension of the concept of preceptoring, in which the past experience as a preceptee could shape present and future experiences as a preceptor of others. This once again confirms the need for potential research that extends beyond the first year of clinical practice to capture the temporality, if any, of preceptoring or the related concept of mentoring. This will be further examined in the next chapter, which focuses on mentoring newly graduated nurses. Being a charge nurse is another milestone, but it is associated with high levels of anxiety due to the increased sense of responsibility, which is not limited to taking charge of oneself, but also involves guiding others as a senior nurse. Having only limited orientation and experiencing overwhelming responsibility, nurses reported a sense of being pushed too soon, as well as a sense of unpreparedness. By the end of the third year of clinical practice, with additional experience gained from

rotating to other clinical areas, nurses reported that they had increased their knowledge of new performance-enhancing skills. They also shared an increasing sense of comfort, confidence, assertiveness, and competence, and were experienced at integrating theory with practice. This correlates with other findings that they also had increased respect from physicians. They also perceived greater capacity to control the hospital setting in order to meet their own needs as well as the needs of their patients (Deppoliti, 2008).

The research studies scanned in this section revealed the significance of conducting further in-depth qualitative study to understand the experience of NGRNs beyond their first year of clinical practice, with a particular focus on the changes and shaping effects along the temporal dimension. Furthermore, it seems imperative to extend the study period beyond the first year of clinical practice in order to capture the meaning of nurses' experiences when they begin to engage in exploring and critiquing their situated health care landscape at the end of the Knowing stage (Duchscher, 2008). It is also important to understand how past experiences of being preceptored or mentored might shape future experiences of being a preceptor, mentor or more senior colleague of the younger generations (Deppoliti, 2008). Though some might argue that the initial months of the role transition and professional socialisation are the most stressful, Kramer, Maguire, Halfer, Brewer and Schmalenberg (2013) emphasized that stress also occurs later, when newly graduated nurses are in the integration stage of forming and affirming their professional identity. It would also be important to use repeated interviews and prolonged engagement.

This section also provided important insight into extending the potential research time period to cover the first two years of clinical experience. In the next section, the focus will be on the place dimension, identifying the need for further studies about the experiences of NGRNs in Asian countries.

3.4 The Place dimension

This section will show the significance of further in-depth qualitative research of NGRNs in the Asian territory of Hong Kong. This social significance is supported by two rationales. First, is the paucity of studies about new graduates in Asian countries

(Feng & Tsai, 2012; Gregg, Wakisaka & Hayashi, 2013; Lee, Hsu, Li & Sloan, 2013; Qiao, Li & Hu, 2011; Tominaga & Miki, 2011; Yeh & Yu, 2009) when compared with the vast amount of literature in the West. This means there is only a limited in-depth understanding of the transitional experience of NGRNs in Asian countries, and whether the conclusions of the literature in the West can be directly transferred to the Asian context is questionable. Second, in the literature that does exist, I was quite surprised to discover that the findings in Asian countries are quite similar to those reported in the West, except for the emphasis on maintaining harmonious working relationships and the prevalence of the blaming or scolding culture. This leads me to wonder whether no cultural differences exist between the experiences of newly graduated nurses in Western and Asian countries. In fact, it is also possible that such highly consistent findings between the West and the East were related to the research design and/or formalistic thinking (Clandinin & Connelly, 2000) of the researchers, leading to some important nuances being overlooked or taken for granted. The following subsections examine some of the studies conducted in Asian countries that provide a limited in-depth understanding of the experience of newly graduated nurses in transition and led me to have the above questions.

Yeh and Yu (2009) investigated job stress and intention to quit among 146 newly graduated nurses still in their first three months of clinical practice at three hospitals in Taiwan, using a cross-sectional quantitative research design. The samples were classified into three categories based on their months of experience, 0-1, 1-2, and 2-3 months. The authors identified newly graduated nurses in their first month of practice as reporting the highest level of job stress, followed by those in 2-3 months and 1-2 months. Major stressors were found to be related to tasks in critical and general care. They include managing emergencies, caring for patients with unknown infectious diseases, using professional English terminology, dealing with death and dying, precise intra-professional communication during end-of-shift handover, identifying the changing conditions of patients, administration of medication and operating medical equipment correctly. It is important to note that 31.5% of the sample in their first three months of clinical practice reported an intention to quit. Logistic regression analysis revealed that newly graduated nurses with higher job stress had a significantly higher intention to quit (Yeh & Yu, 2009).

Tominaga and Miki (2011) were also concerned about intention to leave and its associated factors among newly graduate nurses in Japan. By surveying 737 newly graduate nurses and calculating the Peason's correlation coefficient, it was revealed that their intention to leave correlated significantly with the following factors: effort, subjective psychological health status, work-related cumulative fatigue, and quality of role models. Meanwhile, age and job readiness were independently associated with the intention to leave. In contrast, over-commitment and the presence of rewards were not significantly associated with the intention to leave.

Qiao, Li and Hu (2011) also adopted a quantitative descriptive approach in examining the relationships between demographic characteristics, sources of nursing stress and coping strategies, and psychological well-being among 96 graduate nurses in China. Dealing with death and dying was once again recognised as a major stressor, similar to the findings of Yeh and Yu (2009) in Taiwan. This stressor, together with other stressors, including conflict with physicians, heavy workload, and inadequate preparation, were found to be negatively correlated with psychological well-being. Meanwhile, anxiety, depression and loss of confidence were the most commonly reported psychological symptoms experienced. To cope with the stress, planning, acceptance and positive reframing were strategies most frequently adopted, which were found to have a positive correlation with psychological well-being at a significant level. In contrast, the use of denial and behavioural disengagement as coping strategies was found to be negatively correlated with psychological well-being. Multiple regression analysis showed that the use of denial as a coping strategy and dealing with death and dying as a workplace stressor were the best negative predictors of psychological well-being (Qiao et al., 2011).

3.4.1 Harmonizing working relationships and the blaming culture

Though I am familiar with the concepts of workplace bullying and horizontal violence, I would not use those terms to describe my past experience in the 'villain village' and of being scolded frequently, especially in the initial few months. This leads me to wonder whether there is a Chinese explanation for such negative workplace interactions, since China has a culture that emphasizes interpersonal relationships under the influence of Confucianism.

Feng and Tsai (2012) conducted a qualitative descriptive study in Taiwan by interviewing seven baccalaureate graduate nurses with the goal of understanding their professional socialisation process. Similar to the Western literature, the findings indicated that the transition from new graduate nurse to practicing nurse was a stressful experience, particularly because of the conflict between the professional values of patient-oriented nursing care and the organizational values of task-oriented nursing. The theme 'overwhelming chaos' captures the new graduates' awareness of the organizational and professional constraints, which leads them to feel disorganised, self-defeated and ambiguous about their role. The second theme 'learning by doing' captures the complex process of induction into a variety of formal and informal norms. The new nurses had to familiarize themselves with the unit's rules, rituals and even taboos. They were yelled at in front of others when they did not conform to the norms. Ironically, participants indicated that bridging the theory-practice gap is much easier than learning how to behave appropriately and deal with interpersonal relationships at the workplace. This resonated with my own experience of being scolded by my preceptor in public and I also agree that maintaining complex collegial relationships was even more difficult than skills acquisition. It was not until five months after employment that the new graduates experienced reduced stress and increased confidence, along with a sense of being part of the team. This resulted in the final theme of 'being an insider' (Feng & Tsai, 2012).

Lee et al. (2013) adopted a phenomenological design using 8 weekly focus group interviews at one teaching hospital in Taiwan with 16 new nurses with less than 1 year of experience to understand their transitional process. Similar to another qualitative study in Taiwan (Feng & Tsai, 2012), the findings shows that new nurses struggled to transition from outsider to insider. The nurses were considered outsiders and weak when they were new, incapable and powerless (theme one was 'being new as being weak'). They experienced unfair treatment, such as unequal patient assignments in terms of patient number and acuity, or incivility, such as being embarrassed, blamed and criticised in public after making mistakes. Despite feeling angry, new nurses could only hide their feelings, and they internalized feelings of being treated unreasonably (theme two and three). The authors identified the use of yielding, tolerating abuse and self-oppression as self-protection methods and coping mechanisms was related to the Chinese culture, which emphasizes conformity, power

hierarchy and harmonious relationships. In the late stage of transition, the time frame of which the authors did not specifically identify, new nurses demonstrated changes in their response towards mistreatment. Instead of self-oppressing and tolerating abuse, new nurses demonstrated passive-aggressive behaviours such as not providing assistance to senior nurses when they were busy, and/or established tactful relationships with senior nurses by actively doing favours for them to 'stockpile human favours' or depositing 'savings in the bank'. It was not until new nurses became capable of finishing their assignments independently and helping other nurses or team members that their position shifted in the hierarchy and became insiders (theme four) (Lee, Hsu, Li & Sloan, 2013). This study not only revealed the potential differences in interpretation of mistreatment at the workplace between nurses in the East and West, but also sheds some light on the vicious cycle of workplace violence in which uncivilised behaviours might be internalized by new nurses and re-enacted on the younger generation. While new graduate nurses might attempt to minimize their chances of being bullied by changing behaviour that might affect quality of care and even jeopardize patient safety, understanding the process by which the professional identity is shaken, distorted or maintained will be the focus of the next section.

Cleary, Horsfall, Jackson, Muthulakshmi and Hunt (2013) also conducted a qualitative study in Singapore with 17 recent graduate nurses with about three years of clinical experience. It is important to note that participants perceived that as fresh graduates they had received inadequate support in their respective hospitals and that at the time of the study their need for ongoing day-to-day support was still not being met. Alarmingly, a 'blaming culture' was mentioned, but the study provided limited description of this. Correspondingly, nurses who do not scold but work actively against the blaming culture and advocate senior nurses were recognised as positive role models in the clinical setting. Other important characteristics attributed to role models are: being more patient-related, including having therapeutic communication skills, being caring, compassionate, empathetic, and being assertive patient advocates to safeguard the patients' best interests. Three participants mentioned quitting in the interviews, with two intending to do so and one having already resigned. The factors influencing the intention to leave include the well-acknowledged nursing shortage, the workplace culture of blame and the uncivilised manner of the physicians, limited

autonomy, challenges in their clinical practice, and lack of choice to work in their specialty, as well as unsatisfying pay structure and lack of public recognition of nursing roles (Cleary, Horsfall, Jackson, Muthulakshmi & Hunt, 2013).

In contrast to other studies conducted in Asian countries that try to understand the experiences of newly graduated nurses from the nurses' own perspectives, Gregg, Wakisaka and Hayashi (2013) in Japan explored the subject from the perspective of the nurse managers, who were in charge of the education of all staff. Nine nurse managers whose clinical units demonstrated good staff cohesiveness were selected for interviews with the assumption that they had effective strategies to facilitate the integration of newly graduated nurses into their units. The first three strategies were similar to the standard practices of nurse managers commonly found in the literature. They include understanding the circumstances of newly graduated nurses, providing opportunities for experiencing and learning, and supporting nurses who teach the new nurses. Facilitating self-learning was the fourth strategy with the emphasis on fostering autonomous thinking and learning among newly graduated nurses, focusing on learning at their own pace without comparing them to other new graduates, and motivating them by giving recognition and praise. Promoting awareness of being a practicing nurse is the fifth strategy, accomplished by giving them special reminders of their responsibility when they received their first pay slip and assigning new graduates small real roles instead of routine tasks. Last but not least was strengthening the sense of comradeship in the clinical units, a sense not confined to the personal and professional development of the new graduates, but includes establishing a supportive environment and including new nurses as insiders or members of the family. The low level approach included celebrating the new graduates' birthdays, seeking their opinions, and making changes based on their feedback so as to build a sense of belonging and to show the new graduates that they are valuable human resources. The nurse managers also organised common activities for all colleagues, patients and their families to cultivate a positive and supportive environment (Gregg et al., 2013). This study investigating good nurse managers offers important insights about the characteristics of positive role models that we can use to better support the NGRNs suffering overwhelming stress.

3.5 Summary

The significance of my narrative inquiry studying the first two years of the experiences of NGRNs in transition and in pursuit of good work is shown along the personal-social interaction, temporal and place dimensions. In the personal-social interaction dimension, though the transitional and socialisation experience of newly graduated nurses was repeatedly and consistently reported to be overwhelmingly stressful, further research is needed, for the problem remains prevalent and unresolved. The high stress level is not only related to the unpreparedness of NGRNs to nurse in the complex health care landscape, but also to the unsupportive work environment of incivility and even workplace violence, as well as to professional and organizational constraints that result in established professional identities that are shaken or even distorted. All these interrelated stressors have been recognised as important antecedents of the high turnover rates and low retention rates of newly graduated nurses in their first two years of clinical practice. This phenomenon not only fails to relieve the problem of an aging nursing workforce, but may further aggravate the global nursing shortage problem. Shortage of staff and high turnover rates have been identified as closely related to undesirable patient outcomes, including higher patient mortality, higher failure-to-rescue rates and a greater number of patient falls, as well as undesirable nurse outcomes including job dissatisfaction and burnout (Aiken et al., 2002; Bae, Mark & Fried, 2010). A higher turnover rate was associated with lower levels of workgroup learning, which may further lead to higher incidences of serious medical errors (Bae, Mark & Fried, 2010). This might be the reason why many authors use nursing shortage to show the significance of their research on the experience of newly graduated nurses (e.g. D'ambra & Andrews, 2014; Duchscher, 2009; Lee et al., 2013; Tominaga & Miki, 2011).

Along the temporal dimension, although the initial few months, or the transition stage, might be most stressful, the integration stage is not without stress (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013). Yet this stage remains underexplored. Multiple studies support the conclusion that the development of new graduates does not stop at the end of the first year and further support is needed afterward and that 18 months may be needed to reach the stage of resolution in the process of reality shock (Kramer, 1974), while 24 months may be required for novice nurses to accumulate adequate experiential learning and achieve the level of a

competent nurse (Benner, 1984). The same amount of time may be needed for professional nurses to develop practice readiness (Wolff, Pesut & Regan, 2010), and to understand how past experience as a preceptee or mentee may shape a nurse's present and future experiences as a preceptor or mentor (Deppoliti, 2008). Evidence also shows that some new graduates begin to have a broader perspective in exploring and critiquing how the health care landscape shaped their clinical practice at the end of their first year of practice (Duchscher, 2008). Therefore, extending the research duration beyond the first year of clinical practice might help unveil important nuances that have been underexplored and taken for granted.

In the place dimension, the significance of this narrative inquiry is evident in two ways. First is the paucity of studies conducted in Asian countries, with no publications that can be retrieved about the local context, thus showing a limited in-depth understanding of the transitional experiences of NGRNs in Asian countries. It is questionable whether the conclusions of the literature in the West are directly transferable to Asian countries. Second, the findings of the few studies available in the East are quite consistent with those in the West, except for the aspects of maintaining harmonious working relationship and coping with the blaming or scolding culture. It is questionable whether no cultural differences exist and it is worth examining whether important nuances have been overlooked or taken for granted. Studies in the local context would therefore add insight into the experiences of NGRNs in transition and in pursuit of good work in the Asian region. Such studies would also be useful for further cross-cultural comparisons and consideration when adapting findings from the Western studies to Asian countries.

Identifying the significance of this narrative inquiry also paves the way for the next chapter, which attempts to further understand how mentoring and the related concept of preceptoring has been examined in relation to newly graduate nurses in transition and in pursuit of good work in nursing.

CHAPTER FOUR

SCANNING LITERATURE OF THE MENTORING EXPERIENCES OF NEWLY GRADUATED REGISTERED NURSES

4.1 Introduction

After understanding the difficulties and challenges experienced by NGRNs in their transition to professional nurses in the complex and dynamic health care landscape, this chapter provides an overview of the concept of mentoring. The significance of conducting this narrative inquiry is revealed as the chapter moves from the definitions and historical development of mentoring in the nursing profession to its elusiveness in the nursing literature.

4.2 Dictionary definitions and etymological underpinnings of mentoring

The term mentoring or mentorship is derived from the word 'mentor'. In contemporary English, 'mentor' is a noun, which is defined by the dictionary as 'a trusted adviser of somebody with little experience in a particular field' (Hornby, 1995, p. 731). Etymologically, Klein (1971) defines mentor as 'a wise adviser'. The root prefix *men-* is Indo-European lineage and means 'to think'. The root suffix *-tor* is from the same lineage and is 'a masculine agential suffix' (Klein, 1971, pp. 457, 473). The word 'mentor' originated in Greek mythology, specifically Homer's epic poem, *The Odyssey*. Odysseus was a great royal warrior who left his son, Telemachus, in the care of his friend Mentor when he went to fight the Trojan War. Athene, the goddess of wisdom, disguised herself as Mentor in order to provide a role model for Telemachus in the aspects of doing, thinking and being. Mentor later advised and supported Telemachus to find Odysseus and reclaimed his inheritance (Hamilton, 1942; Homer, 1967). Mentoring processes have four characteristics: they are nurturing, insightful, supportive, and protective, and all four are revealed in this mythology. First, mentoring is a nurturing process that fosters the growth and development of the mentee toward his or her full potential. Second, mentoring is an

insightful process that helps the mentee to grow in wisdom. Third, mentoring is both supportive and protective, ensuring the safety and well-being of the mentee. Finally, role modelling is a cardinal attribute of mentoring, as Athene did for Telemachus (Anderson & Shannon, 1988).

4.3 Increased popularity of mentoring in nursing

Historically, mentoring has been focused on helping men, especially in male-dominated societies where women rarely occupied influential positions (Vance, 1982). Archival research suggests that Florence Nightingale was the first nursing mentor who engaged in a mentor-style relationship. She mentored Rachel Williams, the matron of St. Mary's Hospital in Paddington, England, who later went on to establish a nursing school in 1877 (Lorentzon & Brown, 2003). It was in the early 1980s that mentoring relationships began to be seen as important in the nursing profession. Vance (1982) studied the actual mentoring experiences of both mentees and mentors in a group of 71 prominent and influential nurse leaders. She defined 'mentor' as an individual 'who serves as a career role model and who actively advises, guides and promotes another's career and training' (Vance, 1982, p. 10). She concluded that mentoring was beneficial to women, especially those at leadership levels, and encouraged the promotion of mentoring at all levels in the nursing profession (Vance, 1982).

Dr. Lu Ann W. Darling, another mentoring scholar in North America, responded to questions raised by readers of *The Journal of Nursing Administration* on the subject of mentoring. Her ideas have frequently been cited by researchers of mentoring in both nursing and non-nursing fields. Darling interviewed 150 respondents about their mentoring experiences. One-third of them were nurses, but the details of the sampling criteria, data collection and analysis method were not specified. In the study, 'mentor' is defined as 'a person who leads, guides, and advises a person more junior in experience' (Darling, 1985a, p. 42). It is important to note that Darling interpreted 'mentor' and 'mentoring' differently. Based on her research findings, 'mentoring' is a broader and more inclusive concept. She emphasizes that mentoring focuses on the process. Mentoring should not be limited only to interaction with a particular person or persons. Many of her participants were mentored by events,

situations and circumstances more than by people. Therefore, ‘mentoring’ is defined as a ‘process by which you are guided, taught, and influenced in your life’s work in important ways’ (Darling, 1985a, p.42). ‘Mentoring events’ refer to those occurrences that are not part of the regular flow of life, but are formative in some significant way. It is important to note that these significant events can be beneficial or traumatic, depending on how they are experienced and whether the opportunity present in the situation outweighs the danger. Though events often happen whether or not we choose them, Darling sought to increase our awareness of the mentoring potential of different events and experiences in our lives, and encourages us seek them out actively and deliberately (Darling, 1985a). Darling also identified 14 mentoring roles and formulated them into a tool - the Darling Measuring Mentoring Potential - for evaluating mentor behaviours. Inspirer (attraction), Investor (action) and Supporter (affect) were recognised as three essential roles for a mentor in a significant mentoring relationship. The other mentoring roles include model, energizer, standard-prodder, teacher-coach, feedback-giver, eye-opener, door-opener, idea-bouncer, problem-solver, career counselor, and challenger (Darling, 1984). Mentoring began to gain popularity in nursing following the publication of her work.

Mentoring can and does occur formally and informally. In informal or classical mentoring, the nature and terms of the relationship are initiated informally and naturally by the persons involved, as a result of chemistry, mutual attraction, and admiration. They have shared interests and commit to working together. Informal mentoring is not structured within any programmes or organizations, and the mentor has no explicit financial rewards or recognition. Its purposes and functions are often vaguely defined and the learning support is often unstructured, which depend on the individuals, circumstances and context (McCloughen, O'Brien & Jackson, 2006; Morton-Cooper & Palmer, 2000; Tourigny, Louise & Marcia, 2005). The probable duration ranges from 2 to 15 years (Morton-Cooper & Palmer, 2000). Given its spontaneous, natural and unplanned nature, the informal mentoring relationship is usually named retrospectively when the efforts of the mentor are appreciated and honoured by the mentee, rather than named in advance with the mentee anticipates what might occur (Bennetts, 2002).

In formal or contract mentoring, the relationship is artificially created to achieve specific aims, purposes, functions, and outcomes that are determined by the organization. The individuals involved are often randomly assigned, formally matched, or allowed to choose from a pool of identified mentors and/or mentees. A formal mentoring programme that structures this kind of formal mentoring relationship might provide training, guidance, explicit financial incentives, material rewards, and recognition to mentors (McCloughen, O'Brien & Jackson, 2006; Morton-Cooper & Palmer, 2000). The probable duration ranges from 1 to 2 years (Morton-Cooper & Palmer, 2000). This contrasts with informal mentoring, because mentees in this formal mentoring relationship might not be viewed by their mentors as particularly worthy of special attention and support. Because this kind of mentoring relationship is established within the formal mentoring programme under some degree of structure and pressure, there is no guarantee that both parties of the formal dyad will be motivated or develop a unique nurturing bond (Chao, Walz & Gardner, 1992; McCloughen, O'Brien & Jackson, 2006).

4.4 The elusiveness of mentoring

The elusiveness of the concept of mentoring has been identified in nursing and education literature (Crow, 2012; McCloughen, O'Brien & Jackson, 2006; Vance & Olson, 1998). Vance and Olsen (1998) recognised the complex and elusive nature of mentoring, stating that mentoring is ‘difficult to define and measure. It cannot be seen, but… can be described by those who experience it’ (p. 5). The elusiveness of mentoring might be related to how easily the term can be interchanged with other related yet different terms, particularly ‘preceptoring’ or ‘preceptorship’ (see Chapter 1). In this section, both mentoring and preceptoring literature will be scanned to show how the problem of elusiveness has persisted for almost two decades, and the possible reasons for it will be explored. Since different terms are used in the literature to describe the novice, including ‘mentee’, ‘protégé’ and ‘neophyte’ (Mijares, Baxley & Bond, 2013), the term ‘mentee’ is used in this dissertation for consistency.

4.4.1 Plethora of programme evaluations with limited understanding of mentoring

A scan of the literature on the empirical research of mentoring and preceptoring new nurse graduates in the health care setting shows that attention seems to have shifted markedly in the past 15 years to programme evaluations. A majority of these supportive programmes were conducted in the United States. A relatively smaller number were conducted in Australia and the United Kingdom. The names of these supportive or transition-to-practice programmes vary, and include formal names such as Flying Start NHS, as well as generic names such as fellowship, graduate nurse transition, internship, mentorship, orientation, preceptorship and residency programme. The duration of these programmes varied widely from 1.5 to 12 months, with one extending to 15 months (Bratt, 2009). The published literature did not indicate the duration of some programmes. The programmes were also characterized by their component diversity, in the cases in which no direct relationship could be established between the programme name and its components. Appendix I shows a summary of these supportive programmes, all of which were intended for new nurse graduates working in the clinical setting between 2001 and 2015. Although there is a plethora of literature on evaluating programmes provided to support new nurse graduates, the emerged understanding of mentoring from these studies was limited, which could be discussed in four aspects as follow.

First, almost all of these programmes involved the use of a more experienced nurse or group of nurses, given the title ‘mentors’ or ‘preceptors’ for the purpose of guiding new nurse graduates through their clinical experiences. However, some authors provide no definition of the terms ‘preceptor’ and/or ‘mentor’, and some even use both terms in their articles (Banks et al., 2011; Beecroft, Kunzman & Krozek, 2001; Beecroft, Santner, Lacy, Kunzman & Dorey, 2006; Cottingham, Di Bartolo, Battistoni & Brown, 2011; Halfer, 2007; Herdrich & Lindsay, 2006; Kowalski & Cross, 2010; Owens et al., 2001; Scott & Smith, 2008). These authors probably assumed that their readers and other researchers shared a general consensus on the meanings and definition of mentoring and preceptoring, but this is not the case. McCloughen et al. (2006) identified the problem caused by this assumption that a general understanding of mentoring exists among readers. I discuss this further in a later section.

Second, while mentoring has been defined as a long-term relationship (Bozeman & Feeney, 2007; Meier, 2013; Morton-Cooper & Palmer, 2000; Stewart & Krueger, 1996; Yoder, 1990), it is questionable whether a formal relationship between a new graduate nurse and a senior nurse in a supportive programme that is limited to less than 12 months in duration (Beecroft, Kunzman & Krozek, 2001; Leigh, Douglas, Lee & Douglas, 2005) can be conceptually consistent with a mentoring relationship that has the important time attribute. It is also important to note that more experienced nurses are not naturally attracted to new nurse graduates and their mentoring relationships are often assigned (Beecroft et al., 2006; Cottingham, Di Bartolo, Battistoni & Brown, 2011; Greene & Puetzer, 2002; Nugent, 2008; Young et al., 2008), with only some programmes providing new nurse graduates with an opportunity to indicate their preferred counterparts (Beecroft et al., 2006; Halfer, 2007). Some programmes also offer training, support, and recognition to the preceptor (Bratt, 2009; Cottingham, Di Bartolo, Battistoni & Brown, 2011; Halfer, 2007; Hatler, Stoffers, Kelly, Redding & Carr, 2011; Krugman et al., 2006; Newhouse, 2007; Owens et al., 2001; Vermont Nurse Internship Project, 2009). Therefore, regardless of the name used to identify these relationships, they seem more conceptually consistent with preceptoring or at most formal mentoring relationships, not informal mentoring.

Third, other more general programme components include orientation, classroom learning, skills and procedure practices, seminars, case studies, group discussions, role playing, patient simulation scenarios, self-directed learning modules, and rotations to different units or specialties. Some programmes also include the use of debriefing, reflective learning sessions, clinical narratives and conferences, peer support, ward visits by an additional support personnel, and a graduation ceremony to facilitate the transition of new nurse graduates and enhance retention rates. The additional support personnel also have different titles. Their role is to monitor entire programmes and coordinate between the new nurse graduates and their assigned senior nurses. These personnel include faculty advisers, the programme director, residency coordinator, professional development staff, clinical/nurse educator, clinical scholars, resident facilitator, and clinical nurse specialist/practitioner. These programmes were often evaluated in terms of their success in various outcomes,

including clinical skills and knowledge, confidence and competence, professional development, critical thinking, organization and prioritisation, communication and leadership, perceived support, stress and anxiety, sense of belonging and organizational commitment, control over practice, role conception and discrepancy, professional autonomy, satisfaction with the job and the programme, recruitment, anticipated turnover, retention rate, and return on investment. However, it is important to note that limited information is provided about the experience of both new nurse graduates and their assigned senior nurses in the relationship, despite the fact that this kind of programme evaluation is abundant in the literature.

Fourth, using the system developed by Beck (2001) and later modified by Park and Jones (2011) to evaluate the level of evidence of the published studies shows that they were not strong studies. There are four areas of concern. (i) The study design - the majority of the studies adopted a quantitative descriptive design. Some were longitudinal, while only a few had quasi-experimental study designs. Generally, control groups were used infrequently, and some studies included a comparison group of samples who refused to participate, rather than a group of random samples. (ii) Time dimension – it was common for data to be collected on a one-time basis at the end of the programmes, with only a few studies adopted a longitudinal design. (iii) Sample diversity, size, and response rates - most of the evaluations involved only new nurse graduates. Only a few programmes considered evaluating experiences from the perspectives of other stakeholders, such as preceptors, nursing directors, the steering committee, and the patient care director (Cottingham, Di Bartolo, Battistoni & Brown, 2011; Hatler, Stoffers, Kelly, Redding & Carr, 2011; Kowalski & Cross, 2010; Owens et al., 2001). Convenience samples were commonly used. The sample size of studies population varied widely from 10 to 679, although some studies did not report the sample sizes at all. It is important to consider the low response rates of some studies: some of which were lower than 60% (Salt, Cummings & Profetto-McGrath, 2008), while some failed to report the response rate at all. (iv) Standard of measure used - some studies used self-developed surveys of unknown reliability and validity. Some studies used measures of dubious validity for programme evaluation, such as annual employee opinion surveys (Halfer, 2007), annual client and family surveys with an assessment score based on client's minimum data set coordination (Aaron, 2011), patient overall satisfaction with care, and even clinical outcome for

patients with congestive heart failure (Hatler, Stoffers, Kelly, Redding & Carr, 2011). All of these are considered to be weak levels of evidence. The causal relationship between the supportive programmes and the measured outcomes, therefore, has to be interpreted with caution, as there may be other possible reasons that led to the evaluation results.

While a vast number of additional studies could be cited, I believe the several I mention here can serve as a representative sample for me to express five concerns. First, the literature on mentoring and preceptoring tends to focus primarily on the structures and components of the programmes, functions, roles, and outcomes. This implies a functionalist perspective that focuses on organizational efficiency and equilibrium, as evidenced by the emphasis on retention rates as the cardinal outcome of these transition programmes. Crow (2012) identified the problem of adopting a functionalist perspective on mentoring in that it often overlooks the reciprocal nature of mentoring in which both the mentor and the mentee benefit from the relationship. Jakubik (2008) and Mills (2009) also identified the potential reciprocal impact of mentoring, in which the consequences of initial interactions become baseline behaviours or in narrative term, narrative history in guiding for future actions and interactions with others, shaping a future mentoring experience that is not limited to the initial dyad.

Second, there is a hidden assumption that these formal supportive programmes, particularly the formal mentorship programme, can give rise to a personal mentoring relationship (Bozeman & Feeney, 2007), even though the absence of relational connection has been identified (Ferguson, 2011). Though studies conducting programme evaluations are abundant, their study designs limit in-depth scrutiny of the potentially complex mentoring experiences and provide no details about how the NGRNs are supported. In fact, even though mentees were given a range of different choices prior to mentor assignment, 17% of mentees reported that they did not ‘click’ or get along with their assigned mentors (Beecroft et al., 2006). With the focus on specific tasks and organizational issues, it is doubtful whether that kind of relationship can progress beyond a superficial level to be classified as a preceptoring relationship, or even a pseudo-mentoring or quasi-mentoring relationship (Morton-

Cooper & Palmer, 2000). To what extent is the enabling element of mentoring really present?

Third, almost all programmes were limited to the first 12 months post-hire, similar to the situation in the transitional literature on new nurse graduates. This limits understanding of the mentoring experience beyond the first year of clinical practice. Furthermore, this reveals another hidden assumption: that the mentoring relationship is finished by the end of the programme, at which time new graduates are supposed to have successfully transitioned. However, new nurses might still be in a stressful stage of integration (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013) and struggling to sustain good work. Their experiences and need for mentoring remain underexplored (see Chapters 2 and 3). Also, this lack of research limits understanding of how a nurse's present experience being a mentee can shape the future experience of being a mentor to others.

Fourth, it is common for authors to state in their introductions that transition programmes have the potential to improve patient safety and quality of care. However, after examining the reported outcomes, transition programmes were either not directly or only loosely related to patient safety or quality of care. How mentoring facilitates good work in nursing, if it does at all, is undetermined. It is unclear how mentoring can address the difficulties and challenges experienced by NGRNs in transition, such as managing possible ethical and moral dilemmas that occur when collaborating with different health care workers in the complex health care landscape and avoiding the workplace bullying examined in the previous chapter.

Last, the findings of these programme evaluations seemed to be overwhelmingly positive. For example, in two recent publications, only the responses of the preceptors and preceptees who agreed with the effectiveness of the preceptorship programme were reported. However, the reasons why some participants disagreed with the programme's effectiveness were not reported (Marks-Maran, Ooms, Tapping, Muir, Phillips & Burke, 2013; Muir, Ooms, Tapping, Marks-Maran, Phillips & Burke, 2013). There are three possible reasons for the positive results: it may be due to respondent bias, since respondents participating in the supportive

programmes may have been invited by researchers whom they knew in the institution; or to publication bias (Portney & Watkins, 2009), or to researchers' bias in taking the risks of mentoring for granted. In fact, mentoring scholars have explored negative mentoring experiences from the perspectives of protégés (Eby & Allen, 2002; Eby & McManus, 2004; Eby, McManus, Simon & Russell, 2000) and mentors (Eby, Durley, Evans & Ragins, 2008) using non-nursing samples. Half of the protégé participants reported that they had negative mentoring experiences in their career (Eby et al., 2000). A mentoring relationship continuum, ranking relationships as effective, marginally effective, ineffective, and dysfunctional, was proposed after examining negative mentoring experiences (Eby & McManus, 2004). Eby et al. (2008) pointed out that both positive and negative perspectives could co-exist within the same mentoring relationship. This reaffirmed the potential complexity of the mentoring relationship, which cannot be classified simply in a dichotomous way. A few nursing researchers also made some cautionary reminders about potential negative aspects of mentoring, including having a toxic mentor, variously called as avoiders, dumpers, blockers and destroyers, or criticisers, which can be detrimental to mentees (Darling, 1985d). Nevertheless, Green and Jackson (2014) identified a knowledge gap in the contemporary nursing context, since there is paucity of literature on negative mentoring relationships. Furthermore, in the temporal dimension, it is unclear how present negative mentoring experiences might shape future mentoring experiences in the nursing profession. In order to bridge an important knowledge gap, qualitative studies seem to be the appropriate methodology. It would be beneficial if the qualitative methodologies were not bounded by formalistic thinking (Clandinin & Connelly, 2000), but could foster possible space to examine the taken for grantedness of the everyday practice and challenge the dominant discourse, especially regarding the potential dark side of mentoring (Green & Jackson, 2014). A qualitative research based on long-term relationships with the participants, exploring the question from multiple perspectives, could therefore enhance our understanding of the meanings of mentoring NGRNs in transition and in pursuit of good work.

4.4.2 Little is known about the experience of mentoring NGRNs and registered nurses

Within the abundance of mentoring literature in nursing, there is a strong emphasis on programme development, implementation and evaluation, perceptions of good or

effective mentors and mentees, and the risks and benefits of mentoring. However, there is a paucity of extensive research about the mentoring experience, particularly that of NGRNs. The published studies focus on mentoring nursing students (Atkins & Williams, 1995; Glass & Walter, 2000; Wilson, 2014), rural nurses (Mills, Francis & Bonner, 2007; Mills, Francis & Bonner, 2008a; Mills, Francis & Bonner, 2008b; Mills, 2009), and nurse leaders (McCloughen, O'Brien & Jackson, 2009; McCloughen, O'Brien & Jackson, 2011), mainly from the perspective of the mentor. This knowledge gap was also identified by Mills and her colleagues (Mills, Francis & Bonner, 2007; Mills, Francis & Bonner, 2008a).

Furthermore, it is important to note that some researchers over-generalise in their discussions of mentoring studies without specifying the contexts in which the original studies were conducted. For instance, one discussion paper on the support needed by nurses who assumed preceptor or mentor roles for both nursing students and new graduates was in fact mainly based on studies of mentors' experience with nursing students, but no specifics were given (Henderson & Eaton, 2013). Although some similarities might exist in the mentoring of nursing students and new graduates, new graduates with professional qualifications might be expected to perform differently, especially in a context of a global nursing shortage. In contrasting, nursing students without professional qualifications are expected to work and learn under the supervision of qualified nurses. Hence, the mentoring experience of new nurse graduates and nursing students can be different, even if only to a small degree. Over-generalising and overlooking nuances across various contexts can not only lead to conceptual confusion, but also possibly hinder concept development. In this section, previous studies in four aspects, namely qualitative programme evaluation, informal mentoring, mentoring good work in nursing, and mentoring NGRNs in the local context, are scanned to identify the significance of further inquiry into the different experiences of mentoring NGRNs in transition, integration, and pursuit of good work.

4.4.2.1 Qualitative programme evaluation

DeCicco (2008) used a qualitative summative evaluation in Ontario, Canada, to develop a preceptorship/mentorship model for home health care nurses. Focus group interviews were conducted with various stakeholders, including preceptors,

preceptees, managers, clinical resource nurses, and health service supervisors before and after the development of the model. Key informant interviews were also conducted with eight opinion leaders, and a workflow analysis was performed. The perceived benefits of the preceptorship/mentorship models were analysed and reported in three aspects. First, a benefit to the organization was perceived in terms of greater recruitment and retention. Second, participants perceived preceptors/mentors as sources of career-building and advancement opportunities and saw, in addition, that mentors were satisfied by the growth of novice nurses. Third, preceptees/mentees were perceived as having an increased sense of support and organizational commitment. The importance of having continuity in preceptors/mentors, rewarding and recognising their contributions, and ensuring adequate time in which to precept/mentor was accentuated. A preceptorship/mentorship model was formulated that outlined the role of different parties, namely the manager, clinical educator, preceptor/mentor, and preceptee/mentee (DeCicco, 2008). It is important to note once again that although definitions of preceptor, preceptorship, mentor and mentorship were provided, the terms were used interchangeably throughout the study, leading to conceptual confusion.

Wolak, Mccann, Queen, Madigan and Letvak (2009) conducted a qualitative study in the United States to explore the perception of a one-year mentorship programme in a 9-bed intensive care unit from the perspectives of both mentors and mentees, using separate focus group interviews. The authors reported that the experiences and perceptions of the mentor group were aligned with those of the mentee group in terms of general mentor accessibility for questions and clinical support, establishment of a sense of community, and supporting the clinical and professional development of both mentors and mentees (Wolak et al., 2009). However, the breadth and depth of the findings might have been limited by the small sample size of 6 mentors and 5 mentees, as well as the short interview duration of only half an hour.

Interestingly, another study found that mentors of NGRNs had diverse expectations and anticipations of their mentees. Ballem and MacIntosh (2014), using Munhall's (2007) narrative inquiry, interviews, and observation, explored the experience of

eight experienced nurses in two Canadian hospitals as they worked with and mentored NGRNs at the beginning of their transition. Some of them perceived the NGRNs as disorganised and unable to prioritise their work, requiring close guidance. Some expected the NGRNs to be competent in providing complete patient care. Others perceived that the NGRNs needed time to develop their organizational skills and were pleased to have the NGRNs, since they increased staff numbers and alleviated patient load. The themes of 'keep us on our toes' and 'carrying a greater load' indicated the perpetual cycles of demands and stresses on senior nurses as they are continually called upon to mentor NGRNs and deal with the added staff rotation and attrition of the NGRN programme (Ballem & MacIntosh, 2014).

The perspective of more senior nurses should not be overlooked. More experienced nurses are responsible for ensuring patient safety and maintaining the care quality of their own assigned patients, as well as those of their junior nurses. In view of the problems of nursing shortage, skill imbalance, sick leave, and stressful shift work, more experienced nurses often have to orient, precept, support, supervise, and oversee multiple junior nurses, both NGRNs and/or nursing students who may or may not be otherwise formally assigned. Furthermore, the clinical rotation system of the various transition programmes simply perpetuates the cycle of orientation and preceptorship that can lead to role overload and exhaustion in the more experienced nurses (Clark & Holmes, 2007). In a similar vein, many senior nurses reported that they do not have time to monitor and mentor new nurse graduates and ensure patient care quality and safety, despite having a sense of obligation to do so. This leads to a sense of moral distress, compounded by a context of chronic staff shortage and a mobile workforce. Ironically, 'senior' nurses on the unit might have less than five years of clinical experience, which means that the difference in experience between mentors and mentees can be quite narrow. Many participants in this Canadian qualitative exploratory study had about a year of experience in the practice, education, and regulatory sectors and perceived that the current health care landscape is challenging even for experienced nurses to nurse well. They agreed that it was unrealistic to expect new graduates to transition into such a context with confidence (Wolff, Pesut & Regan, 2010).

Continuing the discussion of clinical rotation in staff development programmes, a qualitative explorative study in the United Kingdom found that newly qualified nurses, preceptors, practice development nurses, and ward managers had contrasting perceptions of rotation. Some new qualified nurses and ward managers believed that clinical rotation was beneficial for broadening their range of skills, while other ward managers believed that it was disruptive to the unit operation when new nurses left after four months of teaching. Also, newly qualified nurses experienced problems in transferring their acquired skills from one unit to another, though the transferability was expected by other senior nurses in the clinical rotation system (Clark & Holmes, 2007). In a similar vein, the phenomenology conducted by Kelly and Ahern (2009) also found negative perceptions held by new nurse graduates of the clinical rotation. Initially, nurses prior to employment looked forward to their upcoming clinical rotation as a chance to broaden their clinical exposure and help them to choose a specialty for further professional development. However, in a later interview, after they had rotated to other units, many participants had changed their minds and no longer supported the idea of clinical rotation. They had developed a sense of belonging in their initial unit and did not want to rotate. Also, none of the participants reported any positive experience in their clinical rotations, but found it to be a stressful and unsettling experience, especially when many of them had no formal support or assigned preceptor after clinical rotation. The subtheme ‘double reality shock’ was used to describe the renewed anxiety, apprehension, and even doubt, resulting from clinical rotation (Kelly & Ahern, 2009).

Latham, Ringl and Hogan (2013) evaluated an RN peer mentoring programme conducted at two hospitals in the United States over a five year period. RN mentors were assigned to each of the new nurse graduates, who were allowed to indicate three choices for their preferred mentor. After two education sessions for both mentors and mentees, the dyads of mentor and mentee are committed to their defined roles in an evolving learning relationship that would focus on meeting the mentee’s learning needs and fostering the mentor’s professional growth. This was a new mentorship programme that was implemented concurrently with an already available preceptorship programme. Analysis of the programme was undertaken by examining mentors’ monthly online journals, transcripts of the monthly mentor support group meeting, and semi-annual meetings with hospital and nursing management teams.

The records showed that the mentees were still experiencing a variable of workplace violence and negativity from other nurses, even their preceptors, as well as doctors, patients, and patients' families. Nevertheless, the authors concluded that the mentoring programme helped alleviate workplace violence and negativity by providing support and coping strategies to mentees, though it is unclear how and to what degree the mentors were in fact helping mentees to adapt to such unacceptable workplace behaviours. It is also important to note that the conclusion was based merely on the mentors' perspective, and the analysis of the data seems to adopt formalistic thinking by fitting into the eight themes identified by Duchscher (2001). The integrative review of D'ambra and Andrews (2014) supports my concerns and criticism in their conclusion that graduate nurse transition programmes seem to be used to acculturate new graduate nurses to incivility without addressing any underlying issues.

Kramer and her colleagues conducted a five-year nation-wide study on nurse residency programmes (NRPs) in the United States, with reference to all special programmes for new graduate nurses, namely residencies, internships, and fellowships. As discussed in chapter 2, the professional socialisation of nurses can be viewed as a three stage process of separation, transition, and integration. It is important to note that among all 34 magnet hospitals, only 4 provided evidence of having multistage NRPs with clear transition and integration stages. Fourteen other hospitals had NRPs that lasted at least 2 months longer than the preceptorship experience, when the NGRNs were not counted in the staffing structure, but still took care of patients assigned to their preceptors. The NRPs also included some components related to professional affirmation and integration. The remaining 16 hospitals provided a NRP with a transition stage only. The nurse participants in the qualitative data, working from four different perspectives, almost universally agreed that preceptors and NRPs were most instrumental in helping NGRNs make the transition from nursing students to fully functioning professional nurses. Effective transition-stage components were recognised from the qualitative data. They included the experience of being under the guidance of a preceptor, skills/demonstrations/practice, reflective sessions, and clinical rotation (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013). This is consistent with the findings of another study (Duchscher, 2008). Discussion sessions were identified as the most

helpful and effective components of integration. Other helpful components included reflective practice/debriefing sessions, identification of dilemmas and issues of concern, and clinical coaching/mentoring presentations. Notably, NGRN participants also reported difficulty distinguishing the differences between mentors and preceptors (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013).

While the authors recognised that stress was most severe in the transition stage, they caution that stress occurs during integration stage also. Furthermore, the majority of the NGRNs, as well as half of the preceptors and nurse managers, also indicated in the interviews that achieving at least two levels of accomplishments was necessary before NGRNs could be trusted as complete professional nurses. The two levels, respectively, are the transition stage, when NGRNs are more dependent and work with their preceptor, and the integration stage, when NGRNs work independently, taking care of multiple patients simultaneously. The authors demarcated the first three months post-hire as the transition stage, and the integration stage as the completion of the first year of clinical practice (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013). However, this finding has to be interpreted with caution, for it has not been empirically established but is merely a theory based on the length of the reviewed NRP, which might have inadequately addressed the NGRNs' needs in the integration stage. Nevertheless, the authors concluded that the integration stage was less clearly articulated by the participants than the transition stage. This provides another confirmation of the significance of extending future research on NGRNs' experience beyond their first year of clinical practice. Research should continue to at least the second year, to understand the potential integration stage when NGRNs' identity is still being formed.

The components and strategies of the NRP's effectiveness in new graduate socialisation were further investigated by Kramer et al. (2013). The Essential of Magnetism II process instrument (EOMII) is used to classify units into three categories: Very Healthy Work Environment (VHWE), Healthy Work Environment (HWE) and Work Environment Needing Improvement (WENI). Based on the principle of 'best of the best', the authors believe they can identify the components which are most effective by asking people who are practicing in units that are recognised as VHWE. This reflects an assumption that the VHWE unit will have an

effective NRP, which might be applicable and transferable to other work environments. It is also important to note that though this part of the study used only qualitative data, a strategy or component is classified as effective if it has been cited by at least half of the participants of half of the units in a hospital. This is a rather quantitative perspective, using frequency count. Preceptor and/or clinical coach councils and evidence-based management projects were strongly recommended by the authors, based on the qualitative data. They were recognised as effective in facilitating the acquisition by NGRNs of management skills (delegation, prioritisation, and clinical autonomy), which are high priorities during the transition and integration stages of professional socialisation (Kramer et al., 2013). Furthermore, in reviewing the retention rate of NGRNs in the three categories of work environments - VHWE, HWE, and WENI units - Kramer et al. (2013) concluded that the quality of the work environment is the most important factor in determining retention of NGRNs, particularly in the first year post-hire. The retention rates of NGRNs in WENI units were significantly lower than those in HWE and VHWE units at 6, 12, 24 and 36 months (Kramer, Halfer, Maguire & Schmalenberg, 2012).

Interestingly, while most of the studies generally reported positively on the supportive programmes provided, a qualitative descriptive study conducted in Taiwan by interviewing seven nurse graduates revealed a rare counter-story. Participants were reluctant to attend the compulsory programmes, preferring to learn by practicing, researching on their own, and asking friendly colleagues in the workplace. They commented that the programmes were too difficult and did not fit their current needs, and that they were also too exhausted to attend the programmes after work (Feng & Tsai, 2012).

Along the same lines as the quantitative programme evaluation, emphases have been placed on identifying different roles held by nurses in the programmes, components and strategies for effective professional socialisation of NGRNs, and the obstacles, opportunities, and benefits of the programmes to the NGRNs their mentors/preceptors, and the organizations. Despite a greater usage of qualitative data collection methods in recent research, an in-depth understanding of the experiences of NGRNs and more experienced nurses in formal mentoring relationships was rarely

addressed. It is a subject that needs further research, especially regarding the both transition and integration stages.

4.4.2.2 Informal mentoring

In addition to understanding the formal mentoring relationship, the informal or classical relationship should not be overlooked, for it has considerable influence on an NGRN's capacity to gain a holistic view of the patients and the entire clinical situation (Tourigny, Louise & Marcia, 2005). It is important to note that nurses in practice often use informal and unit-based resources, namely, experienced colleagues, as sources of new knowledge apart from the knowledge gained from formal continuing education (Asselin, 2001). Tourigny and Pulich (2005) also found that knowledge that is based on personal experience, intuition, judgement, know-how, expertise, and individual insight is generally transferred via social workplace interaction rather than formal education and training. Therefore, in addition to studying structured supportive programmes, the contextual experience of informal mentoring relationships within the complex health care landscape also needs to be examined, especially because they are still underexplored (Ryan, Goldberg & Evans, 2010).

The national quantitative descriptive study conducted by Jakubik (2008) about the prevalence of formal and/or informal mentoring among paediatric nurses in the United States found that approximately 18% of the sample group had a formal mentoring experience, while 29.4% experienced informal mentoring. Meanwhile, with the prevalence of formal mentoring programmes in the United States, it is not surprising that most of the sample group reported having an experience as a mentee in a formal workplace-sponsored mentoring relationship (52%, n = 214) (Jakubik, 2008). This national study provides some insight for further research, suggesting that the mentoring should be studied comprehensively in both its formal and informal aspects, rather than fracturing it into two distinct categories and studying those separately. In such a dichotomous approach, their relationship might be overlooked. Furthermore, almost three-quarters of participants (74%) indicated that they were a mentor at some point, while more than half of them (51%) indicated that their decision to become a mentor was shaped by their past experience as a mentee. This finding reveals the temporality of mentoring. Mentoring is not only beneficial to the

current workforce of mentored nurses, but also has the potential to promote a greater prevalence of mentoring in the future (Jakubik, 2008).

In a similar vein, another study using mixed methods conducted in Australia reported that most new graduates sourced support from a range of staff. A majority of them relied predominantly on other RNs, and a minority relied on support from other new graduates, enroled nurses, nursing assistants, and medical officers. This may correlate with inadequate opportunities to work with their assigned mentors and a lesser degree of satisfaction with the assigned formal relationship. Only 41% indicated satisfaction and 32% indicated dissatisfaction, while 61% reported satisfaction with their relationships with other nursing colleagues (Parker, Giles, Lantry & McMillan, 2014). Therefore, both formal and informal mentoring relationships should be examined to gain a holistic understanding.

Angelini (1995) conducted a grounded theory study in the United States by interviewing 37 female staff nurses and their 8 respective female nurse managers, and analyzing relevant hospital documents to understand their mentoring experiences. Two models emerged from the data: the structural mentoring model and the process mentoring model. Mentoring was manifested in a multidimensional, situational, and relational form, which is more complex than the single mentor-mentee model. In the structural mentoring model, the three primary mentoring influentials identified were people, events, and environments. Nursing peers and managers were recognised as the primary people influencing the mentoring of hospital staff nurses, due to their more frequent contact with them. Clinical nurse specialists and educators, physicians, and family members, however, had relatively less frequent contact and were recognised as secondary influences. Interestingly, ‘self’ was categorized as a secondary influence, but no further information was provided about self-mentoring. The category of environmental influences includes value conflicts, lack of support, limited advancement and recognition opportunities, and unsafe work conditions that might hinder mentoring experience. Appreciation, recognition, support for further continuing education, monetary rewards, and non-material rewards were also recognised as environmental influences that promote good mentoring experiences. The third major category of influence on mentoring was various types of events, including clinical patient situations such as both successful and unsuccessful

resuscitations, a patient's death and dying stages, and career incidents such as the 'first experience' in one's career, ranging from initial employment as a new graduate to the first time taking charge of the unit, to clinical rotation. Other social-political-cultural circumstances happening outside the workplace, such as the influence of women's movement and family illness, were added in a subcategory of the general event category. This empirically-based conclusion is consistent with Darling's (1985a) broad conceptualization of mentoring, which envisions mentoring as something not limited to a particular person, but resulting from various events, situations, and circumstances. Furthermore, within the process mentoring model, these three mentoring influentials interplay in different mentoring dimensions, using different mentoring strategies to lead to career development outcomes. Mentoring strategies, enacted mainly by nursing peers, involved assisting with clinical problem-solving, providing cooperative and supportive effort, and promoting career adaptation. Other mentoring strategies, enacted mainly by nurse managers, also involved providing education and career advancement opportunities (Angelini, 1995). This grounded theory can shed some light on the experiences of mentoring NGRNs in hospital settings; however, the findings may not be directly transferable and have to be evaluated with five main considerations. First, the study was conducted two decades ago and changes in society, such as in health policy and the health care system, and in nursing education and curriculum, might limit its applicability to the contemporary health care landscape. Second, it is important to note that all participants were white women, whereas nurses the contemporary nursing profession is seeing an increasing number of male nurses. For instance, the sex ratio in Hong Kong of RNs (males per 100 females) was 11 in 1987 and had increased to 14 by 2013 (Department of Health, 2015). Third, staff nurses had a minimum of 5 years of nursing experience and 12 years of experience on average. This is in great contrast to NGRNs, who are still in their first two years of clinical practice after professional registration. This might be the reason the mentoring outcomes focused on career development rather than patient care quality, the correct handling of conflicting pressures, and identity formation. Fourth, only positive career development outcomes were reported. Once again it is worth asking whether this is related to any report bias or overlooks any potential risks in mentoring. Lastly - yet most importantly - mentoring for good work - that is, excellent, ethical, and engaging nursing care - was not examined in the study. Nevertheless, the author's suggestion is valuable in

highlighting that further research should explore mentoring influentials - people, events, and environments - in combination, rather than separately (Angelini, 1995).

Mills et al. (2007) conducted a grounded theory to understand the experience of mentoring novice nurses in rural areas in Australia, drawing data from the perspectives of nine rural nurse mentors. The rural nurse mentors cultivate and grow novice nurses under planned face-to-face, accidental face-to-face, and planned distant conditions. The process of cultivating and growing begins by getting to know the mentor - initially a stranger - and progresses as the mentor and mentee deepen the relationship by walking with one another. The process can be catalyzed in two ways: either the nurse mentor recognises the potential in the novice nurse and decides to takes him or her as a mentee or an experienced nurse may informally mentor a novice nurse who has gone through an emotionally impacting critical incident. Preceptoring and accidental mentoring are short-term relationships that provide guidance and support to a novice nurse, and are directed at developing specific clinical skills and handling incidents. If the two parties have shared values and interests, and time is allowed for further development of the relationship, the relationship will not terminate at this point. The mentor and the novice nurse continue to walk with one another and establish increasing levels of trust and engagement. The short-term relationship will further develop into a long-term mentoring relationship. When the mentee becomes more experienced, the power relation shifts to a relationship of more balanced power, which may further evolve into a deep friendship. This natural progression underscores the temporality of mentoring. There is another aspect of the temporality of mentoring. It is important to note that the way the experienced rural nurses mentor the novice nurses was shaped not only by the initial two-day mentor development workshop, but also their own past experience of being mentored (Mills, Francis & Bonner, 2007; Mills, Francis & Bonner, 2008a; Mills, Francis & Bonner, 2008b). This finding in Australia resonates with the one in the United States (Jakubik, 2008).

The importance of informal mentoring as a relational and experiential learning process among perinatal nurses was revealed in a feminist phenomenological study conducted in Canada on five perinatal nurses using interviews, participant observation, and researchers' reflective journals (Ryan, Goldberg & Evans, 2010).

All participants had worked in the obstetric unit for at least two years and had experienced being a mentee, while four of them also had experience as a mentor. Novice nurses learn by observation and imitation, while experienced nurses model perinatal nursing practice as they engage with the birthing women. Participants also model how to engage with other nursing colleagues by cultivating a work environment that is supportive to all nurses, including novice nurses and newcomers. In addition to modelling, a positive learning space is created between the novice and experienced nurses and the birthing women. Learning moved beyond tasks to applying and integrating knowledge into action to support and engage with birthing women. The passion and enthusiasm of the experienced nurses becomes contagious to the novice nurses, and their informal mentoring and relational learning motivates them to commit to good perinatal nursing (Ryan, Goldberg & Evans, 2010).

Ferguson (2011) also conducted a grounded theory in Canada, but from the perspective of new nurses. Using repeated interviews with 25 nurses who had two to three years of clinical experience, the researcher identified a list of important characteristics used by effective mentors to support the transition of new nurses. Effective informal mentoring developed slowly over time and depended primarily on a relational connection between the new nurses and the more experienced nurses, characterized by matched personalities and the new nurse's perception of being cared for as a person. The more experienced nurses not only needed to be friendly, approachable, supportive, and welcoming to establish a relational connection, but also needed to be strong role models whose nursing practice is admired and respected by the new nurses. Role models are knowledgeable and experienced nurses who can manage crises effectively. They enjoy nursing and are engage in their work and are committed to holistic nursing care for the patients and their families. Effective mentors understand the learning needs of new nurses and are instrumental in new nurses' development. They are willing to answer the questions raised by new nurses, guide them in thinking critically and making clinical decisions, and assist them in integrating with the workgroup. All such supportive actions contribute to stress reduction. It is important to note that many of the new nurse participants reported that their preceptors rarely become their mentors, due to the absence of a relational connection. The new nurses had to find other nurses to be their mentors while they were seeking to learn and develop their clinical judgment (Ferguson, 2011).

The literature above gives many insights about the informal mentoring relationship. However, they are inadequate for answering my research question about the details of mentoring NGRNs who are in transition and learning to pursue good work in nursing.

4.4.2.3 Mentoring good work in nursing

Darling's (1985a) broad and inclusive conception of mentoring is that it is a process in which the mentee is guided, taught, and influenced by a particular person or persons, as well as other events, situations, and circumstances. This conception, together with the suggestions of other researchers about the origins of good work (Fischman et al., 2004; Miller, 2006; Miller, 2011; Welk, 2013), reveal the potential relationship between mentoring and the sustenance of good work in nursing. This idea was supported by Parse (2002), who viewed mentoring as consisting of complex, non-linear human interactions that involve collaboration and transformation, both of which are cardinal to cultivate growth among nursing professionals. However, the relationship between good work and mentoring has not been specifically explored in nursing, as discussed in chapter 2. Ronsten, Andersson and Gustafsson (2005) conducted an innovative study on 'confirming mentorship' under the guidance of the theoretical framework known as the Sympathy-Acceptance-Understanding-Competence (SAUC) model. Confirming mentorship was defined as the mentor's efforts to provide evidence that would strengthen the mentee's positive self-assessment and reduce negative self-assessment. Self-assessment is about reaching a situation in which a person self-evaluates as successful, which occurs when she has eliminated the discrepancy between her ideal and actual self. The one-year mentorship programme can be understood as a dynamic process, in which the mentor performs supportive and confirmatory actions while moving through the four phases of sympathy, acceptance, understanding, and competence, as outlined in the SAUC model. The eight new RN participants perceived their mentors confirming them in strengthening their positive self-assessment. For instance, new RNs being confirmed by their mentors manifested increased security and motivation to nurse (S-phase), greater capacity to verbalize nursing situations (A-phase), and improved reflection upon and evaluation of patient situations, viewing patients as unique individuals (U-phase). The authors concluded with the suggestion that mentorship may be a cardinal

strategy for learning professionalism and maintaining quality standards in nursing. However, the relationship in the study was not clearly illustrated and evidence was not provided to show which quality standards are maintained and by what methods. It is also important to note that the new RNs had had previous nursing experience, ranging from 1 to 30 years, working experience which might have shaped their present experience in transition and mentoring. The research findings might not be directly applicable to NGRNs who are fresh graduates of undergraduate nursing programmes.

Perry (2009) conducted a phenomenology with eight exemplary nurses from a hospital in Canada, using repeated interviews and participant observation to understand how excellent clinical nursing practice can be role modelled to other nurses. Although the author did not provide a definition of the elusive concept of 'excellent' or 'exemplary' nursing practice, exemplary nurses were identified by nursing colleagues using this imaginative question: 'Which nursing colleague do you want if you are ill?' These exemplary nurses identified by their colleagues were assumed to have professional knowledge, which is a combination of practice observations, clinical experience, knowledge, and skills, and assumed to be excellent role models for novice nurses. The role modeling behaviours of exemplary nurses include attending to the small things that are often taken for granted, making positive connections with both patients and colleagues, modeling intricacies of excellent nursing care that cannot be learnt from textbooks, and affirming others through positive feedback and appreciation, especially in a stressful environment (Perry, 2009). With research data derived from the perspectives of role models or 'mentors', this study may shed some light on both good work characterized by excellence, ethics, and engagement (Gardner, 2010) and mentoring which has role modeling as a cardinal attribute (Anderson & Shannon, 1988).

Expanding the search to non-nursing literature, the relationship between mentoring and good work was examined by Nakamura, Hooker and Shernoff (2009) in the profession of genetics. They conducted a multigenerational and multi-lineage research design study which went beyond the traditional one-to-one mentor-mentee dyad investigation. Starting with three senior scientists in genetics who exemplified good work and were identified by peers as 'heads' of mentoring lineages, and

extending to 12 of their mentees in the second generation, and further extending to 21 mentees in the third generation, the evolution of values and practices across linked generations of geneticists within the same laboratory was examined. It is questionable whether the findings, drawn from relatively more steady laboratories can be directly transferred to the mentoring experience in the nursing profession, which is frequently interrupted by shift work, dynamicity, and complexity, has a high frequency of change in the flow of people, and can be unpredictable with rapid changes of patients and the overall ward situation. Nevertheless, this study sheds some light on the relationship between mentoring and good work in two ways. First, good mentors influence their mentees directly by modeling high professional achievements that are excellent and ethical. Second, good mentors influence their mentees indirectly by providing a collegial group of able peers and cultivating a specific moral climate and training environment. The mentees can then acquire the necessary technical skills and knowledge while internalizing professional norms of conduct, such as honesty, integrity and cooperativeness. These cultivated young professionals become good mentors for the next generation in the profession of genetics (Nakamura et al., 2009).

4.4.2.4 Mentoring NGRNs in the local context

Last but not least, it is important to remember that the study of mentoring NGRNs from the perspectives of both mentors and mentees in Hong Kong is also underexplored. The Hong Kong Hospital Authority (HA) published guidelines in 2006 for various local public hospitals regarding the planning and implementation of their preceptorship programmes for newly recruited nursing graduates (HA, 2006). Under these guidelines, each public hospital has since developed and adopted its own preceptorship programme for NGRNs, and the outcomes were evaluated individually within the institution. Even after extensive literature research, no information could be found about the various local supportive programmes or the preceptoring and mentoring experience of NGRNs in clinical settings, except for one conducted more than a decade ago that merely focused on nursing students' perceptions on the effectiveness of mentors. Chow and Suen (2001a; 2001b) conducted a mixed method multiple-phase action research study on a mentoring scheme, namely an honorary clinical instructor scheme at a local university. Clinical staff in particular units were assigned as 'mentors' to baccalaureate nursing students during their clinical

placement to teach them about the clinical setting. However, clinical placement normally lasts for only six to eight weeks with a maximum duration of four months, which allows for only limited contact between the mentor and the nursing student. The use of the term 'mentor' in the study might be related to the definition adopted from the United Kingdom, characterized as including these five mentoring roles: assisting, befriending, guiding, advising, and counseling. Nursing students ranked the assisting role as most important, while the guiding and advising roles were the next most important. They perceived that their mentors were not fulfilling the befriending role adequately, but tended to treat them as guests. Surprisingly, the counseling role was ranked least important by the students and not practiced much by their mentors, whilst its importance when nursing students undergo a lot of stress in their clinical placement is much in evidence. However, this use of the term 'mentor' was critiqued by Yonge, Billay, Myrick and Luhanga (2007) as more appropriately describing the preceptor concept. This criticism might be related to the short duration of the relationship, as well as the negligible fulfillment of the befriending and counseling roles, an inadequate psychosocial component commonly observed in preceptoring relationships (Billay & Yonge, 2004).

I have broadened the search of mentoring literature to non-nursing fields in Hong Kong with the hope that this will help shed light on the cultural issues related to mentoring. Lee and Bush (2003) evaluated the nature and effectiveness of a mentoring programme implemented at a local university in which participation was compulsory for all university students. The aim of the programme was to use the faculty as resources to increase the student retention rate and enhance students' academic performance. Each student was matched with a faculty mentor and each pair was expected to have seven one-hour meetings a year. The quantitative data, obtained using a survey, revealed that the mentee's primary motivation to participate was to satisfy the university requirement, while the mentor's primary motivation was to help the student adjust to university life. Both mentors and mentee ranked developing a better professor-student relationship as secondary motivations. There was agreement between the mentors and mentees on the first four perceived desirable mentor characteristics, though they ranked them differently. A good mentor will be understanding and sympathetic, will be accessible to students, will communicate well, and be enthusiastic (Lee & Bush, 2003). The preferences of the university students

are quite different from those of nursing students (Chow & Suen, 2001a; Chow & Suen, 2001b; Suen & Chow, 2001), even in the same local context. The nursing students' preferences regarding mentors in their clinical placement seem to be more instrumental. The differences might be related to the different natures of the two mentoring programmes, as one focuses on clinical learning while the other focuses on student retention, promoting academic achievement, and student satisfaction. Lee and Bush (2003) interviewed five mentors, but reported rather general conclusions. Most of the mentors interviewed enjoyed being a mentor, while one expressed that the satisfaction of the role depends on the attitude of the mentee. Lack of time, training, and recognition were the three main obstacles to good mentoring. These obstacles seem to be universal and are consistent with the findings obtained from nurses in Western countries (DeCicco, 2008; Wolak et al., 2009).

Mann and Tang (2012) conducted a qualitative longitudinal case study to understand the mentoring experience and its role in supporting novice English language teachers in Hong Kong, from the perspective of both mentors and mentees. They identified these seven factors that affect the mentoring relationship: mentor status and role, differences in age and experience between mentor and mentee, reciprocal lesson observation, principal involvement, interaction with other staff, and the induction tool kit (information package for orientation). The mentors perceived mentoring as a compulsory duty rather than a self-selected professional development opportunity, since they were not formally invited, briefed, trained, and recognised. There were discrepancies between the mentor roles they were intended to fill and their actual performance. While the list of perceived mentor responsibilities requires mentors to provide a wide variety of support, the interviews revealed a different story. Except for one mentor relationship, three of the mentors primarily perceived their role as a problem solver rather than problem co-inquirers with their mentees. Therefore, the mentoring relationship was procedural rather than reflective and partnering. In contrast to filling the ideal supportive role, the relationship seemed to centre on reinforcing conformism. This may be related to the induction tool kit, which was perceived as reinforcing existing practices rather than assisting the mentees in becoming reflective practitioners. These two factors revealed that some mentors saw mentoring as a tool for maintaining the organizational status quo rather than cultivating the mentees. It is interesting to note that cultural differences are not

prominently discussed in the publications. But it is doubtful that there is no cultural factor in mentoring across different contexts. Nuances may have been overlooked under the potential influence of the dominant Western mindset.

In the health care landscape in Hong Kong, a former British colonial city and now a special administrative region of the Mainland China, it is unclear how traditional Chinese culture, as well as Western culture, may have shaped local nurses' conceptualization of mentoring. Huang and Lynch (1995) stated that mentoring incorporates the Taoist teaching of self-reflection, simplicity, openness to others, and sharing of ourselves. Under the influence of Taoist simplicity, mentoring is a gentle and subtle guiding, done virtuously and without controlling or imposing an agenda. This creates an atmosphere of trust, inspiration, courage, and harmony that is powerful in creating new visions and possibilities, and enabling true learning and growing. Tao mentoring is a process in which the dyad finds it comfortable and safe to admit 'not knowing' and opening an opportunity to learn. The reward is not only in the mentor teaching the mentee the correct goals, but also in the very process of guiding and growing together. It might be appropriate to compare the mentor and mentee relationship to a dance, which reveals the reciprocity of mentoring, in which both are giving and receiving, and mutually benefit from the dynamic interaction the process. Nevertheless, it is questionable whether the simplicity of Taoism can be directly applied to the health care landscape's time pressures, where efficiency, patient safety, and quality of care are emphasized.

The shortage of information addressing either formal or informal mentoring relationships in the local health care landscape further reveals the significance of this narrative inquiry. Regarding contextual and cultural issues, since Hong Kong lacks a long history of mentoring NGRNs, its perceptions of mentoring might be borrowed or adopted from other overseas countries. However, it is questionable whether the concept of mentoring in the West can be directly transferred to the local context, which as a former British colonial city is a uniquely mixed culture with influences from both the East and the West. It is also unclear to what extent the Western conceptualization of mentoring exists in the local context and whether there are even any specific cultural characteristics inherent in mentoring NGRNs at all.

4.4.3 Need for new understandings of mentoring, especially in the health care setting

In this section, the definition of mentoring is examined with the aid of published concept analysis, revealing that there is another layer of significance for studying mentoring in the health care setting. Even though various literature reviews and concept analyses have distinguished mentoring from other related concepts, the concept of mentoring remains elusive, ambiguous, and even confused. The conceptual ambiguity and confusion may be geographical or contextual in origin. The United Kingdom adopted preceptorship to support newly qualified nurses. 'Preceptorship' is defined as a short-term period of individualized, structured transition during which the preceptee is supported by a preceptor, to develop the preceptee's confidence as an autonomous professional, to refine skills, values, and behaviours, and to continue their life-long learning (Department of Health United Kingdom, 2010). Preceptorship programmes were used as a strategy to recruit and retain newly qualified nurses in the United Kingdom (Leigh, Douglas, Lee & Douglas, 2005; Marks-Maran, Ooms, Tapping, Muir, Phillips & Burke, 2013; Muir, Ooms, Tapping, Marks-Maran, Phillips & Burke, 2013). In contrasting, although preceptors are also used to support newly qualified nurses in North America, the term preceptorship is rarely used in reference to transition programmes. The term 'preceptorship' seems to be more commonly used to describe the relationship between nursing students and the hospital staff nurses who supervise the students during clinical practicum in the United States and Canada (e.g. Billay & Myrick, 2008; Zawaduk, Healey-Ogden, Farrell, Lyall & Taylor, 2014). Meanwhile, this kind of relationship is usually termed 'mentorship' in the United Kingdom (e.g. Gray & Smith, 2000; Myall, Levett-Jones & Lathlean, 2008; Phillips, Davies & Neary, 1996). Using to the definition of mentoring outlined by Morton-Cooper and Palmer (2000), some researchers criticised this type of relationship in the UK as superficial and not a true mentoring relationship, only a pseudo-mentoring or quasi-mentoring relationship (Morton-Cooper & Palmer, 2000). Moreover, the relationship is arranged by the academic and/or practice institution, with nursing students assigned to clinical staff for a short period of time (a few weeks) and confined to specific clinical placements (McCloughen, O'Brien & Jackson, 2006). Meanwhile, in other non-British countries the term 'mentorship' is more commonly employed to describe the relationship between a newly qualified nurse and a more experienced nurse, enacted by

institutions to support role transition and enhance retention (Greene & Puetzer, 2002; Halfer, Graf & Sullivan, 2008). Researchers further identified the conceptual differences between the United States and the United Kingdom. The studies conducted in the US seem to acknowledge the intense emotional dimension of a mentoring relationship, while those of the UK tend to view mentoring as a work-based learning relationship (McCloughen, O'Brien & Jackson, 2006). However, this might not be the only reason contributing to the persistence of conceptual confusion.

Another reason for conceptual confusion is the continual use of ‘mentorship’ interchangeably with terms for other similar supportive relationships, particularly ‘preceptorship’ and ‘preceptoring’ (McCloughen, O'Brien & Jackson, 2006; Mills, Francis & Bonner, 2005; Yonge, Billay, Myrick & Luhanga, 2007). Here are just a few examples, listed chronologically according to their publication dates. Faron and Poeltler (2007) state the definitions of mentor and preceptor clearly, but the use of the term ‘mentor’ in the manuscript fits more readily to the concept of preceptor or at most extended preceptorship (Morton-Cooper & Palmer, 2000). Similarly, the one-month relationship of an experienced nurse and a new graduate nurse was labeled mentorship in a quasi-experimental study conducted by Komarata and Oumtanee (2009) in Thailand, which at most fits the preceptor concept. The third example is a literature review of the experience of staff nurses who were preceptors and mentors of undergraduate nursing students, where the terms ‘preceptor’ and ‘mentor’ were used interchangeably without even indicating the potential differences between the two terms (Omansky, 2010). A recent publication evaluating a preceptorship programme for newly qualified nurses in London continues to use the terms ‘preceptor’ and ‘mentor’ interchangeably (Marks-Maran et al., 2013). Consequently, the use of related yet different terms interchangeably not only leads to conceptual confusion, but also hinders theory development regarding mentoring and its practical implementation (Crow, 2012; Mertz, 2004).

Over the last three decades, at least seven concept analyses of mentoring have been conducted in both nursing and non-nursing professions (medicine, business, vocational, education, psychology, social work, science, anthropology) (Bozeman & Feeney, 2007; Hodgson & Scanlan, 2013; Meier, 2013; Mijares, Baxley & Bond, 2013; Stewart & Krueger, 1996; Yoder, 1990). The definitions of mentoring

identified by all seven concept analyses, which used different analysis methodologies, are provided in table 4.1.

Keeping the concept analyses of mentoring in mind, the definitions they provided should serve as a representative sample from which four main concerns can be raised. First, it is interesting to note that, despite all the changes in different societies and the increasing complexity of the health care landscape, the concept of mentoring in nursing seems to have 'frozen' without marked differences since Anderson and Shannon's (1988) concept analysis 25 years ago. The only discernible difference is the time element, with older concept analyses emphasizing an extended duration (Bozeman & Feeney, 2007; Stewart & Krueger, 1996; Yoder, 1990).

Table 4.1 Findings of seven concept analyses of mentoring		
References	Method	Definitions
Anderson & Shannon, 1988	Non-Specific	'A nurturing process in which a more skilled or more experienced person, serving as a role model, teaches, sponsors, encourages, counsels & befriends a less skilled or less experienced person for the purpose of promoting the latter's professional and/or personal development. Mentoring functions are carried out within the context of an ongoing, caring relationship between the mentor & protégé' (p. 40).
Yoder, 1990	Mix of Walker & Avant (1988) & Rodgerian (1989) concept analysis	'Mentoring occurs when a senior person (mentor) in terms of age & experience undertakes to provide information, advice, and emotional support to a junior person (protégé) in a relationship lasting over an extended period of time & marked by substantial emotional commitment by both parties. If the opportunity presents itself, the mentor also uses both formal & informal forms of influence to further the career of the protégé' (p. 11).
Stewart & Krueger, 1996	Rodgerian (1993) concept analysis	'A teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The nurse dyad relied on the relationship in large measure for a period of several years for professional outcomes; & expanded knowledge & practice base; affirmative action; and/or career progression. Mentoring nurses tend to repeat the process with other nurses for the socialisation of scholars & scientists into the professional community & for the proliferation of a body of nursing knowledge' (p. 315).

Table 4.1 Findings of seven concept analyses of mentoring (Continued)

References	Method	Definitions
Bozeman & Feeney, 2007	Non-specified	'Mentoring: a process for the informal transmission of knowledge, social capital, & psychosocial support perceived by the recipient as relevant to work, career, or professional development; mentoring entails informal communication, usually face-to-face & during a sustained period of time, between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) & a person who is perceived to have less (the protégé)' (p. 731).
Hodgson & Scanlan, 2013	Walker & Avant (2005) Concept analysis	'Mentoring is a relationship between two individuals with differing levels of experience. The relationship is based on mutual respect & common goals, & demonstrated willingness by mentor & mentee to engage in the relationship in sharing of knowledge' (p. 391).
Meier, 2013	Walker & Avant (2011) Concept analysis	'Mentoring is the process of nurturing, in which mentor teaches, sponsors, advises, coaches, & acts as an agent, role model & confidante of a protégé by focusing on professional and/or personal development, & the ongoing caring relationship. Mentor is defined as a knowledgeable guide or established leader who may occupy a senior position, rank, or status & who possesses expertise as well as a proven record of accomplishment. A protégé is an inexperienced, less-proficient, or uninitiated individual' (p. 343).
Mijares, Baxley & Bond, 2013	Walker & Avant (2011) Concept analysis	'A voluntary & reciprocal relationship between a seasoned mentor & novice protégé that involves sharing of knowledge & experience, emotional support, role modeling & guiding. The mentor is a knowledgeable individual who is willing to share wisdom & experience, & the protégé must want the mentor's guidance & support. These two individuals must willingly enter into a mentoring partnership for the best outcomes to occur. Outcomes are improved when mentors are trained in the art of mentoring. Because scholastic & professional realms are composed of individuals from every walk-of-life & with diverse cultural & racial backgrounds, cultural awareness enhances a mentoring relationship' (pp. 26, 27).

Second, the definition of mentoring seems too rigid, without space for further conceptual and theoretical expansion in the dynamic mentoring relationship (Bozeman & Feeney, 2007; Crow, 2012). The seven definitions examined are relatively narrow in referring to only one perspective of mentoring, the dyad perspective, which views mentoring as a relational phenomenon limited to a one-to-one mentor-mentee relationship (Jakubik, 2008). However, mentoring can also be viewed from a triad perspective, which sees mentoring as an organizational phenomenon involving the mentor, the mentee, and the organization (Jakubik, 2008). This triad perspective seems to appear in Appendix I in the list of supportive and transition programmes. Mentoring is initiated under the framework or facilitation of the organization and the benefits of mentoring accruing back to the organization, in addition to the benefits to the mentor and mentee, are underscored.

Furthermore, the definition seems incapable of catching up with the expanding types of mentoring currently in practice (Crow, 2012), especially in the dynamic health care landscape. A classical one-to-one mentor-mentee relationship might be disturbed by shift work, the presence of more than one new nurse or nursing student, a busy workload, and other events. Examples of other types of mentoring include co-mentoring between practice and academic institutions to address the clinical challenge of cultural awareness (Mixer et al., 2012), group mentoring for new nurse graduates and nursing students (Caldwell, Dodd & Wilkes, 2008; Huizing, 2012; Scott & Smith, 2008), peer mentoring for new nurse graduates and nursing students (Grossman, 2009; Latham, Ringl & Hogan, 2013; Scott, 2005), and e-mentoring for nurses in clinical and academic fields (Owens & Patton, 2003; Pietsch, 2012; Scott, 2005).

A third concern about the conceptual ambiguity of mentoring is that researchers often cited the definitions identified in these conceptual analyses. For example, the definition given by Stewart and Krueger's (1996) is frequently cited by different researchers studying mentoring (Mills, Francis & Bonner, 2008; Pietsch, 2012). The definition of Bozeman and Feeney (2007) has also been adopted as an authoritative definition by other researchers (Huizing, 2012). Knowing that similar attributes are often used to describe a concept being defined through different methodologies of concept analysis, Bozeman and Feeney (2007) recommended that boundaries be

incorporated into the definition of mentoring. This would also serve to better differentiate mentoring from other related supportive relationships.

Fourth, a final concern is that the findings of these concept analyses seem to come from a functionalist perspective (Crow, 2012). This is unsurprising and consistent with the perspective of the empirical studies that focus on programme evaluation. In a functionalist perspective of mentoring, the goal of mentoring is to maintain the organization's status quo in and ensure organizational efficiency and equilibrium. This functionalist perspective also assumes a power relationship in mentoring, in which the mentor possesses the power of an expert, while the mentee is the passive recipient of knowledge. It is assumed that the mentor alone possess all relevant expertise, social capital, and support, which will be transmitted to the mentee (Crow, 2012). But this perspective tends to overlook the reciprocal nature of mentoring discussed earlier.

In thinking back about the history and the theoretical foundations of the current pragmatic concept of mentoring, the initial developmental theories seem fundamental and imperative (Dominguez & Hager, 2013). Levinson's (1978) Career stage or Life stage theory is one of the most frequently cited developmental theories. Basing his work on Freud, Jung, and Erikson's developmental theories, Levinson interviewed 40 men and found that mentoring is essential to young adulthood. Two key periods in the life cycle were identified: a stable phase when important life decisions are made, and a transitional phase when changes to life commitments and beliefs are made. He suggested that humans travel across structural, not biological, stages into adulthood, moving through a succession of stable and transitional phases. The work of Levinson quickly became the basis for most subsequent research on adult mentoring.

Kram's (1983) theory of mentoring phases is another commonly cited developmental theory, which incorporates Levinson's career stages into the definition of the roles of mentors and mentees. A conceptual model using a constant comparative analysis method was derived based on an intensive biographical interview study of 18 relationships between junior and senior managers in a large public corporation with 15,000 employees. Based on the empirical research results, Kram identified two main functions of mentoring: career development and psychosocial functions. Career

development functions include sponsorship, coaching, protection, increased exposure and visibility, and providing challenges that help advance the career of the young manager. Psychosocial functions include role modeling, acceptance and confirmation, counseling, and friendship while supporting the young manager in the development of competence, confidence, and effectiveness in his manager role. Kram further identified a predictable pattern in a typical mentoring relationship, made up of these four occasionally overlapping mentoring phases: Initiation, Cultivation, Separation, and Redefinition. The career and psychosocial functions of the mentoring relationships peaked in the Cultivation phase, which Kram recommended beginning in the second year and continuing until the fifth year of the relationship, before the Separation phase.

Though the above two developmental theories had considerable impact on the development of the concept of mentoring in the nursing field, they are not without their own limitations, and caution is necessary when applying the study findings. The participants in both studies were all white males, which may not be transferable to other ethnicities or the female gender. Also, both studies were conducted more than three decades ago. Considerable societal changes have since occurred that limit their direct transferability to contemporary society. Last but not least, it is important to consider the contexts of the two studies, which might be significantly different from that of the health care landscape, which is characterized by fluidity, unpredictability, shift work, staff shortage, heavy workload, and frequent interruptions that get in the way of protected time for mentoring. Nevertheless, if Kram's mentoring theory is applicable to the health care setting, then it means, ironically, that all of the supportive programmes lasting only through the first year of clinical practice might still be only at the Initiation phase. It also means that the end of such programmes forces mentors and mentees to discontinue their relationship prematurely before they can enter the Cultivation phase, where career development and psychosocial functions would otherwise reach great fulfilment. Bozeman and Feeney (2007) made the same critique in their concept analysis, noting that mentoring might have ended prematurely due to short duration of the formal transition and mentoring programmes.

Crow (2012) advocates taking a critical-constructivist perspective of mentoring to address the weakness of the aforementioned functionalist perspective. A critical

constructivist perspective understands that learning is a co-constructed endeavour between mentor and mentee, in which both are actively participating with a critical activism. The new understanding reached by both persons is then used to influence changes in the practice of school leadership. For the nature of learning in mentorship is not merely transmission of knowledge, but co-construction of knowledge through the process of negotiating the relationship, reflection and generating new interpretations. In a critical-constructivist relationship, the mentoring relationship is both a reciprocal and a power relationship, but the power relationship does not operate only in one direction. Both power and learning are multidirectional. Mentoring can be a relationship constellation, building networks that foster skill development and expand opportunities for reflection, inquiry, and creation. In contrast to the functionalist perspective, the main goal of the critical-constructivist perspective is not maintaining the organizational status quo, but emphasizing awareness of preconceived assumptions, and seeking personal transformations that lead to changes in the way one sees oneself and the social world. The major function of mentoring in a critical-constructivist perspective is enabling a process of identity construction that is not merely confined to the individual but involves social negotiation with others. It is important to note that stories have been identified as a critical part of the transformational learning process, for their utility in making sense of mentees' practice and mentoring interactions (Crow, 2012). This critical-constructivist perspective, which focuses on identity construction, seems uncommon in the literature on mentoring nurses, especially in the health care context. Ronsten, Andersson and Gustafsson's (2005) study on confirming mentorship in nursing might shed some light on this perspective. Mann and Tang's (2012) study on the mentoring experience of four novice English language teachers in Hong Kong found that only one of the formal mentor-novice teacher dyads established a reflective mentoring relationship where the members of the dyad worked as co-inquirers of problem. The other three dyads were merely routine mentoring relationships or functioned like a hierarchical apprenticeship, in which the mentors help the mentees in problem solving. This critical-constructivist perspective seems to be appropriate for my research puzzle, which is about mentoring NGRNs to help them sustain good work despite all the tensions and obstacles of the complex health care landscape. Therefore, the above shows the significance of further qualitative research on mentoring NGRNs in the health care landscape from the perspectives of mentor and

mentee, and exploring whether the critical-constructivist perspective can been adopted. Narrative inquiry (Clandinin & Connelly, 2000), which emphasizes understanding an experience through storytelling, thinking narratively in multiple dimensions, and challenging the dominant discourse, might be an appropriate research methodology.

4.5 The hurdles of completing the mentoring puzzle game

In the scanning of mentoring literature, five main knowledge gaps can be identified. These knowledge gaps seem to be the hurdles of completing the mentoring puzzle game or main obstacles to forming a holistic picture of mentoring NGRNs in transition and in pursuit of good work in nursing. First, although there is an abundance of mentoring literature on NGRNs, programme evaluations overwhelmingly adopted a functionalist perspective. The limitations of these programme evaluations, such as their quantitative methodology, collection of experiences from only a single perspective, confinement to the first year of experience, and various other methodological flaws, provide a narrow understanding of the mentoring experience of NGRNs in transition. This is closely connected to the second knowledge gap: the puzzles or full details of the experience of mentoring NGRNs in transition, integration, and pursuit of good work beyond their first two years of clinical experience, explored from the perspectives of NGRNs, mentors, and other stakeholder, are still missing. Also, the reasons for the negative mentoring experience of nursing professionals, particularly NGRNs, remain unclear (Green & Jackson, 2014). Important contextual and cultural information relating to the mentoring experience seems to be missing pieces of puzzles, but is crucial for understanding the complex picture of the dynamic health care landscape. In addition, it is unclear to what extent the Western conceptualization of mentoring NGRNs exists in Hong Kong and whether there are any cultural specific characteristics to mentoring NGRNs in the local context.

Third, the current conceptualization of mentoring NGRNs seems to be too static and too rigid, failing to accommodate the changes and dynamism of the contemporary health care landscape. New understandings, definitions, and boundary conditions to the concept of mentoring NGRNs in the health care setting are needed.

Fourth, the puzzle game of mentoring NGRNs might be difficult to complete, since the discussion intermingles the puzzle games of many different kinds of mentoring, ranging from nursing students, NGRNs, nursing leaders, and faculty, as well as mentoring in non-nursing fields. Although all of these different kinds of mentoring might share some similarities, their subtle differences should not be taken for granted. Subtle differences can also occur between mentoring NGRNs in the health care landscape, where nurses have shift work and where interaction between NGRNs and their mentors is often interrupted, and mentoring in other fields, which have regular office hours and a less disturbed work environment. This leads to severe conceptual confusion and hinders further conceptual development. Further research should make reference to and discuss various mentoring literature by indicating the original sources clearly.

Last, yet most importantly, I agree with the criticism made by Bozeman and Feeney (2007) that the literature is fragmented into bits and pieces without working with an integrated research model. Interestingly, Angelini (1995) had already suggested two decades ago that further research should explore mentoring influentials, namely people, events and environments, in combination rather than separately. With only the mere identification of mentoring roles, functions, phases, benefits, and risks, it seems that a comprehensive picture of mentoring NGRNs is still missing. Earlier researchers have studied only a small part of the broad and complex mentoring concept, and findings are only loosely connected through their shared use of early seminal mentoring studies and concepts. There is an important research gap in understanding the experience of mentoring NGRNs beyond the NGRNs' first year of clinical practice post-registration (Jakubik, 2008). Bridging this research gap is important for enhancing our understanding of mentoring, both formal and informal, as a long-term relationship that often lasts for two years or more (Jakubik, 2008; Morton-Cooper & Palmer, 2000). Furthermore, there is another cardinal research gap about mentoring not only for transition or benefits to the organization, but for sustaining good work in nursing. Once again, qualitative research methods such as the narrative inquiry (Clandinin & Connelly, 2000), which thinks narratively about the time context, people, place, action, and uncertainty of human experience, might

be able to better understand the holistic, complex and multi-layered picture of mentoring NGRNs in transition and pursuit of good work in nursing.

4.6 Significance of the study

The health care landscape or the professional knowledge landscape (Clandinin & Connelly, 1995) are growing in complexity and can be overwhelmingly stressful for NGRNs. With regard to care recipients, an aging population is both a global and local issue that challenges the health care system (Lindfors & Junttila, 2014). Patient acuity also increases along with the increased expectations of the patients and their families (Wolff, Pesut & Regan, 2010). With regard to the health care system in relation to the care recipient, the health care landscape is continuously shifting with dramatic increases in knowledge and technology, and an increasing emphasis on inter-professional care under fiscal constraints (Wolff, Pesut & Regan, 2010). With regard to the nursing profession, the worldwide nursing shortage issue is not only challenged by an aging workforce with generational diversity (Hendricks & Cope, 2013), but a failure to retain adequate numbers of newly graduated nurses (Godinez, Schweiger, Gruver & Ryan, 2009; Kovner, Brewer, Fairchild, Poornima, Kim & Djukic, 2007). A global trend is changing education policies and nurse preparation from a hospital-based apprenticeship and service-type model to a university-based undergraduate education with decreased duration in the professional placement. In the new model, NGRNs are less familiar with the hospital culture, resulting in the development of a new transition phase to help move nurses from the role as university students to RNs (Phillips, Kenny, Esterman & Smith, 2014; Wolff, Pesut & Regan, 2010). Meanwhile, it is not uncommon for new nurses graduated from educational models to engage in role transition as a full-time employee while further pursuing a university degree or masters degree part-time in order to meet their perceived educational expectations and stay professionally competitive. Although inter-professional communication and collaboration are expected after professional registration, to minimize medical errors and improve patient outcomes, pre-qualification nursing education generally adopts a uni-professional approach rather than an inter-professional approach (Chan, Mok, Ho & Hui, 2009; Varpio, Hall, Lingard & Schryer, 2008).

Last but not least, the phenomenon of workplace incivility and violence by nursing and medical colleagues, as well as by patients and their families, persists despite an abundance of research studies in identifying the quality of relationships with the work dissatisfaction and turnover of NGRNs (e.g. D'ambra & Andrews, 2014; Dyess & Sherman, 2009; Hutton, 2006; Kelly & Ahern, 2009; Lee, Hsu, Li & Sloan, 2012; McKenna, Smith, Poole & Coverdale, 2003). Under the shaping of the complex experiences in the health care landscape, it seems impossible for nursing graduates to be equipped for immediate practice readiness during their nursing education.

Meanwhile, various new graduate transition programmes have been used worldwide to support NGRNs undergoing stressful role transitions. They vary greatly in their programme name, duration, components, types of support, and study designs, yet generally report improvement in the competence, confidence, and retention of NGRNs, and in cost reduction associated with recruitment, orientation, and temporary labour coverage for vacancy (Rush, Adamack, Gordon, Lilly & Janke, 2013). They seem to be held up as a panacea and have the quality of a sacred theory/practical story. Notwithstanding, work stress among new graduates, even those with the support of these transition programmes, remained at a moderate (Cheng, Liou, Tsai & Chang, 2014; Wu, Fox, Stokes & Adam, 2012) to a high level (Parker, Giles, Lantry & McMillan, 2014). These programmes might provide support to the new graduates, but in view of the complex health care landscape portrayed above, they do not adequately address many of the workplace stressors. One good example is the issue of workplace incivility and violence. Despite frequent recommendations to implement a strict zero-tolerance policy (Duchscher & Myrick, 2008; Dyess & Sherman, 2009), new nurse graduates still suffer from the negative impact of workplace incivility and violence, even from their formally assigned preceptors (Latham, Ringl & Hogan, 2013). This leads to job dissatisfaction, poor organizational commitment, and intention to leave (D'ambra & Andrews, 2014). Even when a transition programme in place, new graduate nurses suffering from workplace violence reported lower ability to access support when needed and more negative transitional experiences when compared with their counterparts who did not experience bullying (Rush, Adamack, Gordon & Janke, 2014). Without addressing these underlying issues, graduate nurse transition programmes seem to be facilitating

the acculturation of new graduate nurses to workplace incivility (D'ambra & Andrews, 2014).

The issue of workplace violence, particularly against new nurse graduates, was just one of the alarming examples that showed the general tendency to regard graduate nurse transition programmes as a panacea for the problem and continued further implementation of similar programmes. These programmes might have addressed some aspects of the problem, but not its root cause. Metaphorically speaking, these programmes sometimes approached the problem of workplace violence like Western medicine, merely addressing the signs and symptoms of a disease while ignoring the problem of co-morbidity, even fragmenting the complex body into scattered systems which are tackled by different specialties separately, without adequate inter-professional communication and collaboration.

It is time for a paradigm shift to scrutinize the complex problems of the health care setting with a holistic view and address their root cause. To continue the metaphor, this paradigm should imitate the way that traditional Chinese medicine, addresses 'disease' by understanding the dynamic health status of a person and verifying the health issues dialectically before considering appropriate interventions (Pang et al., 2004). An approach that is similar to Clandinin and Connelly's (2000) narrative inquiry which emphasizes thinking narratively within three-dimensional space, a thought paradigm with a high potential to capture the holism, complexity, multi-layered dynamism, emotionality, and particularity of the various stories of experiences occurring in the complex health care landscape.

This narrative inquiry has another layer of significance in studying the importance of mentoring NGRNs for good work in nursing. It is different from many of the other research studies in terms of temporality and morality. This is not merely a comparison of the duration of the study period; rather, it intends to learn how to enhance the sustainability of good work by the NGRNs. Good work, as mentioned earlier, emphasizes not only excellence, but also ethics and engagement (Barendsen et al., 2011; Gardner, 2010; Gardner, Csikszentmihalyi & Damon, 2001). Understanding the sustainability of good work in nursing and its relation to mentoring has both short-term and long-term impact. In the short term, the narrative

inquiry might benefit the identity formation and development of new graduates who want to sustain good work in nursing for the benefit of their patients and patients' families. Through the telling and retelling process of the narrative inquiry, it is hoped that new possibilities can be discovered from their ongoing experiences, with both positive and negative educational results. Thus, the NGRNs can be empowered to rebuild their shaken professional identities or in narrative term, stories to live by (Connelly & Clandinin, 1999). When stories of mentoring NGRNs for good work in nursing are retold, it is hoped that these committed patient advocates can be retained in the health care landscape and can then mentor and support nurses of future generations. It also hoped that this narrative inquiry will resonate with readers in the local and global context, and encourage critical reflections of the problems of mentoring NGRNs for the sustainability of good work in nursing. All these potential changes will eventually bring long-term benefits to the nursing profession, health care field, but most importantly - our care recipients, the patients and their families.

4.7 Summary

Mentoring has been one of the most frequently recommended strategies for facilitating both the transition of new graduates and good work in nursing, as if it had a panacea-like power. Although the term 'mentor' is used in a large body of literature, the concept of mentoring in nursing practice remains ambiguous and confused, and the experience and significance of mentoring NGRNs in transition and pursuit of good work remains underexplored in both the local and global nursing context. The significance of this narrative inquiry, which intends to study the experiences of NGRNs and other stakeholders, is shown in the three chapters of in scanning relevant literature. Nevertheless, as mentioned in Chapter 1, I continued to remain open-minded while I was getting into the field, paying attention to and analysing the experiences throughout the entire inquiry process without thinking restrictively or formalistically.

CHAPTER FIVE

METHODOLOGY – NARRATIVE INQUIRY

5.1 Introduction

This chapter examines the details of the methodological framework of the present study. First, the narrative inquiry as a research methodology is described along with my own research experience. Second, the ontology, epistemology, and paradigm of narrative inquiry are illustrated. Third, the conceptual framework of the three-dimensional space that guides the entire narrative inquiry is presented. Fourth, the justifications for adopting narrative inquiry as the research methodology are examined. Fifth, ethical considerations regarding being in the field and walking into the midst of the stories of the participants are delineated. Sixth, the details of the data collection and analysis methods or, in narrative terms, the details of composing final research texts from the various field texts, are reported. The final section discusses the methodological rigour of the study.

5.2 Opening to narrative inquiry

This study adopted Clandinin and Connelly's (2000) narrative inquiry as the research methodology to understand the meanings of mentoring NGRNs to foster role transition and good work in nursing. Narrative inquiry (Clandinin & Connelly, 2000) is a relational and interpretive inquiry for studying experience as story (Connelly & Clandinin, 2006). It is a research methodology that has emerged from Clandinin and Connelly's 30-plus years of study of teachers' knowledge and education. Narrative inquiry is strongly influenced by John Dewey, an educationalist and pragmatist. The Deweyan theory of experience (1938) emphasizes the inextricable link between experience and education, and the two principles of continuity and interactions (Dewey, 1938). Narrative inquiry has its root in the Deweyan view of experience (1938). It is also informed by other qualitative methodologies, which include grounded theory, ethnography, and phenomenology (Clandinin & Connelly, 2000). Narrative inquiry has been adopted by different researchers to develop a narrative understanding of the experience of teachers in various landscapes, even multicultural

ones (Aimar, 2006; He, 1998; Phillion, 1999; Yu, 2005). The use of this research methodology has further extended to nursing professionals. Its use has not been limited to nurse teachers or educators (Chan, 2001; Schwind, 2004), but has also been used in studies of nurses practicing in the complex health care landscape (Lindsay, 2001; Prindle, 2005).

Narrative inquiry, however, is not as common as the other qualitative research methodologies, such as grounded theory, ethnography, and phenomenology, found in nursing and which have shaped the development of narrative inquiry itself. This perception of its unpopularity was shaped by my personal experience. Throughout the years of my study, whenever I presented my study formally or talked about it informally, I encountered many questions about the 'new' narrative inquiry from other research students, researchers, university teachers, and members of the Institutional Review Boards who had quantitative and/or qualitative backgrounds. Thinking back to my own narrative journey, the methodology was also new to me when it was introduced by my chief supervisor during our initial meetings negotiating the supervising relationship and formulating my research proposal. To open the narrative inquiry, I will start with my own personal story. The process of moving beyond the level of doing to the level of thinking and being, by deliberating on the philosophical underpinnings of the adopted research methodology as they related to my research questions, was a serious challenge.

The first book I ever read about narrative inquiry was *Narrative inquiry: Experience and story in qualitative research*, by Clandinin and Connelly (2000). I can still recall the difficulty I had reading through the book for the first time, especially because I was pressed for time and exhausted from studying part time and working full-time as a registered nurse in the accident and emergency department, where I had shift duties. In that initial reading, I found many of the concepts mentioned in the book difficult to grasp. This might also have been shaped by my own narrative history. Since form four in the secondary school, I have been a pure science student ever and had not had spent much time learning about English literature or even Chinese literature. Honestly speaking, before coming into contact with narrative inquiry, I was not aware of the potential difference between 'Bernice's story' and 'the story of Bernice'. As a young nurse working in the clinical setting immediately after graduation, I was

also trained to think in the bio-medical model of searching for concrete guidelines and certainty. However, the book was written with an intention to 'show' rather than to 'tell' what a narrative inquirer does (Clandinin & Connelly, 2000). Its intention is not to spoon-feed or provide rigid operational guidelines for the reader, as there are multiple possibilities throughout a narrative inquiry. However, I would not deny the process of broadening my horizons was rough and challenging. I crossed boundaries in my quest, moving from always looking for certainty to embracing uncertainty. As I am writing this methodology chapter, I have been thinking about the potential audience, who might not be expertly informed about narrative inquiry, and are new to this rather complex research approach. They may have a similar experience to mine in struggling to understand. It is hoped that this chapter will facilitate even novice narrative inquirers to think narratively. I would like to use the following description of narrative inquiry as a starting point to opening up space for further discussion of its philosophical underpinnings in the next section.

> Narrative inquiry is a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in this same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that make up people's lives, both individual and social. (Clandinin & Connelly, 2000, p. 20)

When I initially read this description, I merely skimmed through it, gaining only a superficial understanding. It was not until I continued in reading more about narrative inquiry and re-read the book again and again with my ongoing *experience* in research in mind that I began to read beyond the words. I started to realise that I could hardly imagine the complex philosophical underpinnings captured in those four sentences.

Experience, as the first sentence of the quote above states, is the key term in narrative inquiry. Collaboration between participants and researcher is required throughout the narrative inquiry, as stated in the second sentence. The third sentence shows that narrative inquiry intends to understand experience as an open-ended process, not only studying the present moment, but also considering how the present shapes and is shaped by its past, and has an imagined future. At the same time, narrative inquiry considers not only the experience of the participants and researchers, but also their

interaction with their social world. Reliving and retelling the stories of the experiences is important, which means generating new relations or new ways of dealing throughout the narrative inquiry. This implies a transactional ontology and revolutionary epistemology of narrative inquiry, both of which are further discussed below.

5.3 The ontology, epistemology and paradigm of narrative inquiry

The transactional ontology of narrative inquiry is closely related to its revolutionary epistemology under the strong influence of the Deweyan theory of experience. Ontology refers to 'the worldviews and assumptions in which researchers operate in their search for new knowledge' (Schwandt, 2007, p. 190) or the quest of 'what is the nature of reality?' (Creswell, 2007) or what we can know about our world (Mayan, 2009). Transactional or relational ontology refers to the ontological assumptions of the narrative inquirer in search of new knowledge, which are the existence of multiple realities and the assumption that reality is constructed intersubjectively through the meanings and understanding developed socially and experientially (Guba & Lincoln, 1994). Epistemology refers to the relationship between the researchers and that being researched, or the quest of how we know what we know (Creswell, 2007). Revolutionary epistemology refers to the regulative ideal of the inquiry, which is to generate a new relation between an individual and her environment, rather than an exclusively faithful representation of a reality independent of the knower or decontextualized themes and subthemes (Clandinin & Rosiek, 2007). The new kind of experienced objects eventually created 'are not more real than those which preceded them but more significant and less overwhelming and oppressive' (Dewey, 1929, p. 219). This quote from Dewey reveals a pragmatic view of knowledge, as knowledge arises from experience and must be returned to that experience for validation (Clandinin & Rosiek, 2007). Pragmatism is a paradigm or a basic set of beliefs that guide action (Creswell, 2007). The focus of pragmatism is on the outcome of the research – actions, situations, and consequences of inquiry (Creswell, 2007). It is concerned with applications, with whether the problems can be solved (Patton, 2002). Cherryholmes (1992) summarized the attributes of pragmatism this way: Pragmatism is not committed to a particular system of philosophy and reality and has the freedom and flexibility to decide the most appropriate methods, techniques, and procedures for finding the truth. Truth is

determined by what works at the time, but is not based in a dualism between reality independent of the mind or within the mind.

Narrative inquiry respects the importance of ordinary experience as a source of knowledge and explores the stories people live and tell (Clandinin, 2013). The Deweyan theory of experience (1938), which identifies continuity and interactions as the two intersecting and uniting principles of experience, is the foundation of the ontology, epistemology, and paradigm of narrative inquiry. The principle of continuity of experience is rooted in the notion of habit, which identifies that every experience both retains something from those in the past and modifies in some way the quality of those in the future (Dewey, 1938). Therefore, each experience should not be viewed in isolation, but always as having a narrative history and changing continuously towards an experiential future. Thinking about the inextricable link between experience and education, every experience is a moving force that leads to growth in different directions. This principle of continuity is then also used as a criterion to determine whether an experience is educative or miseducative (Dewey, 1938). An educative experience is conducive to growth, not only physical, but intellectual and moral (Dewey, 1938). For instance, a meaningful experience in providing compassionate care to a patient despite the challenges of the busy and complex health care landscape, that increases the nurse's perception of his/her own efficacy in pursuing good work in nursing in the future, is an educative experience. In contrast a miseducative experience stops or distorts the growth of further experiences as a result of decreased sensitivity and responsiveness (Dewey, 1938). For instance, the experience of an NGRN who speaks up for her patient whose right was exploited by a senior nurse, but who is not heard leads to a perception of decreased efficacy to advocate for patients and to pursue good work in the future (Law & Chan, 2015). Therefore, this principle of experience has important implications for narrative inquiry by reinforcing the fact that experience has to be studied as a process to see the growth and transformation of both the participants and researcher themselves.

The inquiry is not a search 'behind the veil' for something static, but rather, is fluid, with 'a changing stream that is characterized by continuous interaction of human thought with our personal, social and material environment' (Clandinin & Rosiek

2007, p. 39). Therefore, a sense of tentativeness has to be conveyed in the narrative inquiry to keep alive the possibility that the description can change or transform the quality of experience being described or represented by the narrative inquirer.

Furthermore, narrative inquirers are not merely concerned about the stories of experience lived and told, but also those relived and retold (Clandinin & Connelly. 1998). The fact that the inquiry is altering the phenomena under study is not regarded as a methodological flaw, but is, in fact, the purpose of the research (Clandinin & Rosiek, 2007). The inquiry at present is simultaneously a description of and intervention into experience by acknowledging that the descriptions add meanings to experience, thus making changes in the lives of both participants and researcher (Clandinin & Rosiek, 2007). Therefore, their lives intertwine throughout the process and affect the future experience, when the inquiry concludes in the midst of both lives. Through the process of telling and retelling, new meanings and possibilities are likely to emerge naturally, which might alter future practices (Clandinin & Connelly, 1998). This is why the trustworthiness of narrative inquiry might be different from other qualitative methodologies with different philosophical assumptions and paradigms, which are further discussed in the final section of this chapter.

The second principle of interaction refers to the interplay between personal and social conditions for interpreting an experience in its educational function and force of experience (Dewey, 1938). People cannot be understood only as individuals, but are always in relation and always in a social context. The social condition includes whatever conditions are interacting with personal needs, desires, purposes, and capacities to create the present experience. Therefore, the focus of narrative inquiry is not only on the experience of individuals, but also on exploration of the social, cultural, and institutional narratives within which individuals' experiences are constituted, shaped, expressed, and enacted (Clandinin & Rosiek, 2007).

This principle of personal-social interaction is not limited to the experience of participants, but also the experience of the researcher, as well as the inquiry experience of participants and researcher. The narrative inquirer acknowledges his/her influence on the participants and the inquiry process. He/She is aware that his/her verbal and non-verbal responses, such as a question, voice intonations, a

smile, and even a gaze, could have influenced participants to give a more detailed explanation or change their responses (Mishler, 1986). Narrative inquiry also acknowledges that every representation involves selective emphasis of the experience, despite the effort to render a faithful depiction. The researcher's interpretation is omnipresent throughout the inquiry process beginning with entering the field and continuing with writing the field texts into research texts. Narrative inquiry is a relational and collaborative inquiry wherein research is conducted with the participants as a co-participant, rather than on the participant (Josselson, 2007). The multiple realities of narrative inquiry are co-constructed between participants and researcher about the way individuals make sense of their experience within multiple contexts, such as spatial, place, and people contexts, and contribute to the ongoing sense making (Clandinin & Rosiek, 2007).

Dewey's (1938) two intersecting and uniting principles of continuity and interactions of experience are therefore central to the transactional ontology, evolutionary epistemology, and pragmatism of narrative inquiry. After clarifying the philosophical underpinnings of narrative inquiry, it is easier to understand that narrative inquiry is a research methodology for inquiry into experience by adopting a particular view of experience (Connelly & Clandinin, 2006). Humans are storytelling organisms (MacIntryre, 1984), who individually and socially lead storied lives on storied landscapes and tell stories of their lives (Connelly & Clandinin, 1990). People, things, and events are continuously changing and transforming along time under the influence of internal and external environments. Experience, therefore, can only be understood by taking the entire experience into account, both inner and outer factors. Narrative inquiry uses story as a portal to understand experience.

> People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. (Connelly & Clandinin, 2006, p. 375)

Before examining the reasons why narrative inquiry is an appropriate methodology to understand my research questions or puzzles, I further examine the conceptual framework of the narrative inquiry, the three-dimensional narrative inquiry space.

5.4 Conceptual framework: Three-dimensional narrative inquiry space

The conceptual framework of the study is the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000) made up of temporal, personal and social interactions, and place dimensions that emerged from and are embedded within the philosophical underpinnings of narrative inquiry. Temporality is the central feature in narrative inquiry, under the influence of the Deweyan view of experience (1938) with the emphasis on continuity. It is assumed and believed that each point in life is based on past experience and leads to an experiential and imagined future (Clandinin & Connelly, 2000). Thinking narratively along the temporal dimension, no event, person, culture, institution, and place exists alone at any moment independent from its past and the impact of its future. Each of them has a narrative history and an experiential and imagined future. Therefore, narrative inquiry begins and ends in the midst of the ongoing lives of both participants and researchers. As a narrative inquirer, I attend to the temporality of my life and that of my participants.

Experiences are captured as progressing, moving, and living and as a flow in the dimension of time. The captured meaning is tentative, not as a research finding that is a final static outcome. Narrative inquiry acknowledges that the tentativeness is being studied, as the participants, researcher, and the landscape are continuously changing, depending on the location in time, place, and relationships (Clandinin & Connelly, 2000). It intends to understand the shaping effects between the past and present experience along the temporal dimension and hopes that new understandings and new possibilities will be awakened throughout the story-telling process which would lead to a better future.

The present experience can be shaped by the past experience. Taking myself as an example, my present experience in conducting this narrative inquiry was shaped by my narrative histories as an NGRN of 2007 who had some negative transitional experiences and wondered how mentoring could help in sustaining good work in nursing for the younger generations.

In fact, the present experience can also shape the past experience, for instance, as it did with some conflicts and arguments that occurred during my travels with some companions. These conflicts and arguments led to unhappiness and negative

memories about the journey. Nevertheless, the journey continued. Photos continued to be taken and journals continued to be written. The journey at that time concluded as an unhappy experience. Years later, when I reviewed the photos, my unhappy memories were surprisingly overshadowed by the happy ones. These 'happy' memories seem to have been shaped by my present drudgery as I found myself sitting in front of the computer struggling to finish this doctoral dissertation and yearning for a revitalizing vacation.

In the dimension of personal-social interactions, the three-dimensional narrative inquiry space captures the transactional ontology (Clandinin & Rosiek, 2007) by studying the experiences of people in relation. It is concerned not only with the personal conditions that include feelings, identities, hopes, desires, aesthetic reactions, and moral dispositions, but also the social conditions that attend to existential conditions, the environment, surrounding factors and forces, and people that form each individual's context (Connelly & Clandinin, 2006). NGRNs are always interacting with the others in the health care landscape, including their formally assigned preceptors, other senior nurses and NGRNs, ward managers (WMs), doctors, and patients and their relatives. The interactions with the others are always shaping and being shaped by NGRNs. For instance, the professional identities or 'stories to live by' (Connelly & Clandinin, 1999) of NGRN participants are not only shaped by their narrative histories with a temporal dimension, but also shaping and being shaped by others' stories in the landscape. Under these continuous personal-social interactions, the meanings of experience are always changing as a reflective and learning process.

The personal-social interaction dimension also concerns the inquiry experiences of participants and researcher in relation. As narrative inquirers, our lived and told stories are always in relation to or with those of our participants. As mentioned earlier in the section on transactional ontology, the stories told in the narrative inquiry are influenced by the established participant-researcher relationship and their trust and rapport. The stories told by the participants could be shaped by the questions researchers raise that stimulate thinking and further scrutiny, and the researcher's self-disclosure of his/her experience, perspectives and interpretations. Therefore, the inquirer indeed cannot remove himself/herself from the inquiry

(Connelly & Clandinin, 2006). The lives of narrative inquirers become interwoven with the lives of participants. Narrative inquirers are part of the phenomenon under study and are part of the storied landscapes. Therefore, the researcher and participants are co-participating in the narrative inquiry for the co-composition of stories between participants and researchers.

In the dimension of place, it refers to the places where both the event and inquiry occur, as each place has an impact on the experience (Connelly & Clandinin, 2006). For example, the stories told by the participants in a private and safe place could be different from those at the participant's workplace, which can be regarded as a public place where conversations could be heard and overheard by the others.

Therefore, the stories being told by the participants are influenced and may change and unfold differently at different times, in different places, and as the researcher-participant relationship evolves and grows (Chan, 2005). The meaning is tentative and will change as time passes, depending on the location in time, place, and relationships (Clandinin & Connelly, 2000). The multiplicity of these stories of experiences can be revealed under the guidance of this conceptual framework. It is also important to highlight that three-dimensional narrative inquiry space is used to increase the awareness of the narrative inquirer as much as possible of the many layers in the stories of experience. It is not used rigidly as an analytic framework for reducing the storied experience to a set of understandings or other unnatural and constraining boundaries on inquiry. Lives are unbounded. In the same vein, narrative inquiry is a form of living and an inquiry that is interested in retelling and reliving of stories for growth and changes. The inquiry space is not used as a constraining framework, but used with openness and caution in capturing as many imaginative possibilities as possible. Various narrative terms are not illustrated in detail in this chapter, but summarized in Appendix II. After giving an illustration of 'what' narrative inquiry is, it is important to answer the questions 'why'. The following section provides my justifications for adopting narrative inquiry as the research methodology.

5.5 Justifications for using narrative inquiry as the research methodology

Narrative inquiry is the employed methodology. Congruence has to exist between the employed methodology, the worldviews of the researcher, and the research puzzles (Creswell, 2006). Narrative inquiry (Clandinin & Connelly, 2000) is a methodology that emerged from studying teachers' knowledge and education. It is coherent with the research areas and research questions or puzzles about mentoring NGRNs in transition and pursuit of good work, which is the education of nurses and the development and exchange of nurses' knowledge. Under the influence of the Deweyan view of experience (Dewey, 1938), education, life, and experience are inextricably intertwined, and to study education means to study experience or life. In this case, it is to study the NGRNs' experience with mentoring as part of their life curriculum, what mentoring mean to them and how significantly mentoring will make a difference to their nursing life personally and professionally. Findings of a previous study on mentoring of nurses in the hospital setting have identified mentoring to be influenced by different people, events, happenings and the environment (Angelini, 1995). Mentoring events refer to those happenings that are not part of the regular flow of life but are formative in some significant ways, either beneficial or traumatic (Darling, 1985a), which seems to resonate with Dewey's educative and miseducative experiences. The experience of NGRNs in transition and pursuit of good work are continuously shaped by themselves and others at different times and in different places, and these ongoing experiences constitute the education of NGRNs in shaping their knowledge and practices. Therefore, narrative inquiry, as a methodology that emerged from the study of education, is appropriate and relevant to understanding the research areas and research puzzles of this study

5.5.1 Narrative Thinking

Next, the narrative thinking of the narrative inquiry is not only coherent with my worldview as a researcher, but is also coherent with the research puzzles. Thinking narratively means thinking about the temporality, people, action, uncertainty and context of experience or within the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000). Thinking narratively can capture and retain the complexity, wholeness, and integrity of the situation and person, and the emotional and motivational meaning connected with it (Clandinin & Connelly, 2000; Connelly & Clandinin, 1988; Polkinghorne, 1995). The outcome of the narrative inquiry is also

a story, which is used as a tool to express the analysis while preserving the comprehensiveness, multiplicity, complexity, dynamism, compromise, unpredictability, ambiguity, paradoxes, and emotionality such as tensions, hopes, dreams, wishes, and intentions of lives and experience (Bailey & Jackson, 2003; Clandinin & Connelly, 2000). This is ontologically and epistemologically different from reductionistic thinking that fractures, decontextualizes and reduces experience into categories or themes that are time-free, people-free, and context-free, and merely considers the meanings of an action at face-value and searches for certainty without much consideration of other possibilities. I do not intend to devalue other research methodologies that use a reductionistic way of thinking, which currently dominate the nursing literature. I believe in multiple realities. Polkinghorne (1995) further developed Bruner's (1985) theory in identifying two distinctive types of narrative and paradigmatic cognitions. Indeed, I identify the strengths of narrative inquiry to fill the gaps of reductionism (Bailey & Jackson, 2003).

5.5.1.1 Temporality

Alongside the importance of understanding the phenomenon in context, temporality (Clandinin & Connelly, 2000) or continuity (Dewey, 1938) is one central feature of narrative thinking, says that any thing, event, or person has a past, a present as it appears, and an imagined future. Therefore, thinking narratively is an expression of something happening over time and understanding it as in a process of transition (Clandinin, Pushor & Orr, 2007). If only part of life were analysed and learnt, then the unities, continuities, images, and rhythms of the whole would be lost (Connelly & Clandinin, 1988).

This aspect of narrative thinking is coherent with my research areas - transition, good work, mentoring, and NGRNs - which all have the sense of temporality and are products of continuous and cumulative interactions. Transition of NGRNs obviously has a temporal dimension, with the past experience shaping and potentially being shaped by the present, and with both past and present experience collectively shaping the future experience (Higgins, Spencer & Kane, 2010). The four sets of forces shaping good work in nursing might change across time, at different place/space with different people and happenings. Any alignments or misalignments of these forces could be temporary (Barendsen et al., 2011; Gardner et al., 2001). Thinking

narratively could address the limitations of previous literature on good work in nursing, which oversimplified the concept into a static and time-free one, as identified in Chapter 2, by contextualizing the conceptual 'what' into 'how' something works or does not work. Furthermore, mentoring is also a concept that is not static, but has a strong sense of temporality. There are three aspects. First, previous researchers suggested that mentoring should not be limited to interactions with people, but should be a process shaped by ongoing events happening across time (Angelini, 1995; Darling, 1985a). The second aspect is related to the time dimension for the development of the mentoring relationship. With the passage of time, shared values and interests, growing establishment of trust and engagement, short-term relationships such as preceptoring and accidental mentoring that focus on specific skills or incidents can develop into mentoring. The mentoring relationship may further evolve into deep friendship when the mentee becomes more experienced and the power differential changes to become more equitable (Mills, Francis & Bonner, 2008a). The third aspect fits well with the temporal dimension of the narrative inquiry (Clandinin & Connelly, 2000) or Dewey's (1938) principle of continuity of experience as Mills et al. (2008a) identified that the way the rural nurses in their study mentored the novice nurses was not only shaped by their experience in the two-day mentor development workshop, but also their own experience of being mentored in the past. They use the term 'cycle of mentoring' to describe how the process of reflection informs the present mentoring experience (Mills, Francis & Bonner, 2008b), while other scholars use the term 'resonating phenomenon' (Stewart & Krueger, 1996). Therefore, the meanings of mentoring NGRNs in transition and pursuit of good work are not independent from either its past experience or its future experience. Nor is it static, but dynamic, and have to be understood as a process in time.

5.5.1.2 People

People are a feature of narrative thinking that is closely related to temporality. Each person, as mentioned, is in a process of personal change under the shaping of the narrative history. Therefore, a person has to be narrated in terms of the process. Thinking narratively of people includes thinking about who we were, who we are, and who we are becoming in the future (Clandinin & Connelly, 2000). Under the influence of the Deweyan view of experience with its emphasis on interactions of

experience, such that each experience is constituted of an interaction between subject and object, between a self and its world (Dewey, 1938). This is captured in the personal-social interaction dimension of the three-dimensional narrative inquiry space. Thinking narratively means thinking both inwardly about the person himself or herself, and outwardly about the people around. Thinking narratively, therefore, is appropriate for the four research areas and the research puzzles, as mentoring, good work, transition, and NGRNs cannot be viewed only individually, but must also be viewed socially. Whether mentoring is viewed with a dyad perspective and thus as a relational phenomenon, or with a triad perspective and thus as an organizational phenomenon, it involves more than one person (Jakubik, 2008). The mentoring relationship is not predetermined by the values of the individual but by the shared values, established trust, and engagement established within the mentor-mentee dyad (Mills, Francis & Bonner, 2008a). Furthermore, mentoring might not be limited to a single person. Other people, such as WMs, peers, clinical nurse specialists, educators, physicians, and nurses themselves, can influence the dynamic and interactive process (Angelini, 1995). Therefore, the personal-social interaction dimension is appropriate and important for examining the concept of mentoring. In a similar vein, good work cannot be achieved individually, but is potentially shaped by the forces in the profession, the particular situated professional context, and the society (Barendsen et al., 2011; Gardner et al., 2001). Nurses also affirmed that their interactions with mentors, role models, colleagues, management administrators, and patients could influence them positively or negatively while they were pursuing good work (Christiansen, 2008; Cleary, Horsfall, O'Hara-Aarons, Jackson & Hunt, 2012; Miller, 2006; Welk, 2013). Furthermore, narrative inquiry can reveal the professional identities, the underlying values of a professional, and what one cares about and responds to (Clark, 2014), which are relevant and important for understanding the key research area: good work in nursing that has a strong ethical and moral component.

5.5.1.3 Action

The third feature of thinking narratively is to understand an action as a narrative sign, by considering the people involved in the action and the narrative histories of the involved people. This feature is closely related to the first and second features of temporality and people (Clandinin & Connelly, 2000). For instance, the performance

of an NGRN is a narrative sign. Without understanding the narrative history of the NGRN, the significance or meaning of the performance, the sign, remains unknown. The performance of an NGRN does not in and of itself tell much of anything until the narrative of the NGRN's learning history is understood in relation to the performance. Through understanding the narrative histories, it might be revealed that not only NGRNs themselves and their assigned preceptors, but also others in the health care landscape could have affected the learning and hence the performance of the NGRNs. The NGRN's action could have shaped the environment as well. Thinking narratively does not take the performance of an NGRN as direct evidence of his/her achieved competence. Otherwise, the potentially more complex interpretation pathway between action and meaning through understanding the narrative histories might be overlooked (Clandinin & Connelly, 2000). Thinking narratively of an action as a narrative sign might possibly facilitate more in-depth understanding and represent many of our taken-for-granted assumptions about mentoring, good work, transition and NGRNs for uncovering new understandings.

5.5.1.4 Uncertainty

The fourth feature of narrative thinking is tentativeness and uncertainty. Narrative thinking acknowledges and embraces uncertainty, believing that there are always alternative interpretations of events and that the meanings of an event are fluid and subject to change. Narrative inquirers are trying their best to stay open to other possibilities, other interpretations, and other explanations (Clandinin & Connelly, 2000). The performance of an NGRN is not to be assumed as simply the result of preceptoring to ensure the learning of certainty, but rather, to be open to the meaning of an experience through considering temporality, people, and narrative signs. Thinking narratively by considering the tentativeness and open to uncertainty for its meaning is appropriate for inquiring about mentoring, good work, and the transition of NGRNs situated in the dynamic, unpredictable, and complex health care landscape.

5.5.2 Challenging taken-for-granted assumptions and understanding

The second rationale for using narrative inquiry as the methodology is related to its awareness of the problems of formalistic thinking. Formalistic thinking is a view that things are never what they are, but are rather what the framework of theories, points of view, expectations, perspectives, or outlooks make of them. In formalistic thinking,

an individual does not teach, but mindlessly reproduces a social structure. Individuals do not have emotionally credited intentions but preset expectations. Nor do individuals have experiences that are entirely their own, but are only pushed forward by contextual design (Clandinin & Connelly, 2000). This way of formalistic thinking is problematic in that it devalues experience and the practical knowledge of individuals, and limits the development of new understanding and knowledge. Connelly and Clandinin (1994) borrow the term 'prisons' from Britzman (1986, 1989) to describe the cultural myths and the formalistic thinking that lock us in and limit the horizons of knowing. Narrative inquiry was hence chosen because it is a methodology characterized to challenge assumptions and the taken for granted understanding, and 'finding a way out of a blind alley' (Clandinin & Connelly, 2000). Narrative inquiry values person by reconstructing a person's experience in relation to others and to a social milieu, rather than seeing them as something else such as social structure, ideology, theory, or framework. Instead of focusing on generalisation, abstraction, or certainties, narrative inquirers are interested in the particularities and details of life, in wondering about and imagining alternative possibilities and shifting the taken-for-granted social, cultural, and institutional narrative (Clandinin & Murphy, 2007). Narrative inquiry offers hope of escape from the prisons or the formalistic thinking, to awaken to the possibility of retelling the stories in new ways, and reliving the new and transformed stories (Connelly & Clandinin, 1994).

5.5.3 Benefits of co-participants

Narrative inquiry was chosen for its benefits to the co-participants in a relational and collaborative inquiry. Storytelling and listening in narrative inquiry has a cathartic effect for research participants, while the literature review reveals that the experience of NGRNs in transition and pursuit of good work in nursing can be overwhelming, stressful, and negative (Duchscher, 2009; Jewell, 2013; Kelly & Adhern, 2009). Narrative inquiry allows them to convey the contextualized construction of their stories, provides deep insights into an event or phenomenon as a whole experience and values them as a person and their storied experience (East, Jackson, O'Brien & Peters, 2010). Narrative inquiry also provides a voice to participants (Clandinin & Connelly, 2000; Lindsay, 2006). This fills the gaps identified in the literature review which found that much of the literature related to NGRNs is conceptualized as a research on NGRNs rather than research with them.

Narrative inquiry is educative in and of itself because both participants and researcher can be educated through telling and listening, and retelling and reliving, their stories of experience (Lindsay, 2006). Storytelling is an approach recommended by Benner (1991) to better understand the moral experiences of nurses and therefore the ethics of nursing, one of the key attributes of good work (Gardner, 2010). The stories capture concerns, tensions, meanings, and feelings that can be examined to better understand the contextual, relational, and configurational knowledge lived out in the practice of speaking up (Benner, 1991). Storytelling is also suggested by Lawrence (2011) as one strategy to reduce the negative outcomes of moral distress, which is closely related to work engagement, another key attribute of good work (Gardner, 2010). Retelling of stories is a difficult but important task in narrative inquiry for allowing growth and change with a revolutionary epistemology, rather than merely focusing on the telling of stories at the descriptive level. Throughout the storytelling and meaning-making process of narrative inquiry, and throughout the process of telling and reconstructing their stories of experiences, it is hoped that both participants and researcher will be awakened to see new possibilities. When the co-participants begin to retell and relive their stories in new directions and new ways, they benefit in growing, transforming, and improving (Connelly & Clandinin, 1994; Clandinin & Connelly, 2000). Both participants and researchers may gain a new sense of meaning in transition, mentoring, and good work, and become open to more possibilities in supporting the mentoring of NGRNs for the younger generations in the future for the benefit of not only the NGRNs themselves, but also the NGRNs of the future generation, and their patients and the patients' family members.

5.6 Being in the field with ethical considerations

This narrative inquiry was intended to understand the meanings of mentoring NGRNs in transition and pursuit of good work in nursing. The three-dimensional narrative inquiry space was a conceptual framework that guided the study design, data collection, and analysis (Clandinin & Connelly, 2000). Four different means of data collection methods were adopted to collect field texts from four different data sources. They included the use of repeated unstructured individual interviews and journaling to solicit stories of experience from NGRN participants, the adoption of

focus group interviews to collect field texts from preceptor and stakeholder participants, and the employment of document analysis to understand the perspectives of the different hospitals or clusters. The inquiry involved conducting research with participants recruited from eight public hospitals in Hong Kong (HK) between 2011 and 2012. In this section, an overview of the ethical considerations when conducting a narrative inquiry is provided. Then, the ethical considerations in gaining access into the field and preparing the researcher are delineated. The other ethical considerations are integrated with the subsequent two sections, on composing field texts and writing research texts for more coherent presentation.

Narrative inquiry as a relational inquiry depends on the commitment of the researcher and the participants in the participant-researcher relationship (Clandinin, 2013). The materials disclosed by the co-participants were based on their established trust and rapport (Josselson, 2007). Reciprocally, the narrative inquirer ought to be thinking about and sensitive to his/her responsibilities within a human relationship (Josselson, 2007), or his/her relational responsibility (Clandinin & Connelly, 2000) or relational ethics (Clandinin, 2013) throughout the inquiry. As a narrative inquirer, it is a challenge to maintain equilibrium between the dual roles. As a co-participant with the participant in an intimate relationship, I am responsible for the dignity, privacy, and well-being of my participants. However, this role might be in conflict with the scholarly obligation to be accurate and authentic, and make interpretations as a professional and responsible researcher. An ethical attitude was required throughout the narrative inquiry to resolve the ethical dilemmas. There were ethical considerations in every aspect of the narrative inquiry along the temporal dimension, from the ethics of design to obtaining ethical approvals from Institutional Review Boards (IRBs) and the preparation of the researcher, and from the ethics of the relationship to the ethics of report (Josselson, 2007). The following sections focus on the complicated process of obtaining ethical approvals from the IRBs and preparation of myself as a narrative inquirer.

5.6.1 Gaining access into the field

The study was approved by the ethical committees of the university with which this researcher was affiliated and the eight public hospitals that the participants work in. However, the entire process was complicated and lengthy and lasted for eight months.

Initially, the study was intended to be conducted in all public hospitals in HK where NGRNs were employed in 2010 (35 public hospitals). Upon inquiry and communication with the hospital ethical committees, I learnt that two of the seven clusters of hospitals do not accept research conducted by an outsider not directly employed by that particular hospital. Therefore, the application of ethical approval was limited to the remaining ethical committees of five clusters of which the eight hospitals are under, where participants were recruited.

5.6.2 Preparation of the narrative inquirer

The competence of the narrative inquiry to manage the entire research process, as well as the interactions with the participants, was also an ethical consideration. As a novice researcher, I acknowledged that I had very limited experience in conducting individual interviews and no experience in moderating focus group interviews. Various measures were taken. The first was to make reference to the literature about narrative inquiry and qualitative interview and analysis, reading the experience of other narrative researchers and anticipating the possible data collection situations and management. As a narrative inquirer, I am always aware that my present experience is shaped by my own narrative history. I revisited my past experience conducting a qualitative study for my final-year project in the third and fourth years of my undergraduate nursing programmes. I interviewed both experienced nurses with more than five years of experience as well as entry-level nurses with less than two years of experience. I also reminisced about my volunteer experience inviting two elderly persons to recount their life stories through three interviews and then writing a life story for each of them. In addition, I also recalled memories witnessing interviews and typing transcriptions when I worked as a student assistant for some of my university professors. When I was working as an NGRN myself at the neuroscience unit, I was invited to and participated in two individual interviews, one about transitional experiences, and another about good work in nursing, as well as a focus group interview about proposing a centre of excellence in neuroscience. All these reflections and evaluations, accomplished by retrieving and reviewing all the available interview transcripts and related documents, were valuable in identifying my strengths and the areas for further improvement. A third approach adopted was to invite my supervisor, other more experienced researchers, and research students to share their experiences conducting qualitative research. These kinds of formal

teaching and informal discussions were fruitful in helping me learn from others' experience and accumulated knowledge, especially precautions in conducting focus group interviews with which I had had no prior experience.

5.7 Composing field texts

This section elaborates on the four data collection methods used to collect field texts, along with the related ethical considerations. Field texts refer to the narrative thinking of data, which is a term to indicate that the texts co-created in the field are experiential and intersubjective between the participant and researcher, rather than objective texts found and discovered by either participants or researcher (Clandinin, 2013). Although narrative inquirers try their best to write everything down, they acknowledge that this is impossible. Narrative inquirers enter the field with their research purposes, which influence what they attend to as the foreground, while they move back and forth through different aspects in their understanding of the phenomenon, (Clandinin & Connelly, 2000). Narrative inquirers also acknowledge their influence on the participants and the inquiry. Field texts, therefore, convey a sense of deliberate selection and interpretation and contextualization. Field texts, in an important sense, also say much about what is not said and not noticed, and how these might be shaped by other stories in the professional knowledge landscape (Clandinin & Connelly, 2000) or the social discourses (Riessman, 1993). The unspoken part could be the gold nugget that has importance yet has been taken-for-granted and overlooked (Clandinin & Connelly, 2000). The iterative process in thinking about and rewriting the field texts ultimately contributed to the research texts. In contrast to research texts, field texts are closer to the experience and tend to be descriptive about particular events.

5.7.1 Repeated individual unstructured interviews with NGRNs

Three individual unstructured interviews were conducted with NGRNs at 12, 18, and 24 months after registration to understand the temporal dimension of their transitional experience. There were five main reasons for this study design. First, this design is aligned with the temporal dimension of the three-dimensional narrative inquiry space, which allows for the exploration of the relationships and shaping effects between past, present, and future experience. Second, this design covers the

first two years of the transitional experience of the NGRNs, which is also in alignment with the duration of the two-year preceptorship programme in HK public hospitals (Hospital Authority, 2008; 2010a) and with the development of practice readiness along the career trajectory (Wolff, Pesut & Regan, 2010). Third, the first interview took place when NGRNs had been registered for 12 months, a timeframe with an ethical concern. Previous literature suggests that new graduate nurses may experience a moderate stress level throughout their first year of role transition (Cheng, Liou, Tsai & Chang, 2014) before they begin to gain confidence and comfort with the role (Casey et al., 2004). Participants were expected to be going through the most vulnerable stages of their transition at the time of the first interview and the interview was likely to become an additional stressor to them. However, some critics pointed out that there is still an ethical concern when asking participants to recall any stressful events. Counseling referrals were therefore prepared, in case any untoward emotions or distress occurred to the point that participants could not resume the usual level of function at the end of the interview inquiry process (Mayan, 2009). Only one of my participants experienced some psychological breakdown during the inquiry process. That was an NGRN participant, Heidi, who burst into tears in the middle of our second interview when she was reminiscing about her father who had passed away during her transitional period. The incident happened when she was sharing her retold story of empathy that had been inspired by her father's final stage of life. Nevertheless, Heidi stopped crying and recovered very quickly in that second interview. Heidi and I continued to develop a close and trusting participant-researcher relationship that soon evolved into friendship. After all the data collection was finished, she initiated a request to be a guest at my wedding and reciprocally witnessed me embarking on a new stage of my life.

Fourth, as narrative inquiry is a relational inquiry that depends on the established relationship between participants and researcher, repeated interviews of more than two times can potentially increase the confidence and trust of participants towards the researcher. This, in turn, could potentially address the issue of participants' resistance to revealing their self-exploration of their feelings and understandings to others, especially strangers like the researcher, due to social desirability (Polkinghorne, 2007). Meanwhile, the six-month interval between each interview provides time and space for participants to experience, reflect, and thus deepen their

subsequent responses (Seidman, 2006). The ongoing negotiation between participants and researcher facilitates the establishment of a close researcher-participant relationship that increases the authenticity of the stories of experiences. Hence, the trustworthiness of co-created stories by the participants and researcher can be enhanced. Given the busy life of the NGRNs, I planned a six-month interval between face-to-face individual meetings, while maintaining an ongoing researcher-participant relationship via email at monthly intervals; this strategy is discussed later in this chapter. Last but not least, unstructured interviews are likely to produce stories that are important to the participants and prevent data from being confined by the existing literature and the knowledge of the researchers (Mishler, 1986; Sandelowski, 1991). The role of researcher is to listen to the stories told by participants with minimal interruptions (Richards & Morse, 2007) and ask probing questions for clarification or more details. Other methods of interviews, including semi-structured and structured interviews, were not chosen as they offer a limited scope for recounting stories (Mishler, 1986; Riessman, 1993).

5.7.1.1 Recruiting NGRN participants and negotiating relationships

NGRN participants were purposively recruited to understand the research puzzles about the meanings of mentoring NGRNs in transition and pursuit of good work in nursing. As I cannot imply or assume all nurses are pursuing good work, some nurses might have relatively lower self-expectations for achieving feelings satisfaction, such as getting assigned work done without doing harm to patients or making mistakes (Welk, 2013). Therefore, the following inclusion and exclusion criteria were used to recruit participants who demonstrated intention to pursue good work in nursing. This recruitment strategy has also been used by other researchers (Miller, 2006, Welk, 2013).

Inclusion criteria

(1) 2010 RN graduates, therefore, those having one year or less of clinical experience after graduation upon recruitment; and

(2) employed as full-time registered nurses in any settings and specialties at the eight local public hospitals where ethical approvals were obtained; and

(3) hospital- or university-based nursing graduates with a higher diploma or baccalaureate nursing degree from any local universities or hospitals. Both hospital-based and university-based graduates were included as these were the two nursing education systems in HK at the time of sampling. Participants with different nursing education backgrounds could provide a more heterogeneous group to explore how

their previous educational experiences may influence their present and future experience and hence their meanings of mentoring; and
(4) recommended by senior nurses, peers, or former faculty members, who, based on interactions with them and observations of their performance, recognised their dedication to pursuing good work (Gardner, 2010; Garnder, Csikszentmihalyi & Damon, 2001) or delivering high-quality nursing care. Since different people could have different meanings of good work, a guideline was used to guide the process of recommendation, with some suggested attributes that could be used to recognise NGRNs who intended to pursue good work in nursing (Appendix III). However, the list in the guideline was not exhaustive. The nominators were invited to give their own reasons for recommending NGRNs as potential participants.

Exclusion criteria
(1) Registered nurses converted from enroled nurses were excluded, even if they satisfied the above inclusion criteria. As the aim of the study was exploring the experience of NGRNs in transition immediately after graduation and pursuit of good work and the meanings of mentoring, thus previous clinical experience working as enroled nurses might have smoothed the overwhelming effect during the stressful transition. Also, the nursing education in training of enroled nurses and subsequent conversion courses would possibly also influence the transition. Thus their transition and mentoring experiences were not within the scope of this study.
(2) Nursing graduates from overseas institutions were also excluded to maintain focus on the relationships between the participant's experiences and the local nursing education.

Snowball sampling or network sampling was used, recruiting participants through referrals made by earlier participants who met the selection criteria of the study and were information rich (Creswell, 2007; Polit, Beck & Hungler, 2001). This sampling strategy is a non-probability sampling method that has been commonly used in qualitative research to identify participants who are knowledgeable, articulate, reflective, and willing to have in-depth discussions with the researcher about the study issue. This is important and appropriate for narrative inquiry because, as a relational inquiry, it emphasizes the co-participation of the participants and researcher (Chan, 2005). Participants recruited through snowball sampling could potentially increase the commitment, collaboration, and openness of all co-participants and facilitate the development of close and trusting participants-researcher relationships.

Snowball sampling began from the researcher's established personal networks with different frontline nurses, preceptors, advanced practice nurses (APNs), WMs and administrators, and faculty members, once ethical approval was obtained from the particular hospital. Potential participants who met the above selection criteria were asked by the referrers about their interest in participating after a brief introduction to the study was given. If the potential participants agreed, their contact information, such as name, telephone, and email address, was then passed to me. I contacted these potential participants personally by telephone or email to give them a more detailed explanation of my study, and then gave them time to make their decisions. Meanwhile, I acknowledged the potential drawback of this recruitment strategy through referral and recommendation. I was aware of any signs of subtle coercion, hesitation and discomfort, and stayed thoughtful about what would motivate a person

to participate in my research study. I stayed open in the conversation and encouraged NGRN participants not to hurry in making their decision, but invited them to raise any concerns freely.

Data collection and data analysis took place simultaneously, which guided the subsequent sampling of NGRN participants and any probing questions that were raised. Each new interview was continually compared with previously collected data to determine the point of saturation (Morse, 2000). The sampling of NGRN participants took about seven months because obtaining ethical approval from all eight public hospitals was a lengthy process. Over the course of recruitment, 23 potential NGRN participants were recommended and invited to participate in the study. Eighteen NGRNs agreed to participate in the study on a voluntary basis. Six of them were recommended by APNs, nursing officers, or a department operation manager, eight by senior RNs, two by former faculty members, and two by an NGRN participant.

The end point of recruitment was determined by data saturation. This depended on data quality, which was determined by the participant's level of involvement and ability to articulate and reflect on the study topic, and his/her willingness to share experiences and commit to the study (Morgan, 1997; Morse, 1998; Morse, 2000). Though Polkinghorne suggested in personal communication that six narratives would be a realistic number for developing into case studies through narrative analysis (cited in McCance, McKenna & Boore, 2001), other determining factors that affected the number of participants. The six factors included the study scope, topic nature, data quality, number of interviews, amount of useful information obtained per participant, and the employed study design (Morse, 2000). Indeed, data in the first round of interviews became saturated after interviewing the first twelve participants from four different hospitals. However, six additional participants were recruited from the other three hospitals due to three main reasons. First, the study scope was quite broad to understand the meanings of mentoring NGRNs from the perspectives of different stakeholders. Second, the nature of the topic, mentoring, had been recognised as an elusive concept in the literature (Bozeman & Feeney, 2007; McCloughen, O'Brien & Jackson, 2006). Therefore, more participants might be needed to better understand the nature of the topic. Third, the study design required engagement with the NGRN participants for a prolonged period of time through repeated interviewing and journaling over a one-year study period to understand their transitional experiences and their meanings of mentoring. On the one hand, more data could be generated by interviewing each participant three times, which could indeed reduce the number of participants needed. On the other hand, the attrition of participants was of concern, despite the effort of the researcher to establish a close and trusting relationship with the participants. A previous longitudinal study had reported difficulty sustaining the participation of graduate nurses, with a notable reduction of participants at the third interview (64% attrition rate) (McKenna & Newton, 2008). It was impossible to guarantee that no participant would drop out between the second and third interviews. As it was impossible to recruit NGRN participants again because of the prospective and longitudinal study design, the end of the recruitment stage was carefully planned with precautions against potential attrition.

5.7.1.2 Beginning the participant-researcher relationships

All individual interviews were conducted at the most convenient and preferred time and place outside the NGRN participants' work environment and work hours. Initially I assumed that for convenience and privacy, the private meeting rooms in my research office or in hospitals distanced from their workplace (private space), would be the ideal venue to ensure privacy during the interview. These options were suggested to all participants along with the choice of a more public space, such as a secluded corner of a cafe or restaurant close by their homes. All meetings could take place on their day off or close to their hospital, before or after work, for their convenience. Only five participants chose to conduct the first interview in a private meeting room. The other 13 participants preferred to have their first interview in a public space, despite my reminder about the issues of privacy. All subsequent interviews were conducted in a public space, except for two participants who scheduled our final interview before their afternoon shift and chose to have the meeting in a private meeting room at their hospital. When comparing the demeanor of the participants across the three interviews that took place in a private space as opposed to a public space, it is interesting to note that those in a secluded corner in a restaurant or café, that is, in a public space, appeared to be more relaxed and comfortable about expressing themselves freely. Their comfort might also have been related to the development of our participant-research relationship over the course of a year's time.

Before the commencement of the interviews, the participants were provided with the copies of the information sheet (Appendix IV) and given full explanations about the study purpose, background, and procedure. Participants were assured that any personal information (Appendix V) obtained would be kept confidential and only pseudonyms would be used in any type of publication. Meanwhile, due to concerns that the unique characteristics of the hospital supportive programmes might reveal the identities of participants, stories about the programmes were not presented in the narrative chapters of individual NGRN participants, but only discussed collectively in narrative threads and discussion chapter (see chapter 13). Participants were also assured that they had the right to participate on a voluntary basis and the right to withdraw from the study at any time without requiring a reason and without consequences, and that all their decisions would be duly respected. Time and space

were also provided for participants to raise any issues of concern. Written informed consent (Appendix VI and VII) was obtained from all NGRN participants regarding their voluntary participation and their agreement to have their interviews audio-recorded and their journals collected for further analysis.

I would like to highlight that the signed informed consent at this initial encounter in the first interview was not taken for granted. Process consent was obtained before and after each interview, as well as before publication (Josselson, 2007; Riessman, 1993). This is important for narrative inquiry, as the materials disclosed are highly unpredictable at the time of the signing the informed consent since what is to be disclosed depends on the established trust and rapport with the researcher. Obtaining a verbal consent at the end of each interview could alert the participants to reflect on whether they wanted any materials they had just disclosed not to be included for analysis and publication. Also, with the transactional ontology and evolutionary epistemology, I acknowledged that our perspectives were not static, but were likely to change with new understandings generated throughout the narrative inquiry. Therefore, it was important to obtain the consent of the participants before publication. This served as a good opportunity for a final round of member checking of the interpretive research text written about the participants through the researcher's lens to understand the research purpose.

All interviews were conducted in Cantonese (the participants' mother tongue). Participants were allowed to freely express themselves in either Cantonese and/or English according to their preference. Field notes were written during and after each interview to capture the key points of the interview, any important non-verbal expression, and my own reflections about my experience interacting with the NGRN participants, all for further analysis. The first interview began with an open-ended question: 'Tell me about your transition from a nursing student to becoming a registered nurse.' Participants were allowed to lead their own stories and bring the researcher into their experience of transition, mentoring, and pursuit of good work, without interruption. Subsequent probing and follow-up questions to uncover any necessary details were asked under the guidance of the three-dimensional narrative inquiry space along the dimensions of time, place, and personal and social interactions. Prepared probing questions from the interview guide were asked only if

participants experienced difficulty telling their stories spontaneously (Riessman, 1993) (Appendix VIII).

As a narrative inquirer, I was cautious to stay respectful, non-judgmental, and empathetic. Upon interacting with each of my participants, I was cautious to remind myself to be sensitive to my assumptions, values, and perspectives. This commitment to ethical values is deemed essential for any interpersonal interaction, but is particularly important in narrative inquiry because, as a relational inquiry, the material disclosed by the participants depends on their established trust and rapport with the researcher and the co-construction also depends on the established participant-researcher relationship. The second reason for my commitment was related to my awareness that the narrative inquiry can be an intervention to both my participants and me. Each encounter - and for NGRN participants, their encounters collectively - could inevitably have an impact on the co-participant's life, in the sense that it might lead to some rethinking or the creation of new meaning (Josselson, 2007). This could be positive, negative, or mixed throughout the inquiry. Therefore, throughout the narrative inquiry, I regarded myself not only as a researcher or interviewer, but also a co-participant and supporter. Since I myself had been an NGRN only three years earlier, I listened and supported them in transition and pursuit of good work in nursing. I was aware of my verbal and non-verbal communication and used them to show my eagerness to learn from the participants, the real experts in the research situation. Sometimes I was asked by my participants to share my opinions. Although I had my own perspective, I was aware that saying 'that's good' is just as judgmental as saying 'that's bad' (Josselson, 2007). I usually responded by thinking broadly and even exploring multiple possibilities. Both my participants and I enjoyed this self-disclosure, of both similarities and differences, by me as a co-participant, a recent NGRN, an insider working part-time in a public hospital, and a novice researcher. These recalled experience during the interactions with my participants, were often valuable for further discussion and my critical reflection and analysis.

Since data collection and data analysis took place simultaneously, the interview guide was updated continually and evolved based on interviews with previous NGRN participants. Each interview lasted from one to three hours, except for one

NGRN participant who had a sudden personal issue arise but insisted on proceeding with the interview. The total length of audio-recordings was 1938 minutes, or an average of more than one and a half hour (each recording ranged from 39 to 108 minutes). The first round of interviews with all 18 NGRN participants generated a total of 528 pages of single-spaced verbatim transcripts in Cantonese, with all names and identifying information changed to unique codes to protect identities and ensure anonymity (29 pages on average, with a range of 12 to 47 pages).

5.7.1.3 Developing and ending the relationships in the midst of stories

At the second and final unstructured interviews, I invited NGRN participants to tell their ongoing stories of experiences in transition, mentoring, and pursuit of good work, and further discuss the stories they had shared in their journals between interviews. The participants also received by email the verbatim transcripts of the previous interview in advance, with adequate time given for them to do the first level of member checking. They were also invited to share their feelings and any changing perspectives upon reading and reflecting on their storied experience. Meanwhile, I also shared with the participants some of my preliminary interpretive accounts based on the previous unstructured interviews and collected journals.

The number of NGRN participants in both the second and third interviews was 16. Of the 18 from the first round of interviews, one NGRN participant could not be contacted by email, telephone, or text message after the first interview. Another NGRN participant decided to resign and leave clinical nursing to further develop in academia by pursuing his doctoral research degree. He completed the second interview as the final one, as he no longer fit the inclusion criteria. Another NGRN participant could not participate in the interview at 18 months, but only that at 24 months, which was a time she had resigned from the public hospital and joined a private one. Two NGRN participants in the same unit suggested having their second and third interviews together. Their preference was respected and accommodated. Their second and third interviews were conducted in a private corner of a café, and a private meeting room at the hospital outside their workplace and working hours, respectively. They were also gently reminded that they could freely express their views. The paired interviews proceeded smoothly and fruitfully with their interactions and sharing of similar and different perspectives, as both had

experienced the same events in the same unit. One other NGRN participant was extremely busy and could not make a face-to-face meeting, and instead agreed to conduct our third interview on the telephone. It was also audio-recorded with this participant's verbal informed consent.

Staying non-judgmental and empathetic not only facilitated the establishment of trust and rapport with my participants, but also encouraged more open and in-depth discussion, often in some unexpected areas. Both NGRN participants and I were more relaxed to share our ongoing storied experiences and were more open and found it more enjoyable to discuss our experience and perspectives, and even some secret stories (Clandinin & Connelly, 1996). Most interviews took place during lunch or tea time, except for two final interviews which the NGRN participants chose to have at a dinner gathering, which implicitly implied a closer researcher-participant relationship.

Ethical considerations remained important at the end of each interview for concluding an intimate connection and conversation, and for allowing the co-participants to return to their ongoing lives, whether temporarily or permanently (Josselson, 2007). A final question was usually asked to ensure the participants were comfortable with the ending the interview without their other additional thoughts and opinions. I always appreciated the contribution of my participants in trusting me by sharing their valuable storied experiences and their time. I also tried to end on a positive note, looking forward to their subsequent sharing in email and our next individual interview, as well as any updates they might later send to me with news about their goal attainments, such as requests for clinical rotation, enrolment in and graduation from academic programmes, relationships with significant others, and even wedding preparations.

In the final interview, I raised two questions 'formally': 'If you were writing a book about your experience becoming a registered nurse, what chapter titles would you like to use?' and 'Please use a metaphor to capture your first two years of experience in transition and pursuit of good work'. These two questions were given to each NGRN participant in advance when arranging the time and place for our concluding interview, so that they could be better prepared and have more in-depth reflection in

their personal space. On the one hand, the use of the two questions facilitated the co-construction of the narrative inquiry, as their book chapter titles and metaphors served as an additional guide as I wrote their field texts into research texts. On the other hand, the two questions served as a concluding remark to the one-year narrative inquiry. I am gratified to share that the NGRN participants enjoyed the process, the opportunities given for review and reflection, and the development of our friendship. It is also interesting to note that many of the NGRN participants thought that we had known each other for two years and that I had witnessed their entire transition from nursing student to registered nurse of two years' experience. They were surprised when I 'corrected' them by saying that we began our relationship only when they had worked as an NGRN for one year. That might be the magic or power of narrative inquiry, with its emphasis on the temporality of experience and thus their narrative histories.

Though the duration of the second and third interviews was expected to be shorter than the first interview, about an hour, almost all interviews lasted between one to three hours. This might be closely related to the establishment of a closer participant-researcher relationship. For the second round of interviews with the 16 NGRN participants, the total length of audio-recordings was 1561 minutes, or an average of more than one and a half hour each (they ranged from 47 to 169 minutes). A total number of 505 pages of single-spaced verbatim transcripts (32 pages on average, ranging from 15 to 58 pages) were generated. For the third round of interviews with the 16 NGRN participants, the total length of audio-recordings was 1826 minutes, or an average of almost two hours each (they ranged from 92 to 166 minutes). A total number of 690 pages of single-spaced verbatim transcripts (43 pages on average, ranging from 30 to 79 pages) were generated.

By the end of the narrative inquiry, many of the participant-researcher relationships had gradually evolved into friendships, especially those who shared their experiences and reflections in their journals over email. Informal contacts were maintained after all data collection had been completed. I am grateful to have been invited to the weddings of three NGRN participants and witness them turn another important new page of their lives. Reflecting on my relationships with my NGRN participants as I wrote the field texts into the research texts, I saw that our relationships seem to

mirror mentoring in its strong psychosocial commitment to each other. This might be an additional justification for using narrative inquiry to study the mentoring of NGRNs.

5.7.2 Journaling and email conversations with NGRNs

All NGRN participants were invited to engage in monthly freestyle journaling between the individual interviews throughout the one-year study period on a voluntary basis. Narratives assume different forms: they can be heard, seen, read, told, performed, painted, sculpted, and written, and can be presented in different media language, image, gesture, myth, painting, and conversation (Sandelowski, 1991). Participants were allowed to determine which journaling methods best captured their stories of experiences and feelings in a monthly journaling period. They could be in written, printed, or electronic form, using any language, without word and page limitations, and/or include photos or drawings according to their preference.

The voluntary monthly freestyle journaling was incorporated into the repeated individual unstructured interviews, as it facilitates narrative understanding of the NGRN participants within the three-dimensional narrative inquiry space. Along the personal-social interaction dimension, freestyle journaling allowed participants to write freely about whatever they deemed significant, and they were very descriptive (Sewell, 2008). The journal reflected the internal conditions of the NGRN participants in relation to their ongoing experiences, situated contexts, and place, which allowed the researcher to gain insight into their perceptions or meanings of their experiences (Sewell, 2008). The ongoing sharing and responding between participants and researcher between interviews facilitated the development of close and trusting researcher-participant relationships (Seidman, 2006). In fact, journaling has numerous positive impacts and has also been used by nursing educators to assist the transition of students to registered nurses. It facilitates the development of critical thinking skills, reflection, self-awareness, and self-confidence, as well as new theoretical and practical learning that can improve quality of care. It enhances professional growth, reveals possessed knowledge without awareness, and serves as an ongoing monitoring of knowledge and skill development (Gillis, 2001). The monthly journals could and usually did reflect the ongoing experience, reflection,

changes, and growth of the NGRN participants between individual interviews. Because the stories of experience captured in the journals were discussed in my email reply and in the subsequent individual unstructured interviews about their ongoing experience, another layer of stories could be revealed (Sandelowski, 1991). As the smart phone became more popular in HK near the end of 2011, some NGRN participants preferred to shift our communication from email to free messenger apps, which were regarded as more convenient for them to reply quickly, especially because of their shift duties. Over the study period, I received a total of 73 journal entries from twelve NGRN participants, with an average of 6 journal entries per person (ranging from 1 to 22 journal entries).

5.7.3 Focus group interviews with preceptors and other stakeholders

Although the experience of NGRNs is the central focus of the study, according to the personal-social interactions dimension of the conceptual framework, they interacted with others while learning about themselves. Preceptors, senior nurses, WMs, and doctors were identified as the key influences in the NGRNs' transition (Casey et al., 2004; Evans et al., 2008; McKenna et al., 2003) and mentoring experience (Angelini, 1995). Therefore, preceptor and other stakeholder participants were invited for focus group interviews to share in particular their experiences of the previous two years, which represented the NGRNs' situated health care landscape. These focus group interviews allowed more comprehensive exploration of the mentoring of NGRNs, from perspectives other than those of the NGRN participants themselves. It was also hoped that the field texts composed in the focus group interviews could substantiate the findings of the NGRN participants, thus, facilitating data triangulation and method triangulation and overall enhancing the trustworthiness of the entire narrative inquiry. Therefore, the aim of these focus group interviews was group interaction (Denzin & Lincoln, 2011; Kitzinger & Barbour, 1999; Morgan, 1997) to maximize the opportunity for obtaining a diversity of views about the experiences that these preceptors and stakeholders had of interacting with, precepting and/or mentoring, and supporting NGRNs in general.

Separate focus group interviews were conducted with the groups of preceptor and other stakeholder participants. Other stakeholder participants included APNs, nursing officers, WMs, clinical nurse educators, and doctors. The reasons for separating

preceptors and other stakeholders into different focus groups was concern about the issue of power differential and homogeneity in the participants' background that affects group interactions (Denzin & Lincoln, 2011; Morgan, 1997). Though some APNs or nursing officers could be formally assigned by their WMs as preceptors of NGRNs, especially in some highly specialised units such as the neonatal intensive care, it is more common to find the preceptor in the position of a registered nurse. With the separation, participants in each focus group would find themselves among those of similar rank in the hospital hierarchy that narrowed the class differences. This encourages more free-flowing discussion and expression of opinion, even those that are competing and conflicting, among participants within the group (Morgan, 1997; Sim, 1998).

5.7.3.1 Recruiting preceptor and other stakeholder participants

Both preceptors and other stakeholder participants were purposively recruited. The aim of the focus group interview with preceptor participants was to understand the meanings of 'mentoring' NGRNs through their preceptors' experiences. The selection criteria of preceptor participants were (1) nurses who were formally assigned to be preceptors of NGRNs; (2) current preceptors or former preceptors who had experience preceptoring in the previous two years; and (3) no limit as to years of clinical and preceptoring experience.

The aim of the focus group interview with other stakeholder participants was to understand the meanings of 'mentoring' NGRNs in transition and pursuit of good work through the stakeholders' experiences interacting and supporting NGRNs. The selection criteria of other stakeholder participants were (1) other stakeholders occupying a higher rank than RN in the hospital hierarchy, including APNs, nursing officers, clinical nurse educators, WMs, and doctors, and (2) with experience working and interacting with NGRNs in their workplace or involvement in structuring, implementing, and evaluating any hospital supportive programmes for NGRNs.

Snowballing sampling was adopted in a similar vein to the recruitment of NGRN participants, and began from the researcher's established personal networks with different frontline nurses, preceptors, WMs and administrators, and faculty members.

It is important to highlight that both preceptor and other stakeholder participants were neither recruited because they were matched with NGRN participants, nor interviewed in a dyad, even though the findings could possibly increase the trustworthiness of the entire narrative inquiry. This sampling strategy and study design was out of concern for the relational ethics of protecting the identities and maintaining the confidentiality of the NGRN participants. Furthermore, if the interview had been conducted in a dyad, both parties, especially the NGRN participants, may have found it difficult to express themselves freely or tell secret stories due to being in a power differential situation.

Similar to the sampling of NGRN participants, potential participants who met the selection criteria of preceptor and stakeholder participants were approached by the referrers. The referrers then briefly introduced them to the study and explored their availability and interest in participating in the focus group interview. If the potential participants agreed, their contact information was then passed to me. I contacted these potential participants personally by telephone or email to give a more detail explanation of my study. I then allowed them time to make their decision.

Twenty potential preceptor participants who fit the selection criteria were identified from the seven hospitals where ethical approval had been obtained. Eleven preceptors from five different hospitals participated in the two focus group interviews on a voluntary basis after choosing their most convenient date. One focus group had five preceptors from four hospitals; the other had six preceptors also from four hospitals. Seven of the preceptor participants were from my personal network, while the other four were referred by another preceptor participant, an APN, a department manager, and a faculty member, respectively.

Seventeen potential other stakeholder participants who fit the selection criteria were identified from the seven hospitals where ethical approval had been obtained. Ten other stakeholders from six different hospitals participated in the two focus group interviews. Seven of the stakeholder participants were from my personal network, while the rest were referred by a nurse consultant and a faculty member.

These focus group interviews were scheduled after I had the first interview with the NGRN participants and before their second interview. They were held on the weekday evenings to best accommodate the variety of working hours among participants. The duration of the focus group interview was restricted to two hours out of consideration for the likely exhaustion of the participants after hours of work and their need for rest for the next work day. Having only six participants per group ensured that each had a relatively equal chance of expressing their opinions and sharing their experience in depth within the limited two-hour duration (Morgan, 1997). After potential participants agreed to participate in the focus group interview, they were invited to choose which of two scheduled time slots was most convenient for them. The discussion agenda (Appendix IX or X) was sent to them prior to the focus group interview for their reference and preparation, giving them time to reflect on their experiences interacting, supporting, preceptoring, and mentoring NGRNs. A reminder email or text message was sent to all 21 preceptor and stakeholder participants one day before the focus group interview and all took part in the study as scheduled.

5.7.3.2 Listening to others' stories of NGRNs

Each interview was conducted in a private meeting room at a university in the middle of HK. There was a round table in the meeting room. A nameplate was placed on the table for each participant, to facilitate the discussion. Also, participants from the same hospital or specialty were purposively separated to facilitate group interactions. Another doctoral research student was present as a non-participant observer in each focus group interview to take field notes on both the verbal and non-verbal communications between the participants and the moderator (me), and their order of speaking. This arrangement was made out of an ethical concern, as videotaped recording was not adopted in consideration of the participants' identities and for their potential comfort throughout the process of interview (Krueger & Casey, 2009).

Prior to the focus group interview and similar to the approach to the individual interview, each participant was provided with copies of the information sheet (Appendix XI), and also given a full explanation of the objectives of my study and the focus group interview, their freedom to participate, and right to withdraw. Participants were assured that any personal information (Appendix XII) obtained

would be kept confidential. They were also reminded not to share any of the information discussed during the focus group interview with any outsiders, to ensure confidentiality. Anonymity was also assured by using a code to represent each participant and his/her respective hospital in the verbatim transcript. The same codes would be used in any other publication. Participants were encouraged to feel free to discuss and share their experiences and perspectives, and encouraged to allow one person talking at a time to ensure the quality of the audio-recording. Prior to the interview, participants were given time to read the study information sheet and discussion agenda. Written informed consent (Appendix VI) was obtained regarding their voluntary participation and agreement to have their interviews audio-recorded for further analysis and publication.

All focus-group interviews were conducted in Cantonese (the participants' mother tongue). A less structured and low moderator involvement approach was adopted in the focus group interviews. This approach could prevent the discussion from being confined by existing literature or the researcher's knowledge. I reminded myself to be sensitive to my assumptions, values and perspectives. Each focus group interview began with an open-ended and ice-breaking question for each participant: 'Please kindly introduce yourself and share with us one of your experiences with NGRNs in the recent two years.' Both preceptor and other stakeholder participants were allowed to lead their own discussion. The discussion flowed smoothly and group interactions were vigorous as participants shared their similar or different perspectives and experiences. Generally, while most participants seemed to have a general consensus, some participants felt free to voice their unique experiences and concerns. It was not uncommon to find the discussion flowing along the three dimensions of the concept framework. Both preceptor and stakeholder participants compared along the temporal dimension their past experiences as NGRNs with the present experience of the current NGRNs, and the way they supported their younger generation and their expectations of them. In the personal-social interaction dimension, some preceptors shared their experiences with NGRNs, their identity as preceptors, and the perceived gap between senior and junior nurses. In the place dimension, the hospital supportive programme had had considerable influence on the expectations and experiences of many of the preceptors and other stakeholder participants.

Along with the less structured and low moderator involvement approach of the focus group interviews, the participants could interact with each other freely. I intervened or asked follow up questions only when necessary. The data analysis of the focus group interviews also guided subsequent data collection from focus groups with amended probing and follow-up questions (Endacott, 2008). For instance, negative experiences in mentoring or working with the NGRNs dominated the first three focus group interviews. Whether their experiences were overwhelmingly negative and absent of some positive ones or were shaped by any sacred stories is uncertain. Therefore, in the fourth focus group interview with the stakeholder participants, as an alternative to listening to their negative experiences once again, I intentionally invited them to share their positive experience in working with the NGRN participants. From there, it was not difficult to continue their discussion from a positive perspective. Thinking about what was said and not said opened up more space for in-depth understanding about the potential rationales behind their behaviours. Some follow up questions were also asked, based on the preliminary findings of the first set of individual interviews with NGRN participants. For instance, questions were asked about the impact of pre-registration working experience as Temporary Undergraduate Nursing Student (TUNS) on the post-registration mentoring experience in the same unit, and the common tension that occurred when NGRN participants were taught and forced to follow the different practices of different senior nurses.

In a similar vein to the interviews with NGRN participants, all focus group interviews were digitally audio-recorded and transcribed verbatim in Cantonese. All names and identifying information were changed to unique codes to protect identities and ensure anonymity. The total length of audio-recordings of all four focus group interviews was 517 minutes (ranging from 2 hours to 2 hours 37 minutes). Both preceptor and other stakeholder focus group interviews generated a total number of 88 pages of single space verbatim transcripts, with 44 pages on average (ranging from 43 to 45 pages for preceptor focus group interviews, and from 39 to 49 pages for other stakeholder focus group interviews).

Data become saturated with the second focus group interviews with both preceptor and other stakeholder participants, who generally demonstrated a high level of

involvement and good articulation. Their responses became predictable. The findings from the focus group interviews were valuable for substantiating and triangulating those of the NGRN participants to achieve a more holistic understanding of the meanings of mentoring. Therefore, data collection with preceptor and other stakeholder participants ceased after the fourth focus group interview.

5.7.4 Document Analysis

A review of relevant hospital documents was also conducted to understand the meanings of mentoring from the perspectives of the institutions. The hospital documents are important field texts for revealing the hospital stories or sacred stories and the stories told and lived by the leading and influential hospital executives and administrators. These hospital documents were passed down through the conduit in affecting the practices of frontline staff. By comparing these hospital documents with the stories told by the participants, potential conflicts, tensions, and miscommunication could be further unpacked.

Various hospital documents were retrieved from the hospital intranet system for document analysis. They included policies, protocols, project plans and/or guidelines relevant to supporting NGRNs during their transition from students to registered nurses. Documents were also selected that were relevant to mentoring, preceptoring, orientation plans or programmes, and the career advancement model of the HA. Other hospital documents related to the storied experiences mentioned by the participants were also retrieved. The following are some examples, guidelines, and protocols: on wound management and use of dressing materials, the hospital complaints system, medication preparation and administration, use of special medical equipment such as the ventilator, and newly introduced documentation forms and systems, such as the Modified Early Warning Signs (MEWS) and Red Dot Mobility System (RDMS). All these relevant documents were analysed as field texts to facilitate the understanding of the meanings of mentoring.

5.7.5 The field notes of narrative inquirer

A narrative inquirer's field notes are other important field texts for the entire inquiry process. Throughout the inquiry process, I had taken field notes recording my ongoing experience of the intricate details of my own story of field experience,

which included my visual observations, listening, feelings, interpretations and continual reflections. I reflected on my own actions and behaviours, positions, perspectives, and any preconceptions or take-for-granted assumptions that might have affected the entire inquiry process, especially the important retelling and reliving of stories (Finlay, 2002; Wells, 2011). I also reflected on my relationship with my participants, which might have affected my ultimate understanding of the meanings of mentoring. This reflection and the generated knowledge of self were important to enhancing my understanding of the phenomenon and my awareness of my influence on the inquiry process (Wells, 2011). These field notes were usually written when I was not interacting with my participants in the field. It is also important to highlight that the field notes were not written with a single perspective, but compiled from multiple ones. While I was thinking narratively about my field experience and composing a variety of field notes, I adopted many different roles. While in the role of co-participant, I was actively imagining and participating in their storied experience, while reflecting on how our established participant-researcher relationship created intimacy between me and them. All stories shared by the participants are personally significant to them. When I stepped into my role as a researcher, and a critic, I put myself at a distance from the established intimacy with my participants and the field. In that role I thought not only about the personal significance but also about the social significance of all the stories told. I reflected on challenging myself to see whether there were other alternative interpretations to the one that I had drawn. Field notes were then written about my interpretation and critical reflections on the relationships between the various stories told by different parties in different places at different times, relative to other literature and theories (Clandinin & Connelly, 2000; Finlay, 2002). Some of the field notes are included in the dissertation in italics as a means of providing an audit trail.

5.8 Writing research texts

The process of transforming field texts into research texts was an iterative process that took place simultaneously with the data collection mentioned in the previous section. This iterative process occurred on two levels, in narrative analysis and paradigmatic analysis (Polkinghorne, 1995). Narrative analysis is meant to produce emplotted whole narrative by synthesizing and reconfiguring the field texts to express the meanings and significance (Clandinin & Connelly, 2000; Polkinghorne,

1995). Paradigmatic analysis is quite similar to qualitative content analysis that produces categories (Graneheim & Lundman, 2004) or narrative threads in identifying elements common to all field texts and with special consideration of the temporal dimension (Bailey & Jackson, 2003; Polkinghorne, 1995). Paradigmatic analysis generates knowledge of concepts, but may have the limitations of reductionistic thinking that fails to respect and retain the unique ways the participants tell their own stories. This approach fractures the data into themes, which might lead to loss of the uniqueness, individuality, wholeness, and particularity of each participant (Bailey & Jackson, 2003; Riessman, 1993). In contrast, narrative analysis does not fracture experience but generates knowledge of particular situations and presents these particularities in a storied form with a beginning, middle, and end. This analysis approach retains the complexity of the situation in which an action was undertaken and the emotional and motivational meaning connected to it. It also has the potential to reveal our taken-for-granted assumptions as it attends to intricate details rather than prematurely generalising and categorizing information. Therefore, the incorporation of both narrative and paradigmatic analysis may complement each other to gain a more holistic and in-depth understanding of the experience of the research participants, their meanings of mentoring NGRNs for transition, and good work in nursing. The following section delineates the way I used the two different yet complementary data analysis approaches to transform field texts into research texts.

5.8.1 Narrative analysis

Data analysis began with reading and re-reading all available field texts to gain a holistic understanding of the participants and their storied experiences. The field texts were then re-read and analysed by thinking narratively within the three-dimensional narrative inquiry space of temporality, sociality, and place (Clandinin & Connelly, 2000). Inquiry was conducted in four directions, by thinking narratively in moving backward and forward in time, and inward and outward along the personal-social interaction dimension. Looking backward at the past experience along the temporal dimension could mean understanding who the NGRNs were, and their previous nursing education, clinical practicum, and TUNS experience. Also considered were the participant's narrative histories, other people in the situation, the practices, the culture, the unit, the hospital and the healthcare context. For instance,

how were their present stories to live by shaped by their family histories about the experience of caring for sick family members. Looking forward helped with understanding who they were now and who they were becoming in the future (Polkinghorne, 2004; Riessman, 1993), especially as future mentors of the younger generations. Any retelling and reliving of stories or changing perspectives throughout the inquiry process were also examined. 'Inward' refers to internal personal conditions such as feelings, stress, tensions, dilemmas, and stories to live by as a nurse, while 'outward' refers to existential conditions that are part of the environment, from the workplace environment to the hospital and the entire health care landscape. Outward also refers to people that they interact with, including different health care professionals, patients, and patients' families. In the meantime, not only did I use field texts composed when interacting with an NGRN participant, but other field texts composed with other NGRN, preceptor, and stakeholder participants. I also used hospital documents to better understand the complex health care landscape and examine whether continuity and discontinuity existed among the various stories. Thinking narratively about the place dimension, I also paid attention to the contextual features of the stories of experiences lived and told. For instance, I paid attention to whether different stories were lived and told in different places, such as the public out-of-team place and secret in-team places in the complex health care landscape, and whether they gave meanings to events and contributed to plot advancement.

Thinking narratively, text considered pertinent to the experience of mentoring, transition and good work, and the use of metaphors were highlighted. Upon re-reading the field texts, notes were made beside each portion of highlighted text to indicate their relationship with the central elements of the participants' overall narrative. For instance, notes were made about how the present experience was shaped by the past experience (temporality), the relationship of the participants with the preceptor and others in each storied experience as they supported him/her in transition and pursuit of good work in nursing (sociality), and the different experience of mentoring before and after clinical rotation to different places and the different stories lived and told in different places (place). The field texts were not read merely for content (Riessman, 1993), but also for awareness of the multiple layered stories in the three-dimensional narrative inquiry space. Diverse events were

arranged chronologically to examine the links between one event and another along the temporal dimension, by moving backward and forward (Clandinin & Connelly, 2000; Polkinghorne, 1995). Narrative codings were used to identify possible plotlines, interconnections, tensions, continuities and discontinuities, assumptions, ambiguities, and paradoxes by continuing to think narratively along the three dimensions of the narrative inquiry space. Key elements of the story's plotline were identified. The story of each NGRN participant was then filled in using text quotations and supplementary commentary with a plot in forming the interim text. The analysis grew in complexity as an increasing number of field texts were composed throughout the one year period of interacting with each NGRN participant and an increasing number of NGRN, preceptor, and stakeholder participants. The analysis was conducted in the languages used by the participants in their interviews and email conversations, that is, in both Cantonese and English. The research text was written in English, using a Chinese-English idiom dictionary as a reference tool (Wang, Qiang, Zhou & Chen, 1981), while some original Cantonese, particularly Chinese idioms, are also presented in parentheses to satisfy both English and Chinese readers (He, 1998; He, 2002). The research text was written and re-written to move beyond descriptive to interpretive by continuously asking about the meanings and significance of each experience in relation to the research puzzles and challenging any assumptions, boundaries, and grand narratives (Clandinin & Connelly, 2000). The narrative account captured the identified narrative codings, complexity, multiple layers, dynamism, emotionality, and particularity of the storied experience for each NGRN participant. The accounts were then member checked by each respective participants to validate the interpretation of the researcher. Any reflections and changing perspectives emerging from the member checking that were pertinent to the research puzzles were presented as a post-script.

5.8.2 Paradigmatic analysis

In the second level of analysis, narrative threads were identified by comparing and contrasting the stories of different NGRN participants (Clandinin et al., 2013). These narrative threads were further compared and contrasted with other field texts, that is, the narrative codes identified in the verbatim transcripts of the preceptor and stakeholder focus group interviews and the document analyses. These narrative threads were also used to think narratively in relation to the other literature, not as a

formalistic thinking, but thinking about any similarities and differences and the possible reasons for them. The written research text was then presented in the section of narrative threads and discussion. This was an iterative process: as the data analysis proceeded, previous written research texts might be further revised and refined.

5.9 Trustworthiness

Before going to the detailed discussion of the trustworthiness of this narrative inquiry, it is important to distinguish that the 'truths' or 'realities' that the narrative inquirer is seeking are 'narrative truths' rather than 'historical truths' (Spence, 1982). This is closely related to the philosophy of narrative inquiry, its transactional ontology, revolutionary epistemology, and pragmatism, as mentioned at the beginning of this chapter. Narrative truth emphasizes life-like, intelligible, and plausible stories that consist of continuity, closure, aesthetic finality, and a sense of conviction (Spence, 1982). Narrative inquiry, as an interpretive and relational inquiry, gathers storied text or storied evidence to interpret personal meaning. Stories typically represent a coherent theory of truth in that the narrator strives for narrative probability, that is, a story that makes sense (Spence, 1982). This is different from descriptive inquiries, which emphasize whether the events are accurately described, or whether the events actually happened (Polkinghorne, 2007). Furthermore, these narrative truths are co-constructed by participant and researcher, as mentioned earlier. The narrative inquirer acknowledges his/her potential impact on the participant's responses, as well as his/her potential selectivity when thinking about the storied evidence in relation to the research puzzles. When something is being pulled into the foreground, others will have to be squeezed into the background (Clandinin & Connelly, 2000). Hence, the research texts would not be the historical truth, the exact factual occurrence of the events, but only a narrative truth co-constructed by the co-participants.

There is another layer of narrative truth when thinking about temporality of experience. Narrators, on the one hand, strive for narrative fidelity or a story that is the most internally consistent interpretation of the past-in-the-present, the experienced present, and the anticipated-in-the-present-future (Spence, 1982). On the other hand, the meanings of experience are not static but fluid and evolutionary. The narrative inquiry begins and ends in the midst of the lives of the participants and

researchers. These personal meanings might change alongside ongoing experience as other events occur. Nevertheless, narrative inquiry intends to understand the narrative truths and the meaning of the remembered facts and hopes to retell and relive a new story for both the co-participants, as well as the readers in seeing new possibilities for a better future (Sandelowski, 1991).

After clarifying that narrative inquiry intends to understand narrative truths, I move forward to discuss the trustworthiness of my study. Trustworthiness - or validity, the term more commonly used in positivist and post-positivist research - in general, concerns the believability of a statement or knowledge claim. Narrative inquiry, with its unique philosophical underpinning under the influence of the Deweyan theory of experience, is different from other qualitative research methodologies, especially those with reductionistic or formalistic thinking. Therefore, it is questionable whether the quality criteria that are common and appropriate to other qualitative methodologies, namely, credibility, transferability, dependability, and confirmability (Guba & Lincoln, 2005), are appropriate to narrative inquiry (Clandinin & Connelly, 2000; Riessman, 1993). Connelly and Clandinin (1990) and Riessman (1993) have acknowledged that ways of evaluating the trustworthiness of narrative inquiry are still under development and there is no canonical approach in interpretive work. Thinking along with Connelly and Clandinin (1990), I kept asking myself what made my narrative inquiry into my research puzzle about understanding the meanings of mentoring a good one? Thinking more in-depth about trustworthiness is not simply dichotomous thinking and judging whether a statement or knowledge claim is valid or invalid. Rather, it is about the degree of confidence in the strength and power of the supportive evidence and argument, and the likelihood or probability that the reader will agree with the claim (Polkinghorne, 2007).

I have incorporated the approaches suggested by Polkinghorne (2007), Riessman (1993), and Crites (1986). Polkinghorne (2007) identifies four potential sources of disjunction between a person’s actual experienced meaning and the final research texts. They include (1) the limitations of language to capture the complexity and depth of experienced meanings, (2) the resistance of people to unmask fully the entire complexities of the felt meanings within their awareness shaped by social desirability, (3) the limitations of reflection by participants to unveil the multiple

layers of meaning that are beyond awareness, and (4) the complexity in relation to the fact that the inquiry and its outcomes are co-created between participant and researcher in the narrative inquiry as a relational inquiry. The trustworthiness of my narrative inquiry is illustrated alongside these four sources of disjunction.

5.9.1 Language issues

The texture of experiential meaning might be more complex and layered than the concepts and distinctions inherent in languages. Polkinghorne (2007) suggested encouraging participants to use figurative expressions and symbolical and metaphorical meanings to capture the intricacy of their experience. That was why questions about book chapter titles and metaphors were raised to encourage participants to connote additional layers of meaning. It was fruitful in bridging any potential gaps in language. In fact, the use of story to represent the experience and personal meaning of participants has been considered a figurative expression rather than a literal one by Ricoeur (1984). The stories with their rich details and revealing descriptions provide insight into the variety of experiences among the participants (Polkinghorne, 2007).

Though all participants took part in the narrative inquiry on a voluntary basis, their levels of articulation varied. For some participants who were less articulate, more probing questions were raised by the researcher with reference to their personal and professional experience, stories, and experienced meanings by other participants, as well as reported meanings in the literature. Meanwhile, the researcher was aware of the potential benefits and risks of using these probing questions with an intention to elicit stories and experienced meanings from the participants rather than framing their responses according to the researcher's prejudgments and assumptions.

5.9.2 Social desirability

The study design of this narrative inquiry, as well as my openness as a researcher and co-participant, collectively facilitated my participants to overcome any resistance and unmask fully the entire complexities of the felt meanings within their awareness (Polkinghorne, 2007), even to share some of their secret stories. The specific study design included the use of three individual unstructured interviews, conducted when the participants had worked as NGRNs for 12, 18, and 24 months and ongoing email

conversations with NGRN participants between interviews. This aligns Seidman's (2006) suggestion to use at least three interviews and allow time between interviews. This not only facilitated participants gain confidence and trust in the researcher over time in giving more open responses beyond the limited ones given in the first interview, but also provided time and space for the participants to reflect and give deeper responses in the subsequent interviews.

Furthermore, as one of my NGRN participants, Agnes, suggested, her sense of ease about sharing her stories and felt meanings was related to me being a young nurse. She contrasted me with the more senior nurses, such as the APN in management and those in other leadership positions, with whom she perceived that she might hesitate to express herself authentically. Similarly, my recent experience as an NGRN only three years earlier than my NGRN participants, as well as my ongoing experience as a novice researcher, meant that I shared many similarities with the NGRNs' transitional and mentoring experience. This could have shaped my NGRN participants to feel more comfortable about sharing their inner thoughts and even disclosing their secret stories, and to feel more confident that I would understand and empathize with their stories. This facilitated the relationship building and trust establishment between us, and thus minimizing the disjunction between the actual experienced meaning and the storied description.

5.9.3 In-depth reflection on experiential meanings

Participants, who do not generally engage in reflective practice, might be unaware of the complex and multiple layers of meanings in their stories of experience. In-depth reflections were hence encouraged during the interviews by allowing them time to reflect and give deeper responses. Spaces for in-depth reflections were also created between interviews when participants were encouraged to explore reflectively their own experience and felt meanings in their personal space by writing the monthly journals and member checking the verbatim transcript before the second and third interviews (Seidman, 2006). Also, focused listening and exploration were used throughout the narrative inquiry as suggested by Polkinghorne (2007).

Furthermore, the follow-up questions I raised as the researcher under the guidance of the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000)

throughout the one year study period could have encouraged participants to have deeper reflections beyond their initial awareness. My follow-up questions were shaped by participant's responses, my recent experience as an NGRN myself and my ongoing working experience as an insider in the complex health care landscape. These follow-up questions were also shaped by my ongoing experience as a researcher in interacting with the preceptor and stakeholder participants, related hospital documents, and my reflections. Therefore, both method triangulation and data triangulation played a role in encouraging more in-depth reflection of the meanings of experience. Trustworthiness was enhanced when data and method triangulation were achieved. Trustworthiness was also be enhanced when the triangulation and differences stimulated thinking about more new possibilities.

5.9.4 Co-created text

The complexity in relation to the fact that the inquiry and its outcomes are co-created between participant and researcher in the narrative inquiry as a relational and interpretive inquiry has been acknowledged. As mentioned earlier, I am aware of the various possibilities that both my verbal and non-verbal responses as a narrative inquirer, my attributes as a young female nurse and novice researcher, and my agenda to understand the research puzzles could affect participants' responses (Mishler, 1986; Polkinghorne, 2007). I also used my verbal and non-verbal responses to acknowledge and empower participants as the experts regarding their experienced meaning, while my role there was to understand as a researcher (Mishler, 1986). The use of unstructured interviews (Mishler, 1986) as well as the maintenance of an open listening stance (Polkinghorne, 2007) collectively assisted in ensuring that each participant's own voice was heard and that the research text was not primarily the creation of the researcher on her own.

Though the above four sources of disjunction identified by Polkinghorne (2007) are important for evaluating the trustworthiness of narrative inquiry, they do not seem to be comprehensive. Therefore, the four approaches suggested by Riessman (1993) were also incorporated, namely, persuasiveness, correspondence, coherence, and pragmatic use. They were chosen because they were appropriate to my research puzzles, as well as the philosophical underpinning of narrative inquiry.

5.9.5 Persuasiveness

Persuasiveness is a criterion for determining whether the researcher's interpretations are reasonable and convincing (Riessman, 1993). The persuasiveness of my narrative inquiry was enhanced in three aspects. First, my research texts were supported with evidence from the field texts composed with the participants, and had rich descriptions of experiences along the temporal, personal-social interaction, and place dimensions. Second, the research texts were written by interweaving my own interpretations, even alternative interpretations, together with rich descriptions of the research process. This served as an audit trail for illustrating auditability (Creswell, 2007; Koch, 2006). Last but not least, I also guarded against my prejudgments and assumptions through reflexivity, constant reflections, and regular discussions with my supervisors to ensure my interpretations were reasonable and convincing (Bisaillon, 2012; Finlay, 1998; Finlay, 2002; Hand, 2003). For instance, many of the NGRN participants felt unready for their assigned role and responsibility. In contrast, the NGRNs' senior nurses and WMs perceived them to be ready to practice. Many tensions arose between the NGRNs and others in their situated context. Though this phenomenon was identified in the literature, the storied experience of the NGRNs was more complex. Through my discussion with my chief supervisor, I realised that my analysis might have been limited by my presumptions and dichotomous thinking about practice readiness or unreadiness. A stage of practice semi-readiness was then identified that encouraged more in-depth understanding of the participants' storied experience. This inquiry experience was an educative one in guiding me to practice reflexivity in the subsequent course of inquiry and analysis. I constantly reminded myself to stay open throughout the course of inquiry and analysis, and was particularly mindful to ensure my interpretations were comprehensive by thinking narratively along the three dimensions of the conceptual framework. I kept questioning whether the research texts were sufficient in capturing and representing the meanings and significance of the storied experience to the participants.

5.9.6 Correspondence

Correspondence is defined as a close similarity, connection, or equivalence (Oxford dictionaries, 2015). It s is concerned with whether the research texts written by the narrative inquiry are an adequate representation of the participants' stories of experience (Riessman, 1993). Member checking was used to evaluate and establish

the correspondence of my narrative inquiry (Polkinghorne, 2007; Riessman, 1993). This meant taking the verbatim transcripts, journals, email conversations, my interpretations, and final research texts back to the NGRN participants from whom the field texts were originally composed to evaluate whether the generated text captured the essential features of the meaning they felt (Lincoln & Guba, 1985). Meanwhile, I was also aware that human stories and their meanings are unstable, and the meanings of experience shift with ongoing experience along with changes in consciousness (Riessman, 1993). Therefore, the member checking also served as a means to further explore any question that arose. For instance, what shapes the changes along the temporal, personal-social interaction, and spatial dimensions (Polkinghorne, 2007)? These texts were open to the NGRN participants for further suggestions, amendments, and expansions. Any disagreements with the co-created texts were negotiated and appropriately amended to display their meanings as closely as possible. This was how the correspondence of my narrative inquiry was established.

5.9.7 Coherence

Coherence refers to the quality of being logical and consistent and forming a united whole (Oxford Dictionaries, 2015). This criterion is strongly related to one characteristic of narrative truth – continuity (Spence, 1982). This is the same as Dewey's (1938) principle of continuity of experience, with each experience retaining something from those in the past and modifying in some way the quality of those in the future. The use of method triangulation and data triangulation helped to reveal the coherence of the participants' stories. Focusing on the NGRN participants, when their stories told were consistent in both individual interviews and email conversations, one layer of coherence was revealed. More broadly, when the storied experience of NGRN participants were consistent with the field texts composed with the preceptor and stakeholder participants in the focus group interviews, as well as the hospital documents, this revealed another layer of coherence. The trustworthiness of the research texts is strengthened if pieces of data are linked and coherence is rendered. Nevertheless, the concept of coherence is not easy to achieve. I acknowledge that coherence is a criterion for evaluating narrative inquiry, but the stories told by different stakeholders might not be coherent with each other. And it is the focus of this narrative inquiry to gain deeper understanding of these conflicting

stories and tensions in the complex health care landscape and reveal the coherence that can exist in multiple realities.

5.9.8 Pragmatic Use

Finally, pragmatic use refers to the extent to which the study becomes the basis of other work. It is more future-oriented and relates to the study's application in and extension to other research, practices, and/or settings (Riessman, 1993). This criterion is aligned with the pragmatism of narrative inquiry. Through narrative understanding about the wholeness and particularity of the experience of NGRN participants, the complex process of learning to speak up has been identified and schematically presented (Law & Chan, 2015). It was noted recently that some local practitioners and researchers were interested in further exploring the phenomenon of speaking up in another hospital. The pragmatic use of the research texts generated from this narrative inquiry may be evaluated by future researchers, administrators, policy makers, educators, and practitioners. As far as I know, no in-depth study has been conducted to understand the meanings of mentoring along with the experiences of transition and pursuit of good work among NGRNs by using narrative inquiry in the local or global context. It is believed that this present study will stimulate ongoing study.

5.9.9 Invitational quality

Last but not least, the criterion of invitational quality refers to the ability of the text to invite readers to participate vicariously (Crites, 1986). The trustworthiness of this narrative inquiry is therefore judged by the reader, which is you, according to the degree to which the research texts generates resonance or evokes emotion (Munhall, 2012). If the research text sounds plausible and authentic, then those in the health care landscape or professional knowledge landscape are likely to be drawn into reflection about their own stories of experience and see new ways of thinking about experiences (Clandinin & Connelly, 2000; Connelly & Clandinin, 1999; Lindsay & Smith, 2003). Otherwise, the text is flawed, not because it is ambiguous or contradictory, but only when it leaves no space for the stories of readers (Lindsay, 2011).

5.10 Summary

This chapter examines the methodological framework of the present narrative inquiry, depicting the research methodology, the philosophical underpinning, and the conceptual framework. This narrative inquiry adopted multiple data collection methods to understand the meanings of mentoring NGRNs in transition and pursuit of good work in nursing from multiple data sources in the health care landscape. The trustworthiness of the study was enhanced through various measures, including data and method triangulation, reflexivity, purposive sampling, prolonged engagement, audit trial, and member checking to ensure the written research texts were grounded in the field texts co-composed by the participants and the researcher.

After this methodology chapter are the chapters on the stories of several NGRNs' experiences of mentoring and good work. I would like to invite you, the reader, to pay attention to your thoughts, feelings, embodied sensations, and memories of life experiences that arise when reading the following stories co-created by me and my participants. It is hoped that not only will these stories of mentoring NGRNs in the complex health care landscape be heard by you, but that they will also be retold and relived throughout the inquiry process.

PART THREE

CHAPTER SIX

A GLIMPSE OF MY STORIES WITH THOSE OF MY PARTICIPANTS IN CONTEXT

6.1 Introduction

The research texts of 6 out of the 18 NGRN participants are selected and presented in this part of the dissertation. The participants, Agnes, Edwin, Nancy, Ning, Debby and Heidi (pseudonyms), were drawn from three different public hospitals. This introductory section opens with a description of the tension-filled selection process along with the rationale for writing the six narrative chapters. This is followed by my own story, which looks back on my personal experience of being attracted to the nursing profession and becoming a registered nurse (RN). Recounting my own storied experience serves three purposes. First, it paints an overall picture of the local health care landscape for readers with non-nursing backgrounds or who are overseas. Second, it presents the shared narratives between my stories and those of my NGRN participants that can facilitate my understanding of their stories, contribute to our relationship building and our co-construction of the following interpretive accounts. Third, it identifies the temporal changes occurring within the stories as we moved backward and forward in time during our sharing and living our storied experiences.

6.2 Selective presentation of NGRN participants in narrative chapters

The number of NGRN participants recruited was large, as mentioned in the section about sampling in the methodology chapter, to ensure reaching data saturation by the final interview. Data saturation was important, given the concerns of the broad scope of the study, number of topics, longitudinal study design with repeated interviews and ongoing journaling and email conversations, and participant attrition. However, presenting the research texts for all 18 NGRN participants was considered an unrealistic goal by Professor Donald Polkinghorne. He suggested that six case studies out of 18 cases would be adequate for narrative analysis, as long as the cases

selected illustrated different kinds of experiences (cited in McCance, McKenna & Boore, 2001).

I found the selection process filled with tension as I struggled to balance my dual role as both a co-participant who had close personal relationships with the NGRNs and as a professional researcher in the scholarly community. The following four principles were used to select participants who would illustrate different kinds of experience. Participants must be (1) able to share unique, concrete and powerful stories of good work in nursing that were worth analyzing for developing new meanings of mentoring of NGRNs in transition and for good work, (2) able to establish a close and trusting participant-researcher relationship, as evidenced by their comfort in sharing personal or even secret stories in interviews and/or by email, (3) both articulate and reflective, and (4) able to offer stories that could capture and represent the key elements of the other twelve participants, though the details and context might be different. It is important to point out that although only the storied experience of 6 out of 18 NGRN participants are presented in the following narrative chapters, the stories of all of the NGRN participants were considered in both narrative and paradigmatic analyses.

The 18 NGRN participants were assigned to work in a range of specialities for their first nursing positions. My experience working at the neuroscience unit shared many similarities with the experiences of my NGRN participants, who were also assigned to work in highly specialised units immediately after professional registration despite having limited theoretical and clinical exposure to these specialities in our undergraduate nursing programmes. Three were assigned to work in neuroscience units, three others in paediatrics, and the remaining four in orthopaedics, gynaecology, the special care baby unit (SCBU) and the neonatal and paediatric intensive care unit (N/PICU). The remaining eight NGRN participants worked in general medical and surgical units, which were more familiar areas since new nurses usually spend a majority of their limited hours of clinical practicum there.

Keung's story in the surgical unit was excluded from the analysis, because no further contact could be made after the first interview, meant that process consent could not be obtained from him for publication. Three other participants resigned from their

public hospitals during the one-year study period, they were Timothy, who resigned and continued to pursue a research degree at the university, and Queenie and Virginia, who both resigned to work as nurses in the private sector. While their stories were not selected to be presented in the narrative chapters, some of their relevant storied experiences are presented in the narrative threads and discussion chapter (see chapter 13).

Although all NGRN participants shared valuable and meaningful stories about their learning experiences in pursuing good work, the common experience can be illustrated in the stories of the selected six NGRN participants. Per Polkinghorne's suggestion, the next section provides a short description of the conclusions drawn from each of these six stories and the rationales for selecting them instead of the other eighteen NGRN participants (cited in McCance, McKenna & Boore, 2001).

6.3 Overview of individual narrative chapters

These six narrative chapters are presented chronologically, according to the sequence in which I met my NGRN participants for their first interviews in 2010. This is consistent with the temporal dimension of the three-dimensional narrative inquiry space, for my past experiences with earlier participants might possibly have shaped my subsequent interactions with the others. I hope that this way of structuring my presentation will invite and engage you (my readers) to move through the inquiry process with me.

The participants' stories begin in Chapter 6 with the story of Ning, who worked in a neuroscience unit. Unlike many of the other NGRN participants, Ning was able to work with her assigned preceptor on the same shift for the first month. Ironically, her preceptor taught her everything she needed to know about the neuroscience unit in three days and thereafter refused to answer any other questions. Ning confided secret stories (Clandinin & Connelly, 1996) about learning to pursue good work in nursing as allowed by the facilitation or hindrance of others in the unit, including other NGRNs, her preceptor, and the hospital system. The story of Ning mirrors the experiences of two other NGRN participants, Miranda and Kerwin, who were also working in the neuroscience unit.

Chapter 7 is the story of Agnes, an NGRN participant at the neonatal and paediatric intensive care unit. Her preceptor supported her during transition and as she pursued good work in nursing in the first two years of her clinical practice. However, they were both situated in a unit with a strong hierarchical structure, where many nurses did not dare to speak up or, if they did, would be ignored by those with power and authority. Agnes chose to leave the unit in search of a workplace where she could sustain her stories of good work and stories to live by (Connelly & Clandinin, 1999). Furthermore, Agnes' story revealed that mentoring for good work did not cease after the initial orientation period, but continued until the end of the second year. For instance, Agnes was triggered by several related experiences to self-reflect and self-mentor in realising the importance of bereavement care for the family of a dying child. This 'late' awakening was also experienced by another NGRN participant, Margaret, in the adult medical unit. Meanwhile, the close and satisfying relationship between Agnes and her assigned preceptor resembles those of three other NGRN participants, Caroline, Kerwin and Miranda.

Chapter 8 is the story of Edwin an NGRN in a surgical unit with a scolding and punitive culture. Edwin's mentoring experience and transition were influenced by his former employment experience as a nursing student in the unit before registration and by the nursing shortage problem. His assigned preceptor did not provide much support, so Edwin depended on self-mentoring and the support of other colleagues for transition. Throughout the narrative inquiry, Edwin retold and relived his stories of good work and mentoring. Edwin also shared powerful stories about making differences in the lives of his patients. Edwin's experience was very similar to that of another NGRN participant, Virginia, who also had been employed as a nursing student in the same unit before registration and found herself in a unit with a scolding culture. Another NGRN participant, Wing, shared powerful stories about making a difference in the lives of her patients while living a scolding culture in a gynaecological unit.

Chapter 9 is the story of Nancy, who was an NGRN participant in the paediatric unit. Nancy received support from her assigned preceptor. However, the support was considered inadequate when she was pushed to assume a heavier responsibility as

night in-charge nurse soon after registration. Similar to other NGRN participants, such as Edwin, Queenie and Virginia, Nancy perceived that the human resource arrangement for her support was influenced by her former employment as a nursing student in the same unit. Nancy also struggled and self-mentored during the first two years. Furthermore, Nancy's experience was very similar to those of another NGRN participant, Pansy. Though both appreciated their preceptors' teaching, their preceptors' personalities hindered the development of a close preceptor-preceptee relationship. In addition, Nancy, Pansy and Ning all worked in units where their stories of good work came into conflict with those of their colleagues.

Chapter 10 is the story of Heidi, also an NGRN participant in the paediatric unit. However, she did not have much of a chance to work with and get support from her assigned preceptor because she soon rotated to another unit. She mentored herself, could not see the meaning of mentoring, which was in conflict with the story told by the administrator at the preceptorship programme. When she rotated to the gynaecological unit and experienced the support from her new preceptor, she retold her stories of mentoring and recognised its importance. Her stories to live by that guide her professional practices were shaped by her family history, ongoing professional experience, and reflection. Heidi's self-mentoring experiences paralleled the experiences of two other NGRN participants, Queenie and Isabel. Heidi's experience also echoed that of another NGRN participant, Lucy, who also experienced no mentoring at the beginning of her transition and saw no purpose for mentoring until much later, when she was mentored and supported in preparation for becoming a night in-charge nurse two years after registration.

Chapter 11, the final narrative chapter, is the story of Debby, an NGRN participant in the medical unit with excellent teamwork and a supportive culture. Debby did not always have the chance to work with her assigned preceptor, but she mentored herself and regarded every senior colleague as her mentor and role model. Despite the busy and chaotic work environment with its heavy workload and patient turnover, Debby continued to pursue good work in nursing. Her experience of being mentored and self-mentoring paralleled those of two other NGRN participants, Lucy and Margaret, who also worked in the medical unit in their first two years of clinical practice.

The presentations in the following narrative chapters have not been standardized, since each participant's story is unique and suited for a different style of presentation. Pseudonyms were used for the participants to retain their individual accounts while protecting their confidentiality. Meanwhile, due to concerns that the unique characteristics of the hospital supportive programmes might reveal the identities of NGRN participants, stories about the programmes were removed from the six individual narratives. Those stories are discussed collectively only in the narrative threads and discussion chapter without specifying their pseudonyms and specialties, but merely using a randomized code (Ranging from NGRN01 to NGRN 1000) (see chapter 13). Some narrative inquirers created composites of several participants to ensure anonymity and protect identities (He, 1998). I also considered using an imaginative focus group based on my NGRN participants to discuss their experience as another way to protect participants' identities. However, in doing so I might have used narrative authority to rewrite their story in such a way that it became my story only (McCormack, 2000). I think that the above measures are adequate to protect my participants and preserve their well-being without fictionalizing data.

Once the research text was completed, it was returned to the respective participants for verification and member checking. Participants were reminded that the story is not only an account of all their experiences shared throughout the narrative inquiry but also my interpretive account as the researcher's building from the selected experiences for an understanding of the meanings of NGRN's mentoring in transition and in pursuit of good work. Participants were also invited to confirm that the story was adequately constructed to disguise and protect their identities. Further revisions were made according to the participants' feedback, which were often only minor changes. The final research text presented in the following narrative chapters was member checked and revised with the agreement of the six NGRN participants, who approved my interpretations and style of presentation. They have also given their consent to its publication.

6.4 Thinking about the complex health care landscape through my stories

Before moving to the narrative chapters, I want to first look back to reflect on and share my own story of becoming RN. My storied experience will help readers with non-nursing backgrounds or who come from overseas countries understand the following chapters by painting an overall picture of the health care system and the available preceptoring system in Hong Kong's public hospitals. Thinking narratively in the three-dimensional narrative inquiry space, I realise that my past experience not only shaped my interest in researching mentoring and good work, as discussed in Chapter 1, but also motivated me to interact with my participants and interpret their storied experience. Although I might not have the clinical experience working in each of the participant's unit, my ongoing experience working from being a nursing student to a registered nurse at various local public hospitals would make me an insider of the local health care landscape or professional knowledge landscape (Clandinin & Connelly, 1995), which enabled me to better understand their storied experience and facilitated more in-depth reflection and understanding. Meanwhile, I also have to be aware of any taken-for-granted assumptions endemic to my experience as an insider which might potentially become an obstacle to understanding the meanings of my participants. This practice of reflexivity is important. Throughout the entire process of my research study, from designing the study to writing the proposal, from writing field texts to composing research texts, I kept thinking about the continuities and discontinuities between the stories lived and told by my participants who graduated in 2010, and my own story, as a 2007 graduate. What caused those continuities and discontinuities? What evolutionary changes and contextual changes might have happened in those three years? In this chapter I have incorporated some of my field notes about my personal experience along with notes about various important events that happened as I became an NGRN. They were triggered by the stories told by my NGRN participants and written at various time points during my inquiry.

6.4.1 My Nurse Stories

Nursing?

I cannot deny that medicine was the reason I became interested in nursing. Ever since childhood, I have had a very special interest in the medical field. Anything about medicine, pathophysiology, and technology- and medicine-related television programmes would always catch my attention. My first memory of my interest in medicine was watching a television programme about a young neurosurgeon battling a scientist who wanted to control the world with an intelligent robot he had invented. After watching this show, I decided to become a doctor when I grew up, and my interest in medicine and health care continued to grow. I enjoyed watching movies and television programmes about doctors and hospitals, such as the English television drama ER and a Cantonese television drama produced by a local television company called Healing Hands. I was quite familiar with many of the medical terms and abbreviations used, and even recorded many of them in a note book because there was no internet then and my main resources were the television and the newspaper.

When I was in primary and secondary school, we had assignments that used newspaper cuttings in both English and Chinese. Most of my newspaper reading and cuttings were related to the medical field, such as reports of successful organ transplant cases, medical incidents and complaints, stories by health care professionals who shared their reflections about life and death, stories about patients and their families, discussions ethical issues about health care resource distribution in the society, and news of various types of diseases and new medical technology. I can still recall that the commemorative album written by my primary and secondary school classmates frequently included best wishes that I would become a doctor or a neurosurgeon. I also looked forward to the day I could make use of my medical knowledge by helping people in underdeveloped countries by joining the Medecins Sans Frontieres (MSF).

Since I had a strong interest in becoming a doctor, I chose the science track in form four when I had to choose between art and science. Chemistry and Biology were the two prerequisite subjects in which I had to obtain excellent results in order to enrol at one of the only two medical schools available. I can still remember the 25 choices that I picked in my final year of secondary school. Except for two programmes in music and two programmes in accounting, the rest of the choices were related to health care, including Medicine, Dentistry, Pharmacy, Physiotherapy, Radiotherapy, Occupational Therapy, and Nursing. The first time we had to decide how to prioritise these 25 choices was before the final public examination in form seven. I put two Medicine programmes and a Pharmacy programme in my top three choices. After the announcement of the public examination results, we were given a chance to change the order of our priorities among the 25 choices. I knew I did not have satisfactory results and there was no way for me to get into medical school with such results, so I needed to reprioritise my choices. I put all nursing subjects at the top of my priority list, both baccalaureate and higher diploma, and I was confident that I could get into nursing school with my academic results.

On the day the university programme admission results were announced, I did not check the results myself, but asked my mother to check for me. I was in the middle of the second day of a four-day sailing course at the seaside. I was quite confident in fact that I would be accepted by a nursing programme. It was merely which university was going to give me an offer. Unfortunately, the university that gave me an offer was my second preferred one. Before the day of registration at the university, I double checked with the telephone announcement system once again. I made the call from my parent's room using their phone, which was more stable and had better quality. The system announced:

'Higher diploma in nursing of the Hong Kong Polytechnic University.'

I was shocked! I re-dialed and I heard the same announcement for the second time. I was astonished by the shocking news. I started crying while sitting on the floor. I told my parents, when they found me in a mess. Although my classmates and I had very similar results, they were accepted by the Bachelor degree programme while I was accepted by the higher diploma program. I called my secondary school teachers and sought their advice. After that I decided to beg for a special conditional offer at two universities, but I did not succeed. This was in 2003. I wonder whether the overwhelming competition was related to the outbreak of Severe Acute Respiratory Syndrome (SARS). SARS had brought the attention of the general public to nursing as a meaningful and stable profession. This was how my story of becoming a nurse begins, from a higher diploma nursing programme.

I was becoming a nurse, rather than a doctor as planned. I was a higher diploma student instead of a baccalaureate nursing student. Nothing was going according to my expectations and dreams. There were times I was very angry at myself for not working hard at my studies, though I had worked hard. There were times I felt guilty for not achieving good academic results and not checking the results myself, but instead going sailing the day results were announced. That was a painful time in my life. I had never imagined that I would not enter the university and graduate as a university graduate. I had never expected that. I stuck a copy of my public examination result on my bookshelf in my room to remind myself of the lesson learnt and to prevent myself from repeating the pain again. I struggled for a long time to accept that I was now studying nursing and becoming a nurse, and had to abandon my dream of becoming a doctor. I reassured myself that I could still contribute to underdeveloped countries by joining the Medecins Sans Frontieres (MSF) as a nursing professional. I needed a paradigm shift.

I changed greatly. I became even more serious about my studies. I prepared by reading all the materials available before attending my lectures and seminars. I further read thick textbooks and reference books after class during my leisure time. 'We see only what we know' is a phrase I came across while reading a reference book, and it gave me great inspiration. I did not want to miss any early signs of deterioration in my patients due to a deficit of knowledge. I reminded myself that I was learning to become a nurse. A nurse may cause the death of a patient when she makes tiny little silly careless mistakes. I urged myself to study as much as possible. Instead of writing my notes in a tiny little notebook, I pushed myself to remember everything: physiology, nursing procedures, medication and normal ranges of laboratory results, since I believed I would not have time to refer to my notebook

when things were urgent. I always remembered the pain I had and the risk of not knowing. That I could not bear. I have obtained excellent results with this learning attitude and a strong motivation to learn.

After the announcement of the examination results, I received a call from my programme leader. She told me that I had the opportunity to transfer to year two of the baccalaureate nursing programme. Oh My God! That was one of the happiest moments of my life! The teachers held a meeting with three other potential classmates and explained the pros and cons of the transfer. We all made the decision to transfer to the baccalaureate nursing programme in year two and prepared to work even harder in order to catch up to our new baccalaureate nursing classmates.

I was glad that I persisted in working very hard to prepare myself to become a competent nurse after graduation. I had seized every learning opportunity at the university and made the best use of my time to obtain more clinical experience during weekends and holidays through TUNS (temporary undergraduate nursing student) experience, overseas clinical exchange experience in Shandong and Melbourne, and many other volunteer jobs for the university and the community. I was making excellent academic achievements and won the appreciation of my university teachers. I think I had gradually rebuilt the confidence that I had lost during form seven's public examination. That is how I passed through my four years of colourful university study. In Hong Kong there is a saying that identifies the five important things you have to do at the university: to skip lectures, to find a boyfriend or girlfriend, to become a committee member of a society at the university, to become a hall resident, and to find a part-time job. Except for finding a part-time job to pay my university school fee, I did not do the 'classics' of the university life. I had been a core member of the English debating team, but they had frequent intensive practice every week from 7PM until 12AM, which clashed greatly with my heavy study load. I decided to give up the precious opportunity and quit the team, because I did not want my secondary school experience to be repeated. The university rowing team was another precious opportunity that I gave up, since I knew it would require plenty of practice time and I would probably be exhausted after a full day of practice in the sun.

I graduated with excellent academic results, fortunately, and I was given the precious privilege of giving the valedictorian speech on behalf of my classmates. My university graduation was a very happy day for me, Not only did my parents and my younger brother celebrate with me, taking lots of memorial photos, but my aunt and uncle brought my grandmother in a wheelchair over a long distance to join me on the special day. That was how I become a nurse graduate. (My field notes, 11 January 2013)

6.4.2 Reasons for becoming a nurse

Of my 18 NGRN participants, most were directly attracted to nursing, motivated by their personal interest in health and other people, such as family members, friends, and teachers, as well as nursing's helping nature and its stable income. However, three of them shared a similar experience to my own and were drawn to the nursing

profession indirectly through other health care professions. Agnes is an NGRN in the NICU who initially preferred to study Medicine or Pharmacy. Margaret is an NGRN in the medical unit who initially wanted to become a physiotherapist. Isabel is an NGRN in the orthopaedics unit who had a strong interest in becoming a veterinarian. Although nursing might not have been our first choice initially, Agnes, Margaret and I continued in the nursing profession, while Isabel resigned at the end of her three-year contract at the public hospital to continue her study of Korea and the Korean culture in South Korea. My effort in preparing myself to be a competent NGRN through various learning experience and my excellent academic achievement with the privilege to give the valedictorian speech unveiled another layer of my stories of pursuing good work. This echoed with the stories of some NGRN participants such as those from Edwin and Nancy.

6.4.3 Undergraduate nursing programmes and changes

Although I cannot deny that I cried a lot when I ended up unexpectedly as a higher diploma nursing student, I found that I gained a valuable experience and the satisfaction contributed much to my confidence. My experience studying in both the higher diploma and baccalaureate degree programmes further helped me to understand the experiences of NGRN participants graduating from the two different nursing programmes and establish relationships with them. My experience shares some similarities with that of Miranda, an NGRN participant who graduated from an associate degree with excellent result and was accepted into the second year of a baccalaureate nursing programme.

However, my past experience seems to have contributed to my assumptions. Fortunately, my taken-for-granted assumptions were recognised when I took a more holistic picture of the complex health care landscape from different perspectives via focus group interviews with other stakeholders. Here is an example. When I entered university in 2003, my university was the only one that provided both higher diploma and baccalaureate degrees, while the other two universities only offered a baccalaureate nursing programme. The majority of my participants graduated from these nursing programmes. One of my NGRN participants graduated from a fourth university, which started offering a baccalaureate degree programme in 2005. It was at a later stage in a focus group interview with other stakeholders from whom I learnt

about my wrong assumptions that not all nurses at the universities were trained in an English medium and had their practicums at public hospitals. This realisation served as a continuous reminder to check on my assumptions and to give greater recognition to one NGRN participant, Nancy at the SCBU, who was trained mainly in a Chinese medium and had most of her practicum at a private hospital, her effort in transitioning from a nursing student to becoming an NGRN at a public hospital. In a public hospital, most of the written documents are in English and the culture is very different from that of the private hospitals. One hospital also offered a hospital-based higher diploma programme, from which three of my NGRN participants graduated. They had all pursued a top-up baccalaureate degree programme soon after graduation.

As the years of the study passed, the professional knowledge landscape continued to evolve. In order to alleviate the nursing shortage and to meet the surging demand for nurses, nursing schools that had closed after 2002 started to reopen in 2008. Since 2013, there are now three public hospitals offering higher diplomas for RN training. A new private college also offers a baccalaureate nursing programme. Two universities provide a masters' nursing programme for students who have already obtained their first baccalaureate degree in other fields. Besides training RNs, various public and private hospitals, universities, and colleges offer nursing programmes to train enroled nurses, who can further their studies in a conversion programme to become RNs.

6.5 Complex professional knowledge landscapes

The above reveals the complexity of the professional knowledge landscape. Nurses in a workplace can belong to different generations and be trained at different times in different nursing programmes by different institutions. Graduates from all these various undergraduate nursing programmes might join public hospitals as new nurses and be mentored by my NGRN, preceptor, and stakeholder participants or other senior nurses who might tell either similar or very different stories of mentoring in the future. Besides RN and enroled nurses (EN), there are other employed RNs occupying higher positions in the hospital hierarchy who will work with NGRNs. There are also nursing officers (NO) and advanced practice nurses (APN), which are positions offered before and after the establishment of the Hong Kong Hospital

Authority respectively in 1990. All nursing staff and health care assistants (HCA) are under the management of the ward manager (WM). All units under the same specialty are under the management of the Departmental Operations Manager (DOM). Depending on patient needs, nurse specialists and nurse consultants of various specialties may be consulted. The General Manager (Nursing) [GMN] oversees all the nursing staff in a hospital, while the Cluster General Manager (Nursing) [CGMN] oversees several hospitals in a cluster. Besides nurses, there are other health care professionals, including medical and other allied health care professionals. The medical staff also has its own unit hierarchical structure, ascending from house officer to medical officer, to specialist, to associate consultant, to consultant, and finally to Chief of Service (COS). It was not uncommon for the stories lived and told by me and my NGRN participants to be shaped by nursing colleagues and the HCAs in the lower echelons of the hospital hierarchy, as well as nursing officers, APNs, the WM and DOM, and doctors of various ranks in the higher hospital hierarchy.

6.5.1 Temporary Undergraduate Nursing Students (TUNS) experience

After I graduated from the nursing programme, I was not yet a RN. There is a period of time that new nurse graduates have to wait while practice certificates are issued by the nursing council. I took a break to enjoy a graduation trip to Europe with my best friends and then started to work full-time in the Temporary Undergraduate Nursing Students (TUNS) programme at the male surgical unit of a small hospital where I had been working part-time since Christmas of year three.

TUNS is a programme launched in 2003 to meet the surging demand for nurses at public hospitals in Hong Kong. TUNS participants are second-to fourth-year nursing students from a three-year higher diploma or four-year baccalaureate nursing programme who are employed by public hospitals and work on a part-time basis during weekends and holidays. TUNS receive a brief ward orientation and supervision from any available staff nurse. The roles and responsibilities of a TUNS are mainly basic nursing care, such as monitoring vital signs, bathing, feeding, wound and catheter care, and patient admissions. Depending on the workplace demand and/or the staff's willingness to provide supervision, some TUNS may even have patient assignments. The TUNS programme is similar to the externships found

in overseas countries such as the United States and Canada (Lott, Willis & Lyttle, 2011; Ruth-Sahd, Beck & McCall, 2010; Souder, Beverly, Kitch & Lubin, 2012), which involves both preceptored and employment experiences but is not a required component of the nursing curriculum (Kramer, Brewer & Maguire, 2013).

Local WMs tend to retain TUNS with satisfactory performance to work or, to put it colloquially, to 'upgrade' them from being a TUNS to an RN after registration. Among my 18 NGRN participates, all except three (who resigned before registration) had previous TUNS experience and had been invited by their WMs to 'upgrade' as an RN in the same unit. Only six NGRN participants did so. Nine NGRN participants and I chose to leave our previous TUNS unit to work at another unit or hospital. However, leaving the TUNS unit is not necessarily an easy step. The following is my own story, which is not exceptional. Similar stories have been told by some of my NGRN participants, including Ning and Nancy.

My Story of Struggling to Leave the TUNS Unit

While I was reading the stories lived and told by Nancy, an NGRN participant, and writing her stories into a field text, I recalled my own tense experience of leaving my TUNS workplace. This was also a story I had shared briefly with Ning, another NGRN participant, when she told her story in our first interview of struggling to leave her TUNS unit. Like Nancy I had worked at the surgical unit of a small hospital as a TUNS for more than 1.5 years. This surgical unit was my home. It was where much of my knowledge and skills were cultivated. I loved my colleagues and patients there. I developed such close collegial relationships with nursing colleagues that I felt comfortable sharing my strong interest in working in the accident and emergency department (AED) at another hospital (now my current hospital), which is larger. They supported my decision. However, I was also anxious because I did not want to leave such a familiar environment, where I thought I could pursue good work in nursing because of its less-heavy workload. Yet my ultimate goal was to develop a career in emergency nursing. I articulated my preference to my WM and submitted a request form to her for internal transferal. During the job interview when I applied for a RN position, I shared with the interviewers my dream and my strong desire to work at the AED at their hospital.

I still remember what happened during a morning shift at about ten. All the nursing staff, two WMs from the male and female wards, and the DOM of the surgical department were meeting in the space behind the nursing station. My WM asked me to oversee all the patients in the unit while they were having their meeting. Later, while I was patrolling each cubicle of the unit, I was also called to join the meeting, which I had not expected. As I was walking toward the nursing station, in the presence of all the other nursing colleagues in the meeting, the DOM asked me,

'Bernice, you are going to stay with us in surgery after registration, right?'

I was stunned! My mind went blank. I felt the pressure to respond and make an immediate decision. I intended to leave but I felt embarrassed and pressured to say either 'yes' or 'no' in front of my colleagues. I wondered how many seconds of silence passed before I was rescued. An enroled nurse said, 'Bernice might need some more time to consider.' However, I was not yet relieved from the great stress I had been under during the time after graduation and before registration. My intuition told me that I would regret it if I did not make some changes. I initiated a discussion with my WM at her office about my strong intention to leave. She told me that my name was already on the list of the new staff. I felt desperate, and restated my strong request to leave. I left her office in tears, for I knew that my request would not be entertained. I cried during that period of time and vented my troubles to different people, including former university teachers, colleagues, and classmates.

The turning point occurred when I served as the master of ceremony at a function held by my university. One of the interviewers who interviewed me for my RN job interview was there. He approached me for some casual conversation and praised me for my performance as the MC. After struggling for some time, I asked him whether he had received my request to work at the larger hospital that I had submitted through my WM. His reply was 'No'. I told him my situation. He asked me to go to his office the next morning to sign the form for internal transfer, if it really was my intention to leave the small hospital. Finally, I could work at the larger hospital – now my current workplace. (My field notes, 9 August 2011)

After experiencing frustration and struggling to leave our TUNS unit to pursue professional development according to our interests, Ning and I succeeded, while Nancy failed and was involuntarily upgraded in the SCBU. On one hand, TUNS experience can be seen as an early orientation to better equip TUNS for stressful role transition. On the other hand, TUNS' voices are silenced and their preferences are not considered by their WMs as Nancy, Ning and my stories of transfer based on our interest and career plan were ignored.

6.5.1.1 Pre-RN TUNS versus TUNS

Of the 18 NGRN participants, 12 of them did not work as NGRNs in the same unit where they formerly worked as TUNS. Half of them (six NGRN participants) told me that they had worked as Pre-RN TUNS at their first unit after graduation while waiting for the practicing certificate. This group included Debby, Heidi and Margaret. 'Pre-RN TUNS' was a term introduced to me by my participants. Even though I am a nursing insider, my AED did not employ any TUNS or Pre-RN TUNS during the time I was conducting my research, so initially, I misunderstood and thought that

‘Pre-RN TUNS’ was a new position in the public hospital with a different contract from TUNS. After Nancy helped clarifying in an email the meaning and difference between TUNS and Pre-RN TUNS, I realised that ‘Pre-RN TUNS’ was a new term created for convenience.

> *‘Pre-RN TUNS’ refers to nurse graduates who are newly employed TUNS while they are waiting for a practicing licence from the nursing council. Once the RN licence is available, they will be upgraded from a TUNS to an RN immediately. Pre-RN TUNS is not a formal position and does not have a different contract from TUNS. In a unit, it is common to have TUNS at various stages. Some are in year three, others are in year four, and some others are pre-RN TUNS. We use ‘pre-RN TUNS’ colloquially to easily distinguish the status and ‘seniority’ of the TUNS. I was not called or self-identified myself as a pre-RN TUNS after graduation, since all senior colleagues were familiar with the eight of us [TUNS] and were expecting us to upgrade in the same year.* (Translated from Nancy’s original email from on 2 November 2011)

Therefore, colloquially, ‘TUNS’ refers to nursing students who are employed in the unit before their graduation, and before their job applications as RNs are accepted by the hospital. ‘Pre-RN TUNS’ generally refers to nurse graduates whose job applications as RNs have been accepted but are employed as TUNS temporarily by the unit where they will work as RNs or ‘upgrade’ to RNs immediately after obtaining their practicing certificates. When TUNS and Pre-RN TUNS are expected to work in the unit as NGRNs after professional registration, other nursing colleagues and WMs tend to give them more advanced responsibilities in addition to the basic nursing care usually performed by TUNS. The responsibilities serve as learning opportunities to better equip these NGRNs-to-be and facilitate their role transition to full-fledge NGRNs. Though both TUNS and Pre-RN TUNS perceive they need support throughout their role transition, they might receive contradictory support and expectations, which might result in a negative role transition. Other nursing colleagues tend to have a comparatively lower expectation of pre-RN TUNS when they upgrade to RNs, due to their unfamiliarity with the new environment and less practical knowledge specific to the unit. In contrast, TUNS who have been working in the unit for a year or more are treated with comparatively much higher expectations by their nursing colleagues and WM. However, these TUNS might not have been taught or given the opportunity to learn during the years they worked as TUNS and were assigned to perform very basic nursing care. This reveals a temporal

and place dimension in the past TUNS experience which shapes their future transitional experience, and is further explored in the following chapters.

After making my request to leave my TUNS unit to work at the larger hospital, I disappointed my TUNS's WM and our DOM to such an extent that my WM assigned me to work at the opposite female surgical unit until I got my RN practicing licence. Therefore, I did not work in the neuroscience unit as a TUNS, or to use the term introduced by my NGRN participants, a 'pre-RN TUNS' - but started to work as an RN once I got my practicing licence. My story of becoming an NGRN, illustrated in the image of sailing without a rudder, was mentioned earlier, in chapter 1.

6.5.2 Shift work and changes

In addition to adapting to the new environment, roles, and responsibility, I had to adapt to full-time shift-work schedules. The public hospitals in Hong Kong are quite similar to those in the United Kingdom in that nurses are expected to work a mixture of morning, afternoon and night shifts from weekdays to weekends. The times of the morning, afternoon and night shifts and the number of days off per week might vary slightly from one public hospital to another, but all nurses are expected to work 44 hours per week. We have some 'normal patterns' and it is these shift patterns that prevent me and many other NGRN participants from having work-life balance. These shift patterns include, PAN (afternoon, morning and night shifts), PA (afternoon, morning shifts) and AN (morning and night shift). PAN means a nurse has an eight-hour afternoon shift on the first day, and then a morning eight-hour shift the next day, after which she has an eight-hour break before she returns for the night shift on the same day, which lasts until the next morning. The other PA and AN shift patterns are similar to the PAN shift pattern. With these shift patterns, especially the PAN, it is common for nurses to rest after their shifts instead of doing other social activities so as to ensure they have adequate energy and concentration to manage their work and challenges on their next shifts. Although these shift-patterns are indifferent to the well-being of nurses to a certain extent, they seem to enable nurses to provide a continuity of care for patients and family members. Because doctor rounds and routine nursing care, such as bathing, wound dressing, and catheter care, are scheduled for the morning shift, nurses have comparatively more time to check on the patients and their kardex to understand the handover information written by

previous health care professionals (some specialties like the surgical unit have the doctor rounds in morning, afternoon and night shifts). Thus, the nurse on the afternoon shift is familiar with the patient's condition and can better explain the condition to the patient's family during the evening visiting hours. The next morning when the nurse takes care of the same group of patients again, he or she knows exactly what has to be followed up, such as monitoring the wound healing process for further intervention. In contrast, there are times when the schedule might not be so 'favourable' and a nurse might have to take care of a new group of patients in a morning shift. Without the afternoon shift, he or she has had less time to understand the patient's narrative history. The morning shift is too busy to take time for it then. A better understanding, gained from the afternoon shift, also ensures better end-of-shift communication for greater continuity and higher quality of patient care.

The health care landscape continued to shift due to both governmental and societal influences. In 2007 the hospital authority started initiating and piloting a five-day work pattern. Depending on the preferences of the majority of the nursing staff, some units implemented a five-day work pattern, while others, such as my AED, did not. Under this restructuring, some NGRN participants found that the number of their working hours per shift changed and more hours overlapped between the morning and afternoon shifts, allowing for more communication between the outgoing and incoming nurses. Some of their experiences were affected by the reform, which is further explored in a later chapter.

6.5.3 Division of labour per shift

The number of staff on the morning, afternoon, and night shifts varies. The variation also takes place in different units according to the nature and the needs of patients. Generally, each shift has a shift in-charge nurse in each unit, who can be a RN, APN or NO. All the patients are divided among the other nurses, who are known as team leaders. They are accountable and responsible to their assigned patients. Some units might have an additional position as runner or ward runner. Runners are responsible for providing routine nursing care to all patients in the unit. Routine nursing care includes vital signs monitoring, tube feeding, wound and catheter care, bathing and napkin rounds, administration of medication, new admissions, and escorting patients for intra-hospital transfer. In addition to administration of medication, the roles and

responsibilities of runners are very similar to those assigned to TUNS or nursing students. Therefore, it was not uncommon for NGRNs who have no former TUNS experience in the unit to be assigned to work as ward runner in both daytime and nighttime shifts at the beginning of their transition. Gradually, they would be assigned 'heavier' responsibilities, from daytime team leader to nighttime team leader, from daytime second in-charge to night shift in-charge, and finally to day shift in-charge nurse, like their seniors.

Each shift has some break time and all nursing staff are assigned by the shift in-charge nurse to have their breaks in separate groups. When the shift in-charge takes a break, the second in-charge nurse, who is usually the second most senior nurse in the shift, takes responsibility in overseeing the entire unit temporarily. During break time, when the number of nurses working in the unit is reduced and the patient-to-nurse ratio is increased, emergencies like cardiac arrest, and unexpected events such as fall incidents are not uncommon.

6.5.4 Hospital supportive programmes and changes

In addition to the unit orientation provided by my nursing colleagues, including my preceptor (later evolves to be my mentor and friend), other ENs, RNs, APNs, nursing officers, I was allowed by my WM to attend the orientation programme offered at the departmental and hospital level. After I initiated this research study, I searched through my boxes of documents at home, where I had stored the orientation programme for new nurse graduates along with the programme handouts. As I uncovered the piles of document one by one and read all the notes I had written at the margins, my memory flashed back to the time I was newly graduated and registered. I can still remember sitting with other NGRNs from the medical department along the rows of chairs, listening to presentations by the WM, nursing officers, and APNs in a seminar room. I can also remember when I met my university classmates who worked at the same hospital but in different departments at the hospital orientation programme, which was held in another larger seminar room that had obviously been modified from a ward setting. There were also the times I had full-day orientation programmes with all the new staff from all the hospitals in the same cluster. We gathered at the large lecture theatre at the hospital and listened to speeches delivered by the Cluster Chief Executives and Cluster General Manager of Nursing. I was, in

fact, quite surprised by the diversity of topics that were covered in the nine full-day and half-day programmes over the first three months after professional registration. Many of them were 45- to 120-minute classes. Some were about professional appearance, work attitudes, hospital and department mission, and core values. Some were related to hospital guidelines and practices, such as nursing documentation, infection control, pre-discharge planning, handling of patient's property on admission, handling of missing or walk-away cases, handling of on-loan or borrowed ward items, and disaster plans. Some were about various nursing care and procedures, for instance, Hickman line care, management of patients with continuous ambulatory peritoneal dialysis and haemodialysis, blood transfusion, updates on oral anti-diabetic drugs and insulin therapy, use of restraints, collection of nasopharyngeal aspirate specimens, fall prevention, pressure sore prevention and management, and suicidal prevention and management. There was also a class on stress management.

In addition to these piles of documents was a glass bottle on my book shelf containing two small pieces of paper rolled into a scroll. The glass bottle was a used medication vial that had once contained intravenous antibiotics, but all the instruction labels had been removed. It had been prepared by a group of passionate seniors, including a retired DOM, some WMs, nursing officers, APNs and RNs, who wanted to support us, the NGRNs, in transition. They asked us to write down what we were worried about on pieces of paper and place them inside a glass bottle. They gave each of us another little paper scroll which had an inspirational quote printed on it. Over the years, I had forgotten what I had written and was quite excited to unroll the piece of blue paper.

1) ***Worried about missing something [Chinese: 擔心做漏嘢]***
2) ***I want to work in the AED or Midwifery [Chinese: 想做 AED/Midwifery]***
3) ***Worried about being unable to meet the expectations of myself and my colleagues [Chinese: 擔心 reach 唔到自己，同事的 expectations]***

Although the note was short, I could recall how worried and stressed I had been during my role transition from a nursing student to a RN in a highly specialised unit. I also unrolled the second paper to see what inspirational quote was printed there.

I release my limitations based on old, negative thoughts.

Overall, I had a rather neutral view towards the hospital supportive programme. Honestly speaking, I had learnt some of the contents of these orientation programmes when I was a nursing student or a TUNS, or had been taught me by my nursing colleagues. However, I treated them as opportunities to refresh my memory, and I did enjoy the more systematic teaching in the seminar room. Furthermore, since I was officially released to attend all these programmes during working hours, I regarded them as a break from the stressful clinical environment. I could meet my university classmates and other peers there, and we could vent and share our transitional experiences. I did not have much expectation for the group of passionate seniors, even though they named the programme the 'We Care Programme'. I believed that I had to get through the tough periods by myself, a belief which may be related to the popular proverb 'teachers open the door, but you must enter by yourself'. In fact, I did appreciate their good intentions and attempts to support us through small gestures of goodwill. They organised a lunch gathering at the staff club to create a supportive and caring atmosphere. They also tried to organise a social barbecue gathering and tried to find a time that would work for all our shifts, which was difficult and never actually worked out. Nevertheless, my neutral view towards the hospital supportive programme was quite different from most NGRNs, preceptor and other stakeholder participants.

Given the passage of three years, is there any difference between the old and the new hospital supportive programmes and how do the new ones look like? I reviewed the hospital documents through the intranet system and learnt that my department preceptorship programme was re-designed in 2008 and integrated with the overall hospital supportive programme. To compare my experience with those of my NGRN participants in 2010, who came from different hospitals and were more recently graduated, I retrieved my hospital's preceptorship programme, which was revised in September 2009 and July 2013. I found the contents of the preceptorship programmes from 2009 to be the same as the 2013 version. The only change was in the layout and organization of the different categories. Some of the contents that seemed to be new were in fact the contents of the department preceptorship programme. The following is a list of the new contents of the most recently updated

orientation programme, which corresponds to the ongoing hospital and diseases development.

- Guidelines on referring Patient for private healthcare services
- Guidelines on data privacy
- Professional Development
- Nursing informatics
- Occupation Safety and Health (OSH) Awareness Test
- Drug allergy / Drug intolerance warning (DAW) sheet
- HA Guidelines on Medication management
- Patient care Practices – Infection control Guidelines, Lab results interpretation
- Management of Multiple drug-resistant organisms
- Notifiable Disease Reporting Mechanism & highlights of common notifiable diseases
- Electronic Knowledge Gateway (Hospital database)
- Shift handover
- Simulation Training Programme for Newly Qualified Registered Nurses undergoing Preceptorship Programme

6.5.4.1 Simulation Training Programme for NGRNs

According to the hospital document review, the simulation training programme was initiated in the hospital preceptorship programme revised in 2013. However, all of my NGRN participants who registered in 2010 had attended the three-hour simulation training programme at different times after employment. This was one of the main differences from my experience. However, this simulation programme was rarely mentioned by my NGRN participants during regular conversation. The discussion was initiated by me by asking specifically about their experience and perceptions.

In the past several years, simulation training has gained more popularity at the hospital authority. It is not limited to training only newly qualified RNs, but also trains doctors. It is commonly used in highly specialised areas, such as in the AED for handling trauma patients, or in the adult and paediatric intensive units. It includes elements of interprofessional collaboration and education, as well as Crew Resource Management techniques adopted from the Aviation industry (HA, 2014c).

After providing an overview of the local health care landscape, the following interpretive accounts of the stories co-constructed by me and six of my NGRN participants will be presented in the following narrative chapters.

CHAPTER SEVEN

NING'S STORY – AN NGRN IN THE NEUROSCIENCE UNIT

7.1 Introduction

This chapter about Ning, the second of the 18 recruited NGRNs whom I met in the first round of interviews. Ning and I had had somewhat similar experiences, as both of us were assigned to work in a neuroscience unit immediately after professional registration. This narrative chapter contains a series of interpretations and conclusions about Ning based on our three, in-depth, unstructured face-to-face interviews and on email conversations. Some theoretical literature was used in the interpretive process and has been integrated into the chapter. This chapter begins with the story how Ning and I began our participant-researcher relationship. Next, it includes her stories of good work and mentoring, which are told using the metaphors she chose to describe them. Her stories to live by were continuously shaped and being shaped by the stories of others, as well as by the unit story and hospital story in the complex health care landscape or professional knowledge landscape (Clandinin & Connelly, 1995).

7.2 Beginning our participant-researcher relationship

Ning is an NGRN participant who was nominated by her nursing officer in the neuroscience unit. She showed some hesitations and was cautious about telling me the stories of the others in her unit, particularly in our first interview and our initial email conversations. She worried that her story telling about the others in the research process would appear to be gossiping, which she personally dislikes. Her initial hesitation may also have been related to limited trust on me as a researcher to maintain her anonymity and confidentiality. But over the one-year study period, in which we exchanged many emails and held individual interviews, I was glad to gain Ning's trust. Later, she shared some important secret stories that she had been living in the professional knowledge landscape. That is why I have chosen to reconstruct Ning's story for this inquiry to better understand how her stories of mentoring and

good work were shaped by the stories of the others in her unit, as well as by the unit and hospital stories.

7.3 The taste metaphor

Ning loves food and she used a food metaphor to describe her first two years of clinical experience, classifying everything with four different tastes: sweet, sour, bitter, and spicy. I found the taste metaphor very interesting since I have never thought about nursing in those terms before. Ning was also the first and only NGRN participant to use a taste metaphor in our final interview. This is one fascinating aspect of qualitative interviews: they are always filled with surprises, which I enjoy because they allow me to share in the unique stories of each of my participants. Before Ning elaborated further, she asked about the metaphors my other NGRN participants had used. I told her that others had likened their transitional experiences to learning to walk as a baby or playing a video game. Ning said she identified with both of those metaphors but she highlighted the insufficiencies she saw, particularly in the video game metaphor. The metaphor of the video game, for instance, represents a linear progression of increasingly difficult levels, but the metaphor of the four tastes - sweet, sour, bitter, and spicy - captures the unpredictable and intermingled nature of her transitional and mentoring experiences. The taste metaphor also conveys a sense of uncertainty and expresses the complexity and multilayer of her storied experience.

> [*Bernice: Can you think of a metaphor to describe your two years of experience?*] Ning: Food. I like eating. It includes all kinds of sweet, sour, bitter and spicy… Both metaphors – such as a baby learning to walk or a person playing a video game - are suitable. However, the video game carries a meaning that the next level is always more difficult than the previous one. This is not the case [in nursing]. I mean for each game, the level is different. [But in nursing] sometimes it is peaceful. Sometime it is more stressful. At other times, there were numerous interpersonal conflicts. Some days, you may not be working your best and make numerous mistakes. But there were also times that filled with happy events. Therefore, I do not think it is progressive. (Ning, third interview)

When I initially tried to construct all of my field notes into a coherent research narrative, I used her taste metaphor to structure her ongoing storied experience into four main sections: sweet, sour, bitter, and spicy. Despite blending two different

flavors - bitter and sweet, and spicy and sweet - to capture the intermingled nature of her storied experience, the clues to understanding provided by the temporal dimension seem to have been lost. That was why I completely rewrote it a second time and focused on the temporal relationships between different events without forcing them to fit into the taste metaphor or categories of sweet, sour, bitter, and spicy. Instead, the four tastes would be revealed and highlighted along with Ning's storied experience. 'Sweet' describes times of happiness and satisfaction, and times when Ning's perception of good work aligned with her own clinical practice. 'Sour', 'bitter', and 'spicy' capture conflicting or competing stories with others in the professional knowledge landscape. I believe that the following presentation of Ning's experience is the most appropriate way to represent Ning's experience and her voice in the story.

7.4 Impressive experience: Forgetting the transport and embroiling the others

The story below was the first experience that left a lasting impression on Ning, which she shared at the very beginning of our initial contact. It is about a mistake that she made when she had registered and worked as an NGRN for about four to five months.

> I think the most memorable stories are most likely about something that I did not do well. For example, there was an instance when a patient was admitted overnight for DSA [digital subtraction angiography an investigation procedure], but I had forgotten to book transportation [arrangement of intra-hospital transport of the patient from the ward to the X-ray department]. In fact, there was another patient, a baby who needed an MRI [Magnetic Resonance Imaging], and I had booked the transport for her immediately upon admission. I mean I know [the procedure], but I had really forgotten [to book]. While I was having my breakfast break, the [staff of] the X-ray called at 8:45am sharp [the scheduled appointment time], directly to the ward manager in his room rather than the nursing station. When I returned from the canteen, I saw my in-charge being scolded by the ward manager. Since I had made the mistake, I deserved to be scolded. However, I felt extremely guilty and uncomfortable about getting her embroiled in the scolding. When I later apologized to the in-charge, she said 'It's ok! Sometimes we forget things. I know that you know what you had to do, but just forgot.' That made a great impression on me. (Ning, first interview)

This storied experience is significant not only because Ning made a mistake, but also because her forgetfulness resulted in her senior nursing colleague, the shift in-charge, being scolded by the ward manager. Thinking narratively about the meaning and

significance of this experience as it relates to mentoring NGRNs in transition and to good work, I was also impressed by this storied experience because of how the shift-in-charge acted with understanding and trust toward Ning, who did not make the mistake intentionally. She seemed to have some understanding of the fact that 'to err is human' (Corrigan, Donaldson & Kohn, 2000). She could have perpetuated a cascade effect of scolding from the ward manager down to Ning. This could have resulted in a miseducative experience (Dewey, 1938), as she would have shaken Ning's confidence and influenced her future performance, as well as any future collaboration between them. Ning might even have internalized the scolding behaviour and repeated it with on younger generations of nurses. Fortunately, the shift in-charge's attitude of tolerance, care, and understanding toward her younger co-worker contributed to this educative experience (Dewey, 1938) for Ning. She described to me how she learnt deeply and effectively from her mistakes without the use of scolding or other disruptive behaviours and without suffering from their potentially detrimental effects (D'Ambra & Andrews, 2014; Hutchinson, Vickers, Jackson & Wilkes, 2006; Hutton, 2006). This guilt-inducing yet educative experience can be captured metaphorically by both the terms 'sour' and 'sweet'.

7.5 Being complained about and having a sense of unfairness and powerlessness

Ning went on to share another experience that left a deep impression on her: she was scolded by a patient's relative, who later complained to the Patient Relation Office (PRO). In contrast to the educative experience above, the following story conveys a great sense of powerlessness and is miseducative in two ways.

> One night a relative called to ask about a patient's condition. In fact, the ward manager had lately restated the guideline, 'NO DISCLOSURE OF PATIENT INFORMATION ON THE TELEPHONE' during the handover session. I do not know what had happened [that led the restatement]. The relative called to ask whether the patient was still having a fever. I told her that the fever had subsided and added a gentle reminder, 'According to the guideline, this is all I can tell you on the telephone. I cannot tell you any other more detailed information.' She became agitated immediately and kept scolding me. [*Bernice: Did she scold harshly?*] She did. She asked for my name. I told her but she kept scolding without pause and couldn't hear my reply. She was agitated and asked, 'Do you have a mother? I am asking you for your name!' Something likes that. I felt very angry after hearing this. I said, 'Miss, please stop for a moment. I tell you that my name is Ning.' She wasn't satisfied. She asked me to spell out my name. Indeed I don't think that was necessary, since

> I had given her my name. That was adequate for her to make a complaint. I said, 'I have to hang up the phone, good bye.' Five minutes later, the relative called again and insisted on talking with my night in-charge nurse. I was lucky to work with a very nice senior. They had a very long telephone conversation. At last, the relative made a complaint that I had a 'poor attitude'. My ward manager had a talk with me to understand the situation, but he didn't scold me. [I guess] he knows what had happened. I found this incident quite memorable.
>
> [*Bernice: How do you feel about this incident?*] Of course I felt angry and aggrieved. Being scolded without reason. It is common nowadays for people [relatives] to scold the nurses, but you can't avoid meeting this kind of person. That is out of your control. I felt unfairly treated because our intention is to help the patients, yet many of the relatives treat us this way [in spite of that]. When people cannot get what they want [from the frontline staff] face-to-face, they make complaints at the PRO [to get what they want]. I realise that some patients stay for a very long time. They only have discharge problems, not any health care problems [to justify their stay at the acute hospital]. I wonder why they receive extra attention. Then I realised this was related to the many complaints that were made to the PRO. [When resources are limited at the acute hospital], I think that more effort should be devoted to patients who are more in need, instead of [less ill] patients merely because of they had made a complaint.
>
> I think I am relatively lucky, as I had a nice senior and a ward manager who seemed supportive. [*Bernice: How would you manage a similar situation in the future?*] Depends, as each relative will respond and scold differently. I guess I would avoid them or minimize talking with them in the future. *[Bernice: Could you think of any strategies to improve the situation or prevent the complaint system being abused?*] People in Hong Kong always claim that 'The customer is always right' [Shaped by a popular television advertisement about appropriate attitudes in customer service in the retail and catering industry by the pop star Andy Lau in 2002]. Although the hospital also provides services, it is different from those kinds of services that can be bought in the business field. The business perspective might not always be directly applicable and transferable to the health care context. [*Bernice: If you become more senior and your junior RN encountered a similar situation, what will you do?*] I would provide support and ask her to pass me the phone. With more experience, I might be able to better manage the situation than the junior. I think support is important, as the junior might not know what to do and feel unhappy. A senior has to offer support and reassurance by saying 'many people are like that nowadays'. (Ning, first interview)

At the surface level, this story reveals the importance of support from seniors and managers when NGRNs and frontline staff are involved in interpersonal conflicts or complaints. Ning was grateful for the understanding and trust shown by her night in-charge nurse and ward manager, who did not scold or blame her for the complaint.

Similarly, her experience might have shaped her future attitude about offering support to younger generations of nurses.

However, I considered the above storied experience as miseducative. This was because of Ning's expressed sense of powerlessness and her comment: 'I would avoid them or minimize talking with them in the future.' When I thought from the perspective of Ning as an insider and a co-participant, I understood the reason for her anger and her perceived sense of unfairness to be yelled at by the relative because of her gentle reminder to the relative about their recently emphasized guideline of disclosure of patient's condition over the phone. However, as a critic, I also wondered about why Ning was unable to think beyond herself in understanding the situation from the family member's perspectives and her need to follow the institutional guideline. This self-reflective learning would have facilitated a better way to convey the message to the relative. As a narrative researcher, I acknowledged the strong negative feelings expressed by Ning, and valued the opportunity that the narrative inquiry afforded my research participant to have a voice, both positive and/or negative ones. Notwithstanding the different perspectives, I continued to be puzzled by Ning's inability to retell her story with the relatives despite her reported practice of self-reflection and being a NGRN who have been recommended and recognised for her dedication to pursue good work. Shaped by this storied experience, Ning shifted to adopting more of an avoidance approach in an effort to minimize the chances of having conflicts with relatives. This accords with the reported use of avoidance among newly graduated nurses in conflict management (Kelly, 1998; Miller, 2006). However, this approach might inadvertently reduce communication, which is critical for a better understanding of the needs of patients and relatives and to establish a therapeutic relationship. Good communication, in turn, is essential to good work in nursing. Through reading and re-reading different field texts, as a narrative inquirer, I realised the taken-for-granted assumptions which overshadowed the new possibilities to retell the above story in a positive way. The ward manager and seniors had showed their support with a non-blaming attitude. However, they could also have turned Ning's miseducative experience into educative ones, perhaps if only they know that could be a mentoring moment. This opportunistic mentoring seems to be important not only for Ning, but also the average NGRNs who might have lesser moral maturity.

Thinking narratively along the temporal dimension reveals the first layer of the story. I see the importance of a debriefing, as the practices and mentoring of younger generations might be shaped by the present miseducative experience. Ward managers or seniors can debrief by evaluating the incident, acknowledging the nurse's effort, and then transforming an unhappy or bitter experience into a learning experience that can guide future experiences. This could be a different layer of support or mentoring based on the upcoming opportunity that contributes to reassuring the NGRN's shaken professional identity for sustaining of good work without avoiding the important patient communication and engagement. This debriefing could actually be initiated by any involved party, ranging from ward managers to seniors and even to NGRN themselves. However, such initiative depends on whether they see the importance of mentoring for good work and the opportunity to do so, and whether they have the skill to guide the reflection toward seeing new possibilities. While the NGRNs reported needing both affirmation and critical feedback from their assigned preceptors, other nursing colleagues, and ward managers (Chernomas, Care, McKenzie, Guse & Currie, 2010; Duchscher, 2009; Kramer, Brewer & Maguire, 2013; Kramer et al., 2012;), Ning's storied experience and interpretation contribute to a more in-depth understanding of the necessity of feedback for sustaining professional identity and good work in nursing.

Thinking narratively in the place dimension reveals the second layer of this miseducative experience, which was shaped by the hospital story. It is important to note the guideline that was restated during the handover session in the afternoon: 'NO DISCLOSURE OF PATIENT INFORMATION ON THE TELEPHONE.' The guideline was probably used to protect the confidentiality of each patient. However, it was more like a sacred story passed down from the out-of-team place through the conduit to shape the practice of the frontline nurses in their in-team place. Ning's response of 'I was unsure what had happened' reveals her uncertainty about why the guideline was recently reemphasized and her impression that there had been incidents that led the ward manager to restate the guideline.

The guideline, and the sense of rigidity that its restatement conveyed, was rather miseducative in that it sought to protect patient confidentiality but failed to consider

the vulnerability of patient's relatives. Meanwhile, this sacred story could be in conflict with the story of relatives who felt they had a right to information about the patients' condition during telephone inquiry. The resulting conflicts and even complaints are to be expected. The storied experience reveals the inadequacy of merely stating the guidelines in the complex health care landscape with its multiple tensions. It reveals the importance of giving frontline nurses additional support or training on how to follow guidelines with flexibility and discretion and on skilled communication and how to communicate in a conflict (Brinkert, 2010; Thornby, 2006), in order to empathize with relatives of hospitalized patients and to accommodated their potentially long working hours. This kind of mentoring is especially imperative for novices and advanced beginner nurses, who tend to rely too heavily on principles and rigidly follow guidelines (Benner, 1984), like Ning who attempted to follow the guideline by giving a gentle reminder to the relative directly.

Honestly speaking, I found Ning's response –'many people are like that nowadays' rather disturbing, for it conveys a perceived sense of powerlessness to effect change. Unfortunately, this feeling of powerlessness was not limited to NGRNs at the lower echelon of the hospital hierarchy. It was also expressed by more senior nurses whom I met in both informal social activities and in formal focus group interviews with other participants with relatively more power and authority. I wrote the following field notes after a dinner gathering with my former colleagues who are now working in different units in both public and private hospitals, a group that included a nursing officer, senior RNs, and midwives.

> *The problem of some irresponsible senior nurses who treated new nurses unfairly became one of the main discussion topics tonight. The [recounting of] two unfair incidents led to the sharing of many others. Things were rather ambiguous, as different people have different interpretations about who should be responsible for reporting incidents, such as a patient fall, to the Accident and Incident Reporting System… I felt rather disturbed and astonished that the nursing officer [one of my role models], also asserted that we [nurses] have to accept that some things cannot be changed and this kind of gathering is important for nurses to ventilate their feelings and then return to work afterward. Can it be that even a nursing officer expresses such powerlessness to change and demonstrates no intention to make changes?* (My field notes, 9 July 2012)

Returning to Ning's story, the relative's unreasonable complaint led her to reflect on the meaning of complaints in relation to good work in nursing. Ning's story led me to ask more questions about the complaint system, not merely at the individual level, but at the system level. A complaint system is a two-edged sword. It can be used by the service recipients to give constructive feedback to the service provider. It can also be abused, used to get extra attention and benefits. Nevertheless, it is understandable that the hospital would like to minimize complaints. New nurses have reported conflicts making decisions about appropriate levels of care, especially when the health-care institution had adopted a business-focused approach (Deppoliti, 2008). Scholars have said that health care professions should not be operated in the same way as commercial enterprises which focus on the delivery of certain standardized commodities; otherwise, professionals might have less flexibility and autonomy in their practices (Gardner et al., 2001; Wells, Manuel & Cunning, 2011). Ning's story has created space for reflection and further inquiry: is the current customer service model appropriate for both service recipients and service providers? Do we see complaints as opportunities to learn and improve? How do we handle each complaint? Are the voices of both sides being considered or are there any assumptions being made? How do we support our frontline staff when a complaint has been made? Is there any measure that can be adopted to prevent the complaints system from being abused and protect the frontline staff? We both pondered but with no immediate thoughts.

7.6 Speaking up to withhold a Ryle's tube insertion

To answer my question about satisfying experiences that have left a deep impression, Ning continued with another story. After a late and rushed doctor round, Ning was troubled by a prescription for nasogastric tube insertion. While the patient's oral intake had recently been poor, it had improved that day. Ning critically evaluated the purpose and consequences of tube insertion by using her most up-to-date knowledge about the patient to consider both the physiological and moral aspects of the act. However, the busy neurosurgeons had already left and she could not obtain clarification before the end-of-shift handover. Ning was anxious about whether she should withhold the prescription and talk to a higher authority for the sake of patient safety.

> It was a small matter, trifling incident [Chinese: 好小事/好細微的一件事]. One morning the neurosurgeons had a late senior round, almost at the time of the handover. 'Poor oral intake, insert Ryle's [nasogastric] tube for feeding' was prescribed. I found the prescription strange, since the patient had no swallowing difficulty. He may have had poor oral intake in the previous two meals. However, he ate well of the food brought by his family that afternoon [which had not yet been documented in the oral intake chart]. I couldn't contact the neurosurgeons to clarify because they were in the operating theatre. After much thought, I couldn't think of any reason for me to insert the Ryle's tube. The patient probably would pull out the tube himself. Then you have to restrain him, but this seems inhumane. Also, are you going to give him a milk supplement through the Ryle's tube even if he already had a good oral intake? That's pointless. I described the situation to an incoming colleague and she agreed to clarify with the surgeon in the afternoon. That's how the incident was settled. I think this is how we should do it in humanitarian work. (Ning, first interview)

Although Ning humbly regarded the incident as 'a trifle', as an insider, I appreciated the critical thinking she demonstrated. Her anxiety about withholding the doctor's prescription and risking blame for irresponsibility was understandable. Despite her concern, Ning made a moral decision to speak up for the patient after considering the potential risks and benefits, thus saving the patient from unnecessary suffering. This story is satisfying and sweet, as it is aligned with Ning's story to live by and her story of good work in nursing as 'being patient-oriented and acting in their best interest'.

The experience was educative, in that it led to personal growth and encouraged Ning and other nurses to speak up to protect patient safety in the future. Thinking narratively in the personal-social interaction dimension, Ning was mentoring herself based on her cumulative practical knowledge, in thinking reflectively and making the moral decision to speak up for her patient. However, the story would not be a satisfying and educative one without the nursing colleague's support and the neurosurgeon's understanding and willingness to listen to Ning's explanation regarding the unfulfilled prescription. This can be viewed as collegial support or mentoring for good work based on the opportunity that can be temporarily named as opportunistic mentoring. Together with the self-mentoring, they show the importance of learning to speak up for patient safety and the importance of mentoring to sustain good work in nursing.

Ning shared the three important storied experiences above in our first interview. When I left the café where Ning and I first met and reflected on her stories, I began to feel a bit anxious. While I was listening to and transcribing the audio recording of our interview, I felt even more anxious because the storied experience between Ning and her assigned preceptor seemed to be missing from our interview. While my analysis was rather preliminary, I felt frustrated about whether I could understand my research puzzle well with the limited information. Ning initially had a supernumerary status that was colloquially called 'the extra' - she worked as an additional member to the regular number of staff nurses per shift. In the first month to month and a half, Ning was able to work with her preceptor on the same shift most of the time. Sometimes she worked as a ward runner; at other times, she was assigned to a few patients. After that she began working independently as a full-fledged team leader, without the support of her preceptor. Other than knowing that Ning felt that she did not 'click' with her preceptor, I seemed to know nothing more about their relationship. I initially blamed myself for not asking the right questions, but after talking to my chief supervisor, Angela and reflecting on the matter, I was able to move beyond blaming myself. Instead, I thought about what Ning was telling and not telling me and her potential reasons for doing so. Did Ning feel that there was no point in sharing this information because she and I had similar experiences in having poor or even non-existent relationships with our assigned preceptor? Or did Ning's limited trust in me make her feel uncomfortable about sharing?

7.7 Negotiating for 'additional' mentoring at the central cubicles

After our first interview, I was happy and grateful to receive Ning's first email reply in which she shared about her 'additional' mentoring. It was similar to my past experience, which I described earlier with the metaphor 'the water current continues to push up the rudder while I am sailing'. Ning was also assigned to work at the central cubicles before she was ready and without the necessary mentoring and support, merely because someone else had called in sick. Ning and the other NGRNs could only pray for the shift to be over without any incidents. To my surprise, Ning and her peers spoke up collectively, both for the sake of patient safety and their own professional development.

Dear Bernice,
I have already worked at the central cubicles several times. I worked with another peer (new graduate of 2010) at the central cubicles for the first time (each of us taking care of four critically ill patients). I felt extremely nervous. After that, I was assigned to work for consecutive afternoon and morning shifts again due to staff shortage. Luckily, they were uneventful. Recently, I worked another afternoon shift. [I] want to share something with you.

Previously we had fewer patients and staff was being called off. However, most were the junior nurses. We even had a debit balance of a whole day off. We felt unhappy about this. We suggested to our ward manager that it would be a good idea to find senior nurses to mentor us at the central cubicle when there was adequate staff around. The patients would be safer. We could also learn.

Finally, our ward manager listened to our suggestion. I was being mentored by a senior while working at the central cubicle. The feeling was very different from working on my own. The senior gave me a free hand and backed me up and made sure that I had no mistakes; otherwise, if I did, she would teach me. The feeling was more secure. I am more confident to perform the same thing in the future. I really don't want to rush blindly into things [Chinese: 盲終終咁衝].

That's what I wanted to share with you recently. Will update you when I get something special again. Haha
Hope it's useful to you!

Ning (Translated email from Ning on 26 July 2011 – in both Cantonese and English by adopting the same format & punctuation)

The sense of security and confidence that Ning gained from the additional mentoring reveals the need for ongoing mentoring and support among NGRNs as they take on more advanced roles and responsibilities. 'Additional' mentoring refers to opportunistic mentoring that occurs after the initial one to two months of preceptoring. Additional mentoring is not restricted to the NGRNs' initially assigned preceptors; it can be done by any senior nurse who is given a supernumerary status to mentor and supervise NGRNs working at the central cubicle. My personal experience, as well as storied experience of my participants, shaped me to believe that mentoring should be ongoing and long-term for the development of NGRNs and to sustain good work. It is also important to note that additional mentoring depends on the human resources being available, the NGRNs' initiative to express their needs and concerns about patient safety and professional development, and the ward manager's support. I could see the positive outcomes that resulted from listening to the voices and suggestions of the NGRNs and attending to their needs by offering

three to four ‘additional’ mentoring sessions at the central cubicles. Open two-way communication between the ward manager and NGRNs facilitated the establishment of a trusting relationship.

7.8 Most worrying about not realising what you don’t know

In our second interview, I asked a follow-up question to gain a better understanding of the situation Ning referred to when she wrote in her email about ‘rushing blindly into things’. Ning recounted a dangerous story about mixing up an arterial line with a peripheral line without realising her mistake because she had a knowledge deficit. The patient’s safety was not jeopardized, however, due to opportunistic mentoring.

> The greatest challenge [at the central cubicles] is the busy work on top of all the new things to learn. [It is] most worrying when you could not realise what you don’t know. That is most dangerous. [*Bernice: Did you have such an experience?*] Yes. The patient returned from a procedure with an A-Line [arterial-line]. In fact, I really didn’t know how to manage an A-Line. I didn’t realise that I didn’t know, and I intended to manage the A-Line as a simple peripheral line. I’m lucky. I told the in-charge nurse about the A-Line unintentionally while talking about something else. She helped me to manage the A-Line and taught me how to manage it afterward. Without her teaching, I wouldn’t have realised [my knowledge deficit]. (Ning, second interview)

An important problem was revealed in the recurrence in the NGRN participants’ stories of their reporting a lack of awareness of their own knowledge deficits, and hence, not knowing what questions to ask in order for them to learn and to ensure patient safety. Ironically, the NGRNs’ senior nurses, and the preceptors and stakeholder participants in my research group were unaware of this important problem, but merely offered help or mentoring when the NGRNs take the initiative to ask. It was not uncommon for senior nurses to offer support to the NGRNs by telling them, ‘Ask if you don’t know.’ [Chinese: 唔識就問]. However, ‘ask if you don’t know’ seems to be a ‘ritualized’ question (Holland, 1993) when thinking about its meaning and significance in more depth. If NGRNs really don’t know something, they would normally ask and may be wondering who and when to ask. Therefore, ‘ask if you don’t know’ seems to be a ritual statement devoid of actual meaning and can even convey a sense of unsupportiveness. Ning’s story highlights the false assumption made by NGRNs’ preceptors, other senior nurses and ward managers that NGRNs are fully aware of their own knowledge deficits. In reality, they are not,

and they need more than knowledge and skills. They need mentoring from senior nurses to improve their awareness of their own knowledge deficits.

7.9 Growing enjoyment and fulfillment in being a nurse, but feeling powerless

Before our second interview, Ning and I exchanged another important email that captured the multifaceted experience of her one-and-a-half year of clinical practice as an RN. I had sent my Chinese Lunar New Year greeting to Ning and asked whether she had changed her perception of nursing and how she now saw herself as a nurse. Though lengthy, Ning's email response is presented below in its entirety to preserve its originality. It captures her complex experiences and emotions, her stories to live by, as well as two secret stories. Along with our follow-up conversations, these stories were further discussed in the subsequent two interviews.

> *Actually, I enjoy being a nurse. The longer I work as a nurse, the more I enjoy my work [Chinese: 越做得耐，越喜歡自己的工作]. Of course, there are some aspects I dislike, such as the paperwork and the troublesome relatives.*
> *Nonetheless, [I] still want to continue to work as a frontline nurse. Maybe the Hospital Authority has not driven me crazy in the past one year and five months. HAHA [laughing]*
> *Originally I wanted to become a nurse because of the stable income, as well as nursing's helping nature. After this past year and a half, the person who has received the greatest help might be me. Witnessing the vicissitude of all walks of life [Chinese: 人生百態] leads me to much reflection.*
> *How do I see myself as a nurse?*
> *Indeed I am quite proud of myself in being a nurse. This is not because of the status or reputation of nursing, but because I think I have an occupation that I enjoy, which might not be the case for everyone.*
> *All along, I have thought my ultimate goal as a nurse should be the patient's benefit. Although my capabilities in reality might not allow me to give all or the best to patients, I hope to try my best.*
> *I remember two recent experiences:*
> 1. *A patient has an intractable bleeding buttock wound due to diarrhea. The zinc oxide [usual unit practice for buttock sore] couldn't help as it couldn't be applied successfully on the skin. Then I asked my mentor [colloquial terminology used interchangeably with preceptor], the pressure sore team leader. She didn't agree that we should use the stomahesive powder and asked me to continue using the zinc oxide. In the end, I borrowed a bottle of stomahesive powder secretly to use with this patient.*
> 2. *Another patient also had an awful intractable buttock wound due to a short gut syndrome with very watery stool. My colleague in the previous shift had consulted my mentor, then… […represents no response to the*

inquiry of the colleague]. We asked the doctor to help us to write down a recommendation to consult the wound nurse. Finally the wound nurse taught us how to use different kinds of dressing materials [including stomahesive powder for the intractable buttock wound] to help the patient. These two patients were bedridden. However, you can see their great pain from their facial expressions. I think that as nurses we must help them, otherwise I will feel a twinge of conscience [Chinese: 問心有愧].
I think I still have the passion to be a nurse, but I have inadequate experience and knowledge. I felt powerless. (Excerpt of the translated email from Ning on 4 February – in both Cantonese and English by adopting the same format & punctuation)

As an insider, I resonated strongly when I read and re-read Ning's email, and I could feel the strong sense of her taste metaphor of the intermingling of different tastes paralleling her mixture of emotions of enjoyment, pride, beneficial passion, dislike and powerlessness. On the one hand, I was glad that Ning had a growing sense of enjoyment and fulfillment in her job as a nurse. On the other hand, I understood her sense of powerlessness as an NGRN within the complex health care landscape. Her sense of powerlessness and those expressed by the more senior nurses reconfirmed for me the importance and social significance of persisting my narrative inquiry, with the hope to make a difference, even minute ones, for the benefits of nurses and their care recipients. Our subsequent interviews followed up on Ning comments in her email about paperwork and troublesome relatives. It should be noted that having been the target of a relative's complaint may have shaped her perception of events.

7.10 The conflicts about the use of stomahesive powder

Her stories to live by as a nurse in acting for the patients' benefits were consistent with what she told me in our first interview. Although she was able to maintain her stories to live by after working for about 18 months, the two secret stories captured the tensions that she experienced while sustaining her professional identity and good work in nursing and while maintaining consistent stories in life. They also show how she was being disempowered by different sacred stories in the complex health care landscape.

Ning's patient had bloody incontinence-associated dermatitis (IAD) because of diarrhea. Though administering zinc oxide was the unit's usual practice, it could not be applied to a wound with serous exudate, on a patient with watery stool. Ning

borrowed stomahesive powder from another unit since both zinc oxide and stomahesive are recommended for IAD (Gray, 2010). Her use of the stomahesive came from her practical knowledge. She witnessed its effectiveness as a remedy for IAD while she was working as a temporary university nursing student (TUNS) at a rehabilitation hospital. There, she cared for numerous patients who had intractable pressure ulcers and learnt from wound experts. Her act of advocating for her patients by exploring alternatives was patient-oriented and thus consistent with her stories to live by or stories of good work as a nurse. Unexpectedly and ironically, the pressure sore team leader and her assigned preceptor - the authority figure in her unit who was expected to have more specialised training and knowledge about wound management - insisted that she follows the usual practice, despite its ineffectiveness in that situation. An open discussion between Ning and her preceptor, exploring alternatives for the best interests of patient, was not encouraged, nor was any rationale given for not using stomahesive.

Although Ning had pointed out that that the zinc oxide could not be applied to the wound due to serous exudates and watery stool, her assigned preceptor asked her to continue using it despite the certainty of failure. The usual practice had become a ritual or even an alienation (Jarvis, 1987) to her preceptor, since she was asking Ning to perform an act that was meaningless and ineffective. The words of the pressure sore team leader were like a sacred story or unit story that was so powerful that Ning and other nursing colleagues had to obey despite the lack of evidence. This sacred story was passed down from the pressure sore team leader in the out-of-team place in the same unit to affect Ning's practice in her in-team place when she took care of her team of patients. Instead of being mentored to pursue good work in nursing, Ning disempowered by the unit story or sacred story.

However, Ning found it unacceptable to follow the sacred story when it conflicted with her stories to live by. Rather than becoming involved in a direct confrontation with her preceptor, Ning made another moral decision to advocate secretly for her patient. She had lived a secret story and this secret story was told to her incoming colleagues during handover only if she knew that they would accept the use of stomahesive powder. This secret story was also told to all health care assistants (HCAs) who followed the instructions given by Ning. However, if Ning had to

handover to colleagues in the senior camp, who were not open-minded and merely followed the sacred story, Ning had to tell a cover story and the stomahesive powder had to be placed in the patient's drawer for secret use by HCAs. I greatly appreciated the effort and courage that Ning exercised in order to advocate for her patients. It seems ridiculous that nurse advocacy for the patient's best interest has to be done secretly, while paradoxically, the greatest resistance to the nurse advocacy came from the assigned preceptor.

7.11 Reliving and retelling the story of good work under peer influence

Ning used to avoid interpersonal conflicts by remaining silent or living secret stories, which might have been shaped by her earlier experience of being the subject of a complaint by a relative to the PRO. The following restorying reveals that her story of good work was shaped by her colleagues who had the same work values in patient care. Ning was empowered by other supportive seniors and peers to speak up. Ironically, no encouragement came from her assigned preceptor, who was supposed to be act as a role model for Ning, according to the hospital document (Hospital Authority, 2006). Rather, Ning seemed to be mentored to sustain good work by a kind of peer mentoring.

> In the past, I was quite scared, scared of offending the others. I always think it's better to do less rather than more [Chinese: 多一事，不如少一事]. Sometimes I ignored things that were not directly related to me and stayed aloof from affairs [Chinese: 置身事外]. In fact, my heart was not without anxiety. After experiencing several conflicts over patient care [with seniors], I realised that I should act for the patient's benefit. Otherwise I would have a guilty conscience [Chinese: 於心有愧]. [*Bernice: I was glad that you didn't swim with the tide* [Chinese: 隨波逐流].] If I was fighting a lone battle [Chinese: 孤軍作戰], I might not have done so. My ward still has some peers and seniors who are nice and have a heart for caring for patients. (Ning, second interview)

The conflicting stories did not come to an end. Then, an opportunity arose for her to speak up collectively with other NGRNs to suggest the use of stomahesive to the ward manager, who agreed to conduct a pilot study. Later, unexpectedly, the ward manager did not follow through and said instead that some seniors found that the stomahesive was not effective; however, he gave no further explanation. These few words left Ning and other NGRNs confused. They did not understand why the ward

manager had changed his mind without examining the effectiveness of the alternative approach, relied rather on the opinions of the nurses. Once again, the opinions of the seniors became the sacred story or unit story and shaped the attitudes and practices of Ning and other nurses in their in-team places. The ward manager appeared to have an open mind when they spoke up, but failed to cultivate an open space for nurses with different narrative histories and practical knowledge to negotiate in their search for the best way to care for the patients.

This made me think of the metaphor 'ingrained in the woodwork', which newly qualified Scottish nurses used to describe the attitudes of more experienced nurses and nursing assistants who had entrenched views on patient care and resisted even minor changes that were for the patients' benefit (Horsburgh & Ross, 2013). Meanwhile, Ning's attempt to avoid direct confrontation by living a secret story also led me to wonder whether Confucianism—which emphasizes harmonious interpersonal relationships - had some influence in the local context (Xu & Davidhizar, 2004). Confucianism's influence has been reported on the experience of newly qualified nurses in Taiwan who struggled to maintain harmonious collegial relationship (Feng & Tsai, 2012; Lee, Hsu, Li & Sloan, 2013).

My document analysis further revealed how hospital guidelines or the hospital story might have shaped the process of learning to speak up or mentoring of good work. It was difficult to find concrete guidelines or protocols specifically related to the kind of intractable buttock wound mentioned in the two stories. I found one guideline and one protocol on pressure sore management, as well as one guideline on chronic wound care with a statement that is relevant to Ning's story: 'Use appropriate dressing that manages exudates to keep the pressure sore moist, but prevent maceration of surrounding skin.' Having a general hospital guideline on wound management is good, as the intention may be to give nurses the autonomy and resources to apply their practical knowledge. However, an ambiguous or vague guideline may implicitly give authority figures the power to tell their own sacred story in dictating their own practices to NGRNs. It inadvertently creates tension and dilemmas as NGRNs pursue good work, while also preventing their voices from being heard.

Thinking narratively about Ning's experience showed me that it is so complex that it cannot simply be classified as miseducative. The experience is miseducative in the social dimension and might have made Ning and other NGRNs hesitant about speaking up in the future. However, Ning took the initiative to transform this miseducative experience into an educative one in the personal dimension by searching for new ways to sustain her professional identity. These include her secret use of stomahesive, speaking up collectively with the other NGRNs, and later requesting a clinical rotation. She wanted to sustain her learning and her professional identity in a place where it was possible to speak up for patient safety publicly and where evidence-based practice was not simply rhetoric.

The above storied experience reveals that the stories of good work in nursing of Ning and her assigned preceptor were in conflict. From the patient's perspective and my perspective, the preceptor was not pursuing good work when she continued the futile intervention and merely completed her work, rather than using her expert knowledge actively to search for a better way to improve the patient's condition. In fact the stories of mentoring of Ning and her preceptor were also in conflict.

7.12 Ning's and her assigned preceptor's conflicting stories of mentoring

As mentioned earlier, I was frustrated after my first interview with Ning because the character of Ning's preceptor was largely absent from her storied experience. It was until our third interview that Ning felt more comfortable in sharing her transitional experience with the disappearance of the expected preceptoring.

> She [Ning's assigned preceptor] expected me to remember and know everything after the first time she taught it. If I asked, she scolded me and merely replied that she had told me before and asked me to think on my own. [Ning's a bitter smile] I had to ask the others secretly. (Ning, third interview)

As an NGRN, Ning initially felt very lucky to have a preceptor who was willing to teach. However, she was soon surprised to realise that the preceptoring disappeared on the third day after registration. In three days, her preceptor had taught her everything about the complicated neuroscience, from general ward routines, and management of all paperwork and procedures to interpretation of the hypodensity and hyperdensity of the computer tomography scans. After those three days of

teaching, her preceptor refused to answer any follow-up questions and had no interpersonal exchanges with Ning. Ning perceived that her preceptor did not enjoy teaching. I wondered if the preceptor's change of behaviour stemmed from a dislike of some personality traits of Ning. However, Ning observed her preceptor repeating the same pattern of limiting teaching to the first three days after registration with the new graduates in the following years, 2011 and 2012, so this seemed to be her preceptor's story of preceptoring.

The above interview excerpt reveals an important underlying problem - that of the hospital story of preceptoring in the context of a severe nursing shortage. It is assumed that nurses have the responsibility and ability to teach and support their younger generations. Every nurse, whether senior or junior, is formally assigned to be the preceptor of the NGRNs or informally expected to provide support while they are working with the very juniors. However, Ning's preceptor story, as well as the findings from my focus group interviews, reveals three layers of problems. First, some of these nurses may not be motivated to teach and support others. The ward manager may assign them the role of preceptor without considering their willingness to go through the rite of passage and take up the preceptoring role as time passed and more new graduates joined the workforce.

Second, nurses assigned to be preceptors may not have the necessary pedagogy. Ning's preceptor, who expected her to learn everything about the neuroscience unit in three days, exemplifies this. Her preceptor also seemed to treat the preceptoring role as a task to be completed, rather than a relationship for the mutual exchange and development in the two parties. According to the demographic data obtained from all 11 preceptor and 10 stakeholder participants, the majority did not receive any special training in preceptoring, mentoring, or specifically in supporting NGRNs in transition. Three had received some kind of training from the hospital authority, three others had only received training about supporting, supervising and assessing nursing students from individual educational institutions, and another three reported previous training without indicating the nature of the training. The duration of all training ranged from half a day to a maximum of three days.

Third, the seniors' complicated situations should not be overlooked. These were reported by the preceptor and stakeholder participants in the focus group interviews. Many were heavily engaged with their basic responsibilities as team leaders or shift in-charge nurse, as well as being preceptor to their own preceptee(s) and supervising all other junior nurses at work. They reported preceptoring and supervising up to four new graduates. Therefore, many of the seniors seemed to take care of the entire unit's patients and staff on their own because the new graduates and juniors were still highly dependent. The severe nursing shortage and imbalance in the number of senior and junior nurses certainly put patient safety at risk and exhausted both junior and senior nurses without benefiting their professional development and job satisfaction. As a result, requiring these exhausted senior nurses support NGRNs for good work in nursing seems unrealistic. Alarmingly, the literature reports that mentoring has a temporal dimension in which the kind of mentoring provided is shaped by the mentor's past experience as a mentee (Deppoliti, 2008; Jakubik, 2008; Mills, Francis & Bonner, 2007; Mills, Francis & Bonner, 2008a; Mills, Francis & Bonner, 2008b). Ning's storied experience also shows this potential effect of the temporal dimension of mentoring.

7.13 Living and telling, and reliving and retelling the story of mentoring

Ning's experience preceptoring that disappeared after three days of seems to be a miseducative experience that shaped the initial story of mentoring she told in our first interview. Ning showed low motivation to help her younger generation of nurses actively at work. Alarmingly, Ning seemed to have also internalized the 'ritualized' statement, 'Ask if you don't know.'

> *[Bernice: How are you going to support the new graduates or students?]*
> Take it easy [Chinese: 慢慢黎啦]. I don't think it has to be done deliberately [Chinese: 刻意地]. If they see you are one year older than them and have a similar level of experience, I think they will take the initiative to ask questions or ask for help. (Ning, first interview)

As time passed, Ning's story of mentoring seemed to undergo some changes and retelling. She briefly shared her increased awareness of the importance of mentoring in our email conversations between interviews.

> *Seeing the new graduates [of 2011 learning to be RNs] by following their mentors leads me to reflect on the importance of mentorship. Having a good mentor is important, as the transition will be much easier. (Excerpt of the original email from Ning on 3 November 2011)*

> *If I see there is any problem facing the new graduates, I will tell them honestly or teach them if I can. Cos [because] I understand the importance of teaching from [the] others when I dunno [don't know]. (Excerpt of the original email from Ning on 30 May 2012)*

Thinking narratively along the temporal dimension, I saw that this restorying could have been shaped by her own experience of additional mentoring in the central cubicle. Ning also told me that her peers' stories of mentoring had influenced her positively. Ning had witnessed one peer, a nice NGRN also in the class of 2010, treat the nursing students very well. She also saw two other nursing colleagues effectively mentor their new graduates in 2011 and establish trusting relationship and even friendships with them. These stories of mentoring aligned with Ning's initial expectation of mentoring and the 'ideal' version of mentoring she told me about in our first interview. Ning initially looked forward to having more communication and a mutual, more holistic exchange with her assigned preceptor that was more than an exchange of skills. She even looked forward to a preceptoring relationship that could evolve into friendship. While this did not materialize, the story below fortunately seems to have an element of peer mentoring or role modeling by peers that shaped Ning to relive and retold her story of mentoring, which was demonstrated by an increased willingness to support the younger generations.

> They [two RNs who graduated in 2007] are really good. They become friends with their mentees. They are not only teaching technical things about case management and paperwork. They taught many things from a more holistic perspective in relation to the person. When they heard feedback from the others about their mentees, such as needing to show more initiative, politeness, or responsibility, they reminded their mentees as a friend. Even though their duties were not matched for a period of time, the mentee would say 'I miss you very much' to their mentors and would share their secrets with their mentors, such as feeling aggrieved after being scolded. I appreciated the goodness of that relationship. (Ning, second interview)

Influenced by peer role-modeling and her growing self-reflection, Ning 's story of mentoring was relived and retold by demonstrating more initiative, motivation, and empathy towards her young generations. In our third interview, Ning told me that

two months earlier, she had joined other nurses in supporting the new graduates of 2012 by informally beginning to act as their mentors.

> I remember that you had asked in our first interview about the impact I perceived of how the experience as a mentee could affect the future experience as a mentor. At that moment, I had not thought much about that before. Now, I realise the positive impact of a good mentoring relationship on the role transition of new graduates. The junior can share her difficulties with her mentor. Also, she can feel more comfortable about asking questions when she doesn't know something, without worrying about being scolded by her mentor. I think the junior may feel less stressed. (Ning, third interview)

7.14 The disempowering effect of excessive paperwork on good work

Paperwork was an issue of concern to Ning, which she mentioned in her first email excerpted earlier and, in fact, throughout all three interviews. The following excerpt from the interview transcript reveals that she had not anticipated the reality of clinical nursing. Although Ning agrees with the importance of documentation, she had not anticipated finding to be paperwork so excessive and sometimes duplicated. It occupied a large amount of her time that could be better spent on and with her patients.

> Surprised at the abundance of paperwork
> [*Bernice: Is what you are doing now as a nurse the same as what you expected before registration?*] I think that there must have discrepancy. Nevertheless, this [nursing] is the work I want to do. [*Bernice: What were your expectations?*] Didn't expect so much non-nursing work, such as the large amount of paperwork, much of the time has been spent on paper, rather than patient care… [*Bernice: What do you think is unnecessary?*] I think documentation is important, as they [hospital administrators] have said, for legal protection. However, much of the information has to be written repeatedly on different forms. (Ning, first interview)

Newly-qualified nurses in other countries also report that paperwork and non-nursing tasks distracted them from patient care and communication (Duchscher, 2008; Maben, Latter & Clark, 2007). The following story further provides a deeper understanding about excessive and duplicate paperwork. It shows how the issue of paperwork affected Ning's strong intentions to leave her neuroscience unit upon her upcoming clinical rotation to another unit.

Excessive paperwork and a new mobility assessment tool

That [the desire for rotation] is related to the excessive paperwork. My hospital has a lot of paperwork and my unit has even more. The HCA said they had to compile 19 forms for each newly admitted patient. I guess we have more now. A nurse from another hospital came to our unit for her practicum in her neuroscience specialty training. She thought the four forms in her unit were excessive already and was surprised to see the large number of forms to be filled out upon admission in my unit.

We have one more Red Dot [Mobility] System lately. Another form to be ticked each morning shift. It is used for assessing the mobility of each patient. [*Bernice: Each day? Even for a patient who only had a 'three' score in GCS [Glasgow Coma Scale; with no response in eye opening, verbal, and motor responses?*] You still have to assess and [indicate] 'Unable to ambulate' and put it on the signage after the assessment. [*Bernice: What do you think?]* Actually. *[Took a deep breath and gave a bitter smile*] Actually it is meaningless. [*Bernice: What is the difference from the fall risk?]* You think so! [Ning laughed] That's fall risk and this is not fall risk. (Ning, second interview)

The above story reveals the meaning of excessive paperwork, which could be five times more than that in the neuroscience unit of another hospital. Although each form had its own meanings and objectives when it was developed and adopted by administrators and senior officials of the hospital hierarchy, it turns out to have no integration with other existing forms.

By reviewing the hospital document about the Red Dot Mobility System, I learnt that the system was adopted from Australian hospitals and was initiated minimize manual handling of operation injuries. This was a good intention to enhance manual handling operation safety among health care providers. However, both Ning and I could see that the fall assessment tool and the new mobility assessment tool were so similar as to be interchangeable. We could not see the reason for the new mobility assessment tool, which took up time and effort and thus inadvertently decreased the time spent on patient care. The only difference I saw between the two tools was in their objective, since fall assessment is aimed at preventing patient falls and mobility assessment is aimed at preventing occupational injuries to health care providers. This story reveals two layers of problems in relation to the hospital story. First, different policies, guidelines, and protocols might have been initiated and implemented to solve various problems over the years. However, when adopting a problem-solving approach, the interrelationships between different problems might be overlooked and,

highly similar tools might then be designed, leading to the problem of duplication reported by frontline staff like Ning. Considering the entire situation from a more holistic perspective may reveal the possibility for retelling and reliving a new story, one that integrates, reforms or even transforms of the current health care system in terms of paperwork and documentation. The second layer of problems revealed by this story is that top-down management still prevailed and that communication between administrators and frontline staff might be ineffective, such that the frontline staff does not fully understand the meaning of each new policy, guideline, and protocol. This ineffective communication creates issues of conflicts for the frontline nurses in their own different accounts of the story.

Though Ning disagrees with the hospital story in requiring excessive paperwork, she could not escape it. Without a way to alleviate the disempowering nature of the hospital story, Ning developed strong intentions to leave and find a place where she could live a story of consistency rather than conflict. This story parallels her story of the patient's relative who complained about her in its sense of unfairness and powerlessness. It further reveals that mentoring alone without a radical change in some problematic hospital systems may not resolve the global and local nursing shortage.

In our final interview, I asked Ning whether she would like to voice concerns that she perceived had not been heard by the senior officials and administrators of the hospital hierarchy. She told the following story, which reveals that the hospital story of emphasis on paperwork shaped her practices. She had to prioritise her work within the limited time she had each shift, which in fact, competes or even conflicts with Ning's story of good work in providing patient-oriented care. Embedded within it is Ning's bitterness over her inability to the shaping of this hospital story, and being disempowered from sustaining her good work in nursing.

> 'Putting the cart before the horse' (Chinese: 本末倒置)
> Sometimes I think they focus [too much] on the statistics. To me, the number is meaningless… You know the fall risk form has no meaning to me besides ticking. I don't think the score is valid and reliable. You know for bedridden patients, they are immobile and have no fall risk, but they score very high marks [representing the patients have a very high risk of fall]. [Laughs]

> There were many times the patients scored zero in the fall assessment upon admission and had low fall risk. [Patient was allowed to self-ambulate.] However, the patients fell afterward. The fall assessment seemed unexplainable because there had been a fall incident. Then someone [seniors] would ask the nurse who conducted the fall assessment before the fall incident to change the fall risk score from low back to high [to make the fall incident seems explainable by the fall risk score]. This seems to be meaningless.
>
> Pressure sores also. They are concerned with the number of sores, the statistics, and taking photos of the wounds regularly. However, they wouldn't think about how we can treat the patient. [*Bernice: And continue to wash the wound merely with normal saline.*] Yes. I think this is like 'putting the cart before the horse'. [*Bernice: Do these incidents have a great impact on you?*] Yes. I was conflicted. I was scared to be scolded. Yet I was scared that the patient's condition would deteriorate. I had to ask for the opinions of my colleagues, those who are trustworthy. Then I had to further consider what I was going to do. (Ning, third interview)

7.15 Reliving and retelling the story of difficult relatives and patients

In addition to paperwork, difficult relatives were another issue of concern to Ning, which she also mentioned in her first email, excerpted earlier. Besides the relative's complaint case, the nurses in Ning's neuroscience unit often had conflicts with the patients and/or their relatives about discharge plans. Patients and/or relatives often refused to be transferred to the rehabilitation hospital, where they could have better and more intensive physiotherapy, occupational therapy, and speech therapy. Through her communication with these patients and relatives, Ning found that they generally perceived the care and resources of the acute hospital to be better than those of the rehabilitation hospitals. However, Ning found that they had an ingrained misconception about rehabilitation hospitals. Based on her past experience as a TUNS at a rehabilitation hospital, she perceived it to be a more appropriate place for long term rehabilitation when compared to an acute hospital. Despite all the explanations from different health care professionals, Ning and her fellow nurses had a difficult time and felt powerless to alter the ingrained subjective misconception about rehabilitation hospitals and resolve the conflicts. In our third interview, Ning shared the minor changes she made in her attempts to relieve the tension. Her increased awareness of the discharge problem motivated her to have better communication with patients and their relatives. She gave them earlier notice of the plan to transfer the patient to another hospital for further rehabilitation after the acute

stage (Ning, third interview). Further research might be necessary to better understand and address the issue of the general public's ingrained perception about rehabilitation hospitals.

Arranging meetings between patients, relatives, and doctors put Ning and her colleagues in a state of great tension. Because visiting hours are scheduled at a different time than the doctor's rounds, relatives rarely have the opportunity to meet the doctor responsible for the patients. Therefore, Ning and other nursing colleagues act as the bridge between patients, relatives, and doctors for meeting arrangements. However, it was not uncommon for some doctors to ignore the relatives' requests and the nurses' reports. Although Ning tried to explain the conditions of the patients and answer the relatives' questions, relatives were rarely satisfied unless they met the responsible doctor. Ning thought that the time spent resolving the tension created by some unresponsive and irresponsible doctors could be better spent taking care of other patients who were in need. This was even a challenge for her ward manager, who initiated the use of a book to record relatives' requests to meet with doctors, the date of the request, and the date of the actual meeting. However, it did not successfully resolve the tension between staff, patients, and relatives because the doctors decided whether a meeting was 'necessary' and what time it would occur.

The tension between patients, relatives, doctors, and nurses about arranging meetings reveals ineffective collaboration between the four parties in a situation dominated and controlled by the doctors. This was once again shaped by the hospital story of ambiguous guidelines and monitoring of the communication between patients, relatives, and doctors to protect patient's right to information. The unclear and ambiguous guidelines created space for doctors to escape from their duties and responsibilities under the power differential of the hospital hierarchy system. On the one hand, hospital administrators and managers of the medical and nursing fields might have to rethink the true meaning of interprofessional collaboration for the mutual benefit of each profession, as well as for patients and relatives. On the other hand, communication, emotional intelligence, and assertiveness might be the potential components to be included in the hospital supportive programme so as to better prepare NGRNs to manage interprofessional and interpersonal conflicts and tensions (Pfaff, Baxter, Jack & Ploeg, 2014a; 2014b).

Though Ning and her nursing colleagues seemed to be quite powerless to handle some conflicts with patients and relatives, I am glad to share from our third interview some restorying from Ning about difficult patients. Ning had shared her experience establishing close and therapeutic relationships with two difficult patients'. One patient kept pressing the call bell all day and had multiple requests each time. Another patient had a very bad temper. Over the course of about one year of their hospitalization, Ning could see changes in their relationship, despite all the tensions and conflicts. The patients gradually came to realise and appreciate the care of the health care professionals, and the health care professionals also gained a better understanding of the habits and preferences of these two 'difficult' patients. Ironically, the experience took on both spicy and sweet flavours as Ning perceived it was easier to establish a trusting relationship with her patients than with her colleagues. 'It's funny', she said. 'There were times I vented my anger with them after some conflicts with my colleagues. They comforted and kissed me.' (Ning, third interview)

7.16 Leaving in the midst and pending an opportunity for reliving

Though there were some educative experiences, the miseducative and conflict-generating experiences she had in her first two years of practice after registration fueled Ning's growing intention to leave her current neuroscience unit. She realised how the unit narrowed her own vision and that of her colleagues. She looked forward to broadening her horizons and exercising her clinical judgment and autonomy with her next clinical rotation.

I am glad that Ning's trust in her relationship with me. Reflecting on my relationship with Ning, I was glad that the trust we established provided her with a safe space to tell her many important secret stories with the hope of making a difference in some aspect of the complex health care landscape for better mentoring NGRNs in transition, as well as for sustaining their good work in nursing. Also, I am very grateful to have witnessed her transition from a new graduate to a professional nurse, and to celebrate her joy as she transitioned to another stage of life at her wedding.

CHAPTER EIGHT

AGNES' STORY - AN NGRN IN THE N/PICU

8.1 Introduction

This chapter is about Agnes, my sixth NGRN participant, whom I met in the first round of interviews. Agnes' experience shared some similarities with mine, not only because she was also assigned to a highly specialised unit immediately after professional registration - the neonatal and paediatric intensive care unit (N/PICU) - but also because we shared the same interest in working in the accident and emergency department (AED). I still remember that Agnes' story was the first comprehensive interim text that I wrote after I finished interviewing all the NGRN participants and making verbatim transcriptions. I chose to write about Agnes first because she was articulate and several of her stories were important to uncovering assumptions that are often taken for granted. However, her articulateness led to another problem: a lengthy interim text of almost 100 pages. As I read and re-read the written interim text, struggled to find a better way of representing and reconstructing her stories without losing sight of the key narrative threads. Agnes saw her experience in the first two years of clinical practice as having three important aspects: physical, psychological, and social. I kept thinking about how the meanings and significance of the three aspects of her experience might relate to the three dimensions of the narrative inquiry space, in furtherance of my research. Eventually I decided to present her stories within the temporal dimension, to convey the complexity of her mentoring experience to be a competent nurse. Agnes had to learn to sustain good work in nursing in a context of many other competing and even conflicting stories (Clandinin et al., 2006).

8.2 Becoming an NGRN in the N/PICU because of TUNS experience

Agnes had been working as a part-time temporary undergraduate nursing student (TUNS) in the general paediatric unit of her current hospital since her third year of her baccalaureate nursing study. This is where our inquiry begins. Agnes was

referred to me by my friend, a senior RN in the paediatric department, who had been observing Agnes' performance since she was a TUNS. Because of the high attrition rate at the paediatric department, Agnes expected to be asked to stay in the department after registration. However, she would have preferred not to work in paediatrics or N/PICU, because they had very different natures which might pose a challenge to her ability to adapt to another specialty in the course of clinical rotation. In contrast to the other three NGRNs at the N/PICU, Agnes did not make any request to work in a highly specialised unit, and never expected to become an N/PICU nurse herself.

> I have been working as a TUNS in the paediatrics for more than a year, but I want to work at the other specialties to gain different experience. I was concerned that I couldn't adapt to the adult general unit upon my next rotation. Working at the NICU [for about one year] in taking care of only 2 to 3 cases is embarrassing, because those at the medical [unit] might take care of 16 [patients]. I don't think I have the ability to do that [now]. (Agnes, first interview)

Like the stories told by my ward and departmental managers (see Chapter 6), TUNS was used as a recruitment tool to identify potential employees, and therefore shaped the initial workplace of NGRNs. The same practice was reported in the literature; ward managers (WMs) evaluated nursing students' performance in the final clinical practicums (Chernomas, Care, McKenzie, Guse & Currie, 2010) or externship programmes (Dempsey & McKissick, 2006; Lott, Willis & Lyttle, 2011; Rhoads, Sensenig, Ruth-Sahd & Thompson, 2003) as part of their recruitment strategy. However, the NGRNs own interests, professional development plans, and concerns were often overlooked or even ignored, and recruitment seemed to convey an uncaring message instead of a caring and supportive one.

8.3 Walking into the unfamiliar environment – N/PICU

As I had no previous experience working in or even visiting the N/PICUs of any hospitals prior to my initial contact with Agnes, I invited Agnes to describe her unit and working environment, and asked many questions. By describing the unit to me, she walked me through the N/PICU and helped me gain a better understanding of her situation. The initial description helped me imagine her initial experience walking

into such a new and unfamiliar environment. The NICU was crowded, to the extent that the doors of the incubators could not be fully opened. The overcrowding naturally raised concerns in me about patient safety and Agnes' feelings about working in such an environment.

> My ward consists of the neonatal and paediatric intensive care unit, separated by the nursing station. The majority of the NICU patients are pre-term infants or infants in the first month. They may need ventilator supports for their respiratory problems. Some may have cardiac problems. Others may have gastrointestinal problems requiring antibiotic treatment or TPN [total parenteral nutrition]. Neonates termed for a month will be transferred to the PICU. There are no specific bed statistics. We claim to have eight NICU beds, three special care beds, and three PICU beds; however, we have to receive every case transfer from the obstetric unit of our own hospital. We can only refuse transfer-in cases from private hospitals when we are full.
>
> The situation is further complicated by the influx of mainland parents who give birth in Hong Kong (HK) for citizenship. It is not uncommon for these mainland parents to use in-vitro fertilization, which results in twins or even triplets, and the mothers often give birth to pre-mature infants who require NICU support. Our NICU, therefore, is always a 'full house'. When we have more than ten NICU cases, we have to squeeze in extra incubators for the new admissions, even using the place where the emergency trolley was located originally! However, there is no wall oxygen supply or suction system, and so we require portable ones.
>
> Therefore, the environment is very crowded. The doors of the incubators cannot be fully opened because they are blocked by other equipment, such as ventilators. When I try to take a baby out of the incubator, I have to slide her out through the half opened door. Sometimes you may kick something or bump against the computer. At other times you may find no electrical socket available for the equipment! Very often you feel very disturbed and inefficient at work.
>
> The occupancy of the PICU often exceeds 100% because we have three long-term dependent cases. Yet, the situation of the PICU may actually be better and less crowded [when compared with the NICU], since we can discharge more stable patients to the paediatric unit [while pre-term neonates are unlikely to be transferred out]. (Composite of Agnes' first, second and third interviews)

The story above captures the unique health care landscape in Hong Kong, with its influx of mainland pregnant women who may or may not have made arrangements to give birth in HK. There are two main reasons for this influx. First, any Chinese citizen born in HK is entitled to the right of abode irrespective of the residential

status of his/her parents, in accordance with Article 24 of HK Basic Law as ruled in the Chong Fung-yuen case by the Court of Final Appeal on 20 July 2001. As a HK citizen, a child is entitled to medical, educational, and social benefits, even if his/her parents have not contributed to HK through taxes or other means (Cheng, 2007; HK Information Service Department, 2013c). Second, under the mainland's 'One-Child Policy', couples who have more than one child are penalized and the second child is not entitled to all the social benefits of mainland China (Cheng, 2007). This drives many of these couples to deliver in HK, which is geographically close, has high standards of health care, and will grant the child all the benefits of a HK citizen. The influx in recent years caused the local obstetrics, neonatal, and paediatric care services, which had been downsizing prior to the influx, to experience severe staff and resource imbalances (HK Information Service Department, 2013c; Legislative Council Secretariat, 2012). Meanwhile, the health care landscape continues to suffer high attrition in nursing staff. Seasoned nurses in particular decided to leave, and their vacancies were filled by junior nurses or even new graduates. However, Agnes' story shows that it was still impossible for specialty units like the N/PICU to maintain optimal one-to-one intensive care. A nurse may be required at any time to take up three critically ill neonates. The increased patient workload is a likely contributor to the stress levels and burnout experienced by nurses, particularly inexperienced new graduates (Aiken, Clarke & Sloane, 2002; Cavaliere, Daly, Dowling & Montgomery, 2010; Rudman & Gustavsson, 2011). Agnes herself felt rather disturbed and disappointed by the uncaring and irresponsible mainland parents, who left their sick children in her unit 'like orphans' after delivery. Many of them could not be contacted once they returned to the mainland, which adversely affected medical decisions and nursing care for their children.

Furthermore, the landscape continues to evolve, and this inquiry captured the uncertainty of the NGRNs' experience. Between 2006 to 2012, demonstrations were organised by the general public protesting the influx (So, 2012, January 16). An ongoing intense debate had drawn growing public attention, especially when it escalated alongside other HK-mainland conflicts. It was not until 2013 that the public hospitals suspended all bookings made for obstetric services by non-local pregnant women. Private hospitals also unanimously agreed to stop accepting bookings from

pregnant mainland women whose husbands were not HK permanent residents (HK Information Service Department, 2012).

This narrative inquiry recognises and acknowledges the effects of the shifting landscape on NGRNs' experiences. This background information will be important for understanding the Agnes' story, and those told by other NGRN participants (see Chapters 10 and 11).

8.4 Learning from the assigned preceptor with three other NGRNs

The growing shortage of nurses and the increased demand for neonatal and paediatric services contributed to Agnes' preceptoring experience. In the past, her unit had provided previous new graduates with three months of orientation or supernumerary status, allowing them to learn and familiarize themselves with the highly specialised unit, without dealing with their own patient assignment. However, when Agnes arrived, this orientation period was shortened to one month and the assigned preceptor had to teach three other NGRNs besides Agnes, while also taking her own patient assignment. She and the other NGRNs spent their first three weeks at the NICU and the final week at the PICU.

Agnes called her assigned preceptor a 'mentor' and I have preserved this usage when quoting her. However, it is important to reiterate that when I am writing my interpretive account, I use the term 'preceptor' when the relationship is prescriptive and functional, which had an organizational dimension and functioned within a structured framework, but use the term 'mentor' when Agnes was guided, taught, and influenced in informal ways (Angelini, 1995; Darling, 1985a). As mentioned earlier in Chapter 1, a preceptor can evolve into a mentor if the relationship continues to grow and develops the psychosocial component absent in a preceptoring relationship.

> At the beginning, I was very scared in the NICU. I found every face unfamiliar. It was better that we did get to work with our mentor in the first month, although the teaching was very basic. My mentor is an APN [Advanced practice nurse]. The first four days, she gave us lectures in the seminar room about common neonatal and paediatric diseases. I could hardly remember and grasp all the theoretical knowledge, particularly about managing ventilators, without practical experience. On the fifth day, our mentor trained us all together at bedside in taking care of one neonate. This

> was the first time I ever bathed such a small neonate with all those 'lines' connected to her body. Her legs were moving continuously. Although our mentor supervised us, I still felt a bit scared at the beginning. We eventually learnt to take care of a baby who was intubated and connected to the ventilators. After a while, two of us were assigned to take care of one neonate under the supervision of our mentor. The four of us always worked in groups of two or four; therefore, we didn't have much of a chance to manage a case independently. We didn't encounter any emergency or special case during the first month when we worked with our mentor. (Agnes, first interview)

8.5 Struggling to take care of neonates independently

Agnes and her peers were told that they would work independently after the first month of preceptoring. As Agnes expected, she got her first patient assignment beginning in the second month. She also rarely, if ever, worked with her preceptor on the same shift. However, she did not expect that she would discover so many things that she did not know, which had not been covered during her one-month preceptoring. The interview excerpt below shows Agnes' unpreparedness to take care of her neonate patients independently and her frequent requests for assistance, as well as her intense emotions about her lack of competence.

> After the first month [of preceptoring], I felt very scared about working independently. I found so many things that I didn't know and I discovered how incompetent I was. I asked about everything, even simple things. I didn't know how to carry out simple treatments [referring to preferred practices], make documentation, or search for information in the computer system. I found myself very useless! I felt bad and ashamed to call for help from the others all the time when I was earning a salary. (Agnes, first interview)

Although other colleagues understood that Agnes was new to the N/PICU and did not have high expectations of her, welcomed questions, and encouraged her to ask, Agnes expressed a strong sense that she was burdening others by asking too much. This echoed the 'fear of burdening' reported by new graduates in Canada, although different stakeholders, including senior nurses, believed that new graduates would have faster and more satisfying transitions if they felt comfortable asking for help (Romyn et al., 2009).

The reasons behind frequently needing assistance from others and struggling to gain necessary operational knowledge after one month of preceptoring are two-fold. First, necessary information cannot be retrieved easily at work in the workplace. It may

even be unwritten. While she was taking care of her neonates in the fast-paced and busy health care landscape, Agnes had limited time and space to find answers on her own for her many questions. Thus, she had to ask her senior colleagues during work hours. Though she taught herself after work by revisiting and studying any unfamiliar cases or abbreviations that she encountered in her clinical practice, this kind of self-mentoring seemed inadequate. Nursing literature reports that new nurses face similar difficulties in getting simple procedures done, since necessary information was often unwritten and was, instead, stored in people's minds (Parker, Giles, Lantry & McMillan, 2014).

The second main reason Agnes sought assistance from others was related to the inadequate one month of preceptoring, in which important details of practice were taken for granted by both preceptors and NGRNs. The story below is an example. Important differences in prescriptions were usually updated between the junior and senior doctor rounds, but her preceptor neglected to mention this and Agnes discovered it experientially only because of her vigilant attention to the changes. It was possible that Agnes' preceptor had guided the four NGRNs through following different doctors' prescriptions, but thinking that they were unlikely to change.

> I didn't know about some usual practices. After the doctor prescribed the treatments, I carried them out immediately. I was astonished that the prescriptions were later changed by another doctor. It was not until I asked again that I learnt that the treatments are subject to change and I **should wait after the senior doctor round** before carrying them out. (Agnes, first interview, emphasis added)

Agnes seemed to engage in a self-mentoring process to discover her knowledge deficits and mentoring needs when her personal practical knowledge (Connelly & Clandinin, 1988) was insufficient to solve the problem in the present situation and the answer could not be gained by comparing her practice and performance with others'. It was this awareness of knowledge deficits that motivated Agnes to take the initiative and seek further clarification and mentoring needs from other nurses. I call this kind of unplanned mentoring, which takes place by chance and depends on the mentee's experience and awareness of mentoring opportunities, as opportunistic mentoring. Opportunistic mentoring has two main antecedents. NGRNs become aware of their own knowledge deficits and mentoring needs through self-mentoring,

or by discovering mistakes or listening to the stories of other NGRNs. If opportunistic mentoring triggers a systematic and comprehensive teaching-learning process, the knowledge and certainty gained in that context can guide NGRNs in their present and future situations.

Nevertheless, opportunistic mentoring is not without its own pitfalls, as revealed in the following story. In an unfamiliar environment with unfamiliar people, Agnes had to identify the right person to ask to get the right answer that would both help her address the present situation and guide her practice in the future. However, the right answer in context might not be easily obtained through opportunistic mentoring. Some seniors advised Agnes to use the trial and error method - which encourages delays in the process of reporting abnormalities and jeopardizes patient safety.

> I didn't know who should I call when reporting abnormalities, whether the case MO [medical officer] or the on-call MO. How could I know whether the case MO was off-duty or at the out-patient clinic? I asked my nursing colleagues again. Some colleagues asked me to check with the doctor duty list but no information was indicated! Then I was told that they seldom checked with the list but simply called the case MO directly. If there was no reply, they will call the on-call MO. I felt very confused. (Agnes, first interview)

8.6 Conforming to the seniors while straddling their different 'usual' practices

Self-mentoring and opportunistic mentoring were the strategies Agnes used to learn about the '*usual practices*' in her unit, to socialise herself, and to gain a sense of certainty and security about managing future similar situations. However, the following story was the first story recounted at the beginning of our interview that revealed that these '*usual practices*' were unwritten or hidden. Indeed, different nurses seemed to have different '*usual practices*', a reality that may ultimately lead to similar outcomes and still not do any harm to the patients. However, as the NGRN occupying the lower echelon of the hospital hierarchy, Agnes was expected by some senior nurses to follow their own '*usual practices*'. This created great tension, uncertainty, and confusion for Agnes.

That's our '*usual practice*' - weaning off CPAP to nasal cannula

The experience that made the greatest impression on me was being criticised by a nursing officer, Miss A. The baby could be weaned off of CPAP [continuous positive airway pressure ventilation therapy] to nasal cannula. However, I didn't know their *usual practice* in adjusting the litre flow and air mix. As the CPAP prong was always dislocated by the baby without deterioration of the SaO_2 [Arterial Oxygen Concentration], I thought the baby could tolerate low oxygen level well. Also, I hesitated to give 100% oxygen, since I was told by my senior colleagues that this would affect the baby's eye development and other organs. I had given 0.5L/min and 0.2 FiO_2 [fractional concentration of inspired oxygen – Low Flow]. I monitored the baby, who showed no desaturation. During the handover to the incoming APN of the afternoon shift, she felt uncomfortable about the setting and wondered aloud whether it was prescribed by the doctor. I said 'No, I adjusted that and I find he tolerates it well.' The APN said 'Oh! That's not our *usual practice*. We usually start from the ratio of one-to-one'. One-to-one!? I didn't even know what that was! Then, I was told that one-to-one means 1L/min and 100% oxygen [High Flow]. I asked why. And this APN just replied '*that's our usual practice*!' [Chinese: 不嬲都係咁做] without any further explanation. She was concerned that we would be scolded by the senior doctor the next day. I responded by adjusting the setting back to one-to-one immediately. Then Miss A called through the intercom asking me to change the documentation on the computer from 0.2 and 0.5L/min flow to one-to-one. I hesitated as that was not what I had already done. Then Miss A came into my cubicle and started scolding me, **'**This is written on the nursing protocol! Don't tell me that you don't know! If you don't know, ask the senior instead of adjusting yourself!**'** Every one was there while she was shouting at me.

I felt quite unhappy and confused and I didn't know what to do the next time. I tried to review the nursing protocol but I couldn't find any guideline [suggesting a one-to-one ratio]. I consulted another APN, who said that there was a guideline, but we failed to retrieve any when searching on the computer system together. Then she told me that some nurses self-adjust according to the case's condition, while other nurses insist that the setting should begin with one-to-one ratio. She asked me to ask the doctor each time and not take the scolding of Miss A too seriously. I asked some other nurses as well but no one could give me an explanation for the one-to-one ratio. They simply replied '*That's our usual practice***!'** I wonder why we have to follow the '*usual practice'* and why it was unacceptable to adjust case-by-case based on our assessment and judgment. Also, the outcome has no difference from the expected one as the baby is still alive [without desaturation]! If I didn't follow the '*usual practice'*, I was considered as doing wrong. However, I really think that I didn't make any mistakes. (Agnes, first interview)

The above story is rather complex, with at least four layers. First, and once again, it shows the potential problem in relying on self-mentoring and opportunistic mentoring to ensure patient safety after an initially short and inadequate preceptoring period. Agnes had not been taught the usual practice when a neonate under CPAP

support changes to using nasal cannula for oxygen supply. Agnes did not realise her knowledge gap at that time and thus did not engage in opportunistic mentoring. Her lack of awareness was probably due to the presence of her practical knowledge, gained from observing the condition of the neonate who removed the CPAP prong from her face without incurring desaturation.

The second layer was related to the three different practices for managing the same doctor's prescription in the NICU (the 'one-to-one' ratio, asking the doctor each time, and making adjustments based on the patient's condition, the SaO_2 level, and the nurse's judgment). Agnes wondered why nurses could not exercise their critical thinking and nursing judgment to provide care according to the needs of individual patients, instead of following the '*usual practice*'. It raises the question of whether the advice to 'ask the doctor each time' robs nurses of their autonomy. The responses from Agnes' senior nurses - '*that's our usual practice* - leads me to ask different questions. What is '*usual practice*'? To whom does the '*usual practice*' refer? How can NGRNs like Agnes know the different '*usual practices*' without being told? Can they realistically meet the expectations of different seniors with different practices or is it unreasonable to expect them to remember different nurses' preferences and to use their specific '*usual practice*' when working with or handing over to them? How can the NGRNs satisfy some senior colleagues without disappointing others when such a dualistic paradigm exists? This recalls my past experience of not knowing there were different 'usual practices', such as when my assigned preceptor threw a suture set at me (see Chapter 1). The expectation to conform to the different 'usual practice' of seniors created another layer of stress and confusion for Agnes and me when we were in transition. This kind of situation is widespread, as demonstrated by a study done with some Swedish new graduates, who also experienced difficulty learning the unwritten 'prevalent values' and 'prevalent system of rules' without assistance from the senior nurses (Bisholt, 2012). New graduates also reported a sense of confusion resulting from the contradictory recommendations provided by their senior colleagues, and struggled to choose between those conflicting viewpoints when making urgent clinical decisions (Dyess & Sherman, 2009). The '*usual practice*' of Miss A had a particularly strong effect on Agnes in discouraging her from sustaining her stories of good work and critical thinking that she had cultivated at the university. Should we accept multiple possibilities and different ways of

practices so long as the underlying principles are not violated and patient safety is not jeopardized, which is what is taught at the university? What kind of 'mentoring' are we creating?

Third, Miss A and some other senior nurses expected Agnes to conform to their '*usual practice*'. However, it was interesting that an open and respectful discussion of the rationale behind their practice was not encouraged. Rather, Miss A scolded Agnes to ensure she conformed to her '*usual practice*'. Agnes was hesitant about following the 'usual practices' without a rationale, but she was under pressure to conform to the hierarchy and the ward culture. Although the use of control and criticism is effective for correcting mistakes and guiding new graduates to follow experienced nurses, it is less effective for acquisition of knowledge which can be transferred to other situations (Bisholt, 2012).

The fourth layer came to light when I conducted a document analysis on the use of oxygen therapy for neonates in Agnes' paediatric department. The only guideline I could retrieve from the hospital's intranet was one that was last updated in August 2004. Just like the search results that Agnes and the APN found, the one-to-one ratio cannot be identified. The guideline merely provides a suggestion for the ratio when initiating an oxygen therapy via nasal cannula, but not when changing from the CPAP to nasal cannula. It is important to highlight two points stated on the guideline that seem relevant to Agnes' situation:

> After the initial stabilization, the choice of oxygen delivery system and the target SaO_2 range should be adjusted according to various situations; FiO_2 should be adjusted by nurse to achieve the target SaO_2 range.

Ironically, the guideline that I retrieved contradicts what Miss A told Agnes, and in fact supports Agnes' preferred approach. It acknowledges the nurses' practical knowledge and judgment of nurses, and gives them autonomy to adjust. After further clarifying with Agnes, I was told that the guideline was suggested by an associate consultant who had already left the department. It had never been changed or updated. Agnes also felt unfairly criticised for doing wrong when no 'revised' nursing protocol that affirmed Miss A and others' views could be retrieved. This reinforces the importance of reviewing protocols and guidelines regularly and

publicizing their rationales to the frontline nurses, especially because nursing takes place in a context where standardization are employed to minimize human errors and ensure patient safety (Fawcett & Rhynas, 2014; Francis, 2013). Guidelines are important to novice and advanced beginning NGRNs who depend on rules and protocols to guide their practices and decision making (Benner, 1984). As a cautionary note, these protocols and standards should not be overemphasized in their physical and systematic aspects, but should be structured to ensure the uniqueness of each individual through patient-centred care (Francis, 2013).

It was alarming to note that Agnes' future practices were shaped by the powerful sacred story told by Miss A. Unless the doctor specified details in the prescription or clarification could be sought immediately during the doctor round, Agnes felt compelled to conform to and succumbed to the '*usual practice*' in giving the one-to-one ratio. Nevertheless, Agnes weaned her patient off the oxygen at a faster pace, adjusting to the neonates' SaO_2 level throughout her shift, due to her concerns about the complications of oxygen therapy, especially when the one-to-one ratio is high flow. One of her statements, '*I could think critically but I couldn't exercise it in reality*', best captures her agony trying to sustain good principles in the midst of the many similar miseducative experiences.

Furthermore, as Agnes' preference to have autonomy balanced against her need to obtain the right answer and certainty at the beginning of her independent practice, her growth and professional development increased. She seemed to have developed increased personal practical knowledge and confidence in her own judgments in some situations where she yearned for more trust and autonomy as a professional nurse.

8.7 Restorying to sustain her stories to live by

As time passed, Agnes' stories reflected some changes in her demeanor towards her colleagues' unfair criticism. As she continued to discuss her situation with her peers and senior colleagues, Agnes learnt that her practices and rationales were supported by some colleagues. These discussions, together with her self-reflection, were important for Agnes in reliving and retelling a different story. Agnes developed the

assertiveness to defend herself by directly stating her rationales when she was criticised, instead of merely conforming to the seniors' instructions. Agnes was peer-mentored by the other three NGRNs, not merely in terms of peer-support, but also peer-teaching, peer-sharing, and peer-discussion about the proper ways for Agnes to be assertive and give her own rationales. Her discussions with other senior colleagues can be seen as opportunistic mentoring that was educative to her future practice. Therefore, all the peer-mentoring, opportunistic mentoring, and self-mentoring collectively might have contributed considerably to Agnes' ability to sustain her stories to live by and stories of good work in a context with other competing and even conflicting stories.

> Story of the use of duoderm under the CPAP prong
>
> Duoderm patches [a hydrocolloid dressing material] are used under the CPAP prong to prevent the development of pressure sores. I was taught this by my mentor and at the university. However, some colleagues claimed that it is meaningless to use it and that the duoderm causes air leakage that triggers the ventilator alarm. They dislike this practice and criticised me for wrongly applying the duoderm during handover. I was scared at the beginning and replied 'Ok, I won't apply in the future.' However, I felt unhappy with the criticism, as I had been taught to do it this way and I had done nothing wrong. They have their own rationale for not applying it, but shouldn't criticise my practice as wrong [without evidence to support them]. They can remove the duoderm by themselves. With ongoing exchanges with other colleagues, I learnt that everyone has different ways of doing things. I realised that my way of doing things was also supported by some others. Now if someone criticises me, I reply 'There is no leakage [alarm].' I leave the duoderm there. (Agnes, first interview)

8.8 Craving opportunities to learn about managing emergency and uncertainty

In addition to her story about learning the diverse '*usual practices*', Agnes's first interview was dominated by her frustration with and uncertainty about handling emergencies and having only limited learning opportunities during her one year of work experience as an NGRN. Agnes recounted three experiences of increasing complexity to illustrate the different layers of stories related to how she learnt to take care of intubated neonates. Although Agnes attended a half-day simulation workshop offered by the Hospital Authority (HA) for all NGRNs, the scenarios used were all adult cases. Agnes found that what she learnt was not directly transferable or closely

relevant to her practice at the N/PICU. Agnes also attended the two-day Paediatric Advanced Life Support (PALS) Course. Unfortunately, the knowledge gained from these two courses was not adequate to give her the confidence and certainty to deal with the unpredictability of real-life situations in the N/PICU, where patients were critically ill and subject to sudden deteriorations. Agnes was aware of her incompetence and inexperience in to handle emergency situations and knew she was in need of experiential learning. The following two stories show how Agnes seems to have self-mentored promptly by comparing her present and past experiences, realising her knowledge deficits and seeking help from others. While self-mentoring could be accomplished via observation, as in the first story, Agnes identified its relative ineffectiveness when compared with opportunistic mentoring. In the second story, the situation was so critical that there was no room for further self-exploration. The importance of opportunistic mentoring is shown in the way others taught Agnes and shared their clinical wisdom, contributing to Agnes' personal practical knowledge. These educative experiences gave Agnes more certainty and confidence to manage future situations and embrace uncertainty.

> <u>Re-stripping the ETT!? 'Oh my god!'</u>
> The first time I heard about re-stripping the ETT [endotracheal tube], 'Oh my god!' I exclaimed. I didn't know how to do it while the others seem to be ready with their positions. I took the initiative to ask and a nice colleague taught me, 'When we need to re-strip the ETT, we get ready with the emergency trolley and suctioning system. We prepare this and that'. After her teaching, I knew what I was going to do next time. However, if nobody tells me what to do next, I can only watch and learn on the side by myself while doing other things. I may not grasp the complete picture and may not be able to pick up next time when I encounter a similar situation. It's much better to be taught. My colleagues are nice in welcoming questions and encouraging me to take initiative and ask. They remind me that '*Nobody will take pity on you when you make mistakes*'. (Agnes, first interview)

> <u>Kept bagging the baby but she was still desaturating</u>
> I had been giving all kinds of stimulation but the baby desaturated and remained unconscious. The heart rate remained at about 40 beats per minute. I felt very scared and didn't know what was happening. I kept bagging the baby while seeking help from the others. Eventually a senior colleague thought the ETT [endotracheal tube] may not be in-situ but at the stomach. I extubated the patient immediately and ventilated him through the resuscitators and the problem was solved. I think this requires experience. I have studied this before. However, at that particular moment in practice, I couldn't associate the problem with what I had studied. Seniors would remind me about this-and-that to solve the problem. Without the advice of the seniors,

> I might have continued bagging the patient, doing something that was fruitless. (Agnes, first interview)

Despite the personal practical knowledge gained in the above experience, Agnes continued to experience a great deal of uncertainty about managing emergency situations. She learnt experientially to manage some emergency conditions that could be handled individually, but she needed further mentoring to manage complex emergency situations that required collaboration with other members of the health care team. Nevertheless, the following story reveals the problem of mentoring NGRNs to manage uncertainty and emergency situations, since they might not be given an opportunity to learn experientially. Patients are the priority in such situations. Ironically, Agnes was aware of others' views of her and perceived their expectations to be determined mainly by her years of clinical experience rather than her actual experience managing emergencies.

> <u>Struggling to position herself in collaborating with others during emergency</u>
> When an intubated infant in poor condition was newly admitted, the senior colleagues were cooperative with each other, or they had already taken their positions and knew what to do. For me, I really wanted to help. However, I didn't know what to do since they had already taken all the positions [such as taking the vital signs, documenting the data on the computer system, preparing and administering medication]. Meanwhile, I seldom took up the position of drug calculations, as I worried that I might mess up when things are so urgent. I tried to help in taking vital signs. There were times I was assigned to take care of other more stable patients. I felt like an observer and felt useless. Some nurses or senior doctor might think that I was not helpful and some might scold.
>
> I think there is a problem with this approach. The senior colleagues always take up all the positions during emergencies and the junior staff never gain hands-on experience. When others finally give me the chance to handle emergencies after one year [post-registration], I will not be competent [Chinese: 就唔上手]! I am worried about the criticism 'You have been working for one year. You can't manage this kind of case?' They [seniors] were not aware that I was not trained and the conditions of the neonates were often so poor and urgent that they wouldn't allow me to work slowly… You [Bernice] were probably in a similar situation at the AED in managing something urgent and critical. What is your experience when nobody tells you what to do while you are expected to help? Could you take a position to help? [*Bernice: Yes, such as Trauma! My senior colleagues had taken up all positions automatically and I wondered what I could do, especially when I was responsible for resuscitations in [those shifts]. I attempted to provide some assistant while showing my perplexity. Then I heard, 'help me…'*] Yes, I always tell my colleagues directly, 'Please let me know how I can help.' I

> think this seems to give others a better impression instead of conveying the sense that I am unwilling to help. (Agnes, first interview)

Thinking merely in the personal dimension, Agnes could be criticised or even blamed for paying inadequate effort to prepare herself for emergency and unexpected situations. This seems to be aligned with the criticism of NGRNs by senior nurses in the focus group interviews and literature (Chernomas, Care, McKenzie, Guse & Currie, 2010). Nevertheless, thinking in the personal-social interaction dimension of the narrative inquiry space might open up to new possibility to better address 'mentoring' in the support of NGRNs learning in transition and their sustenance of good work. Connecting the story above with the earlier reminder from Agnes' seniors that '*nobody will take pity on you when you make mistakes*' led me to question whether adequate support or mentoring had been provided to NGRNs before they made mistakes and were blamed for their knowledge deficit. Bisholt (2012) also identified the problem, noting that new graduates were supervised when performing routine and individual tasks, but received limited supervision during unpredictable and urgent patient situations. They were expected to manage such situations autonomously, though this expectation was unrealistic. Patient safety was surely the priority in such critical situations. Nevertheless, an important mentoring gap was evident, especially when NGRNs were gradually assigned more advanced leadership roles in which future patient safety is also of concern.

Agnes' experience highlights the importance of addressing the NGRNs' mentoring needs by debriefing or opportunistic mentoring after emergency situations, even though NGRNs cannot participate in some critical situations, but merely act as distant observers. Such debriefings and discussions provide a valuable mentoring opportunity for NGRNs to learn reflectively and experientially, ask questions, and contextualize their knowledge for present use as well as imagined future experiences. This method might give both NGRNs and their seniors more confidence about allowing NGRNs to have increased participation in further experiential learning. It may also complement the learning from simulated-based patient safety courses, enhancing skill training and team dynamics in highly specialised areas such as the intensive care unit (HA, 2014c).

8.9 Gaining competence, confidence, certainty and appreciation

Except for managing emergency situations, I was glad to share similar experiences of growth with Agnes in terms of increased knowledge, competence and confidence, and improved sleep quality. It is important to note that Agnes experienced insomnia in the first two months. This psychosomatic symptom is evidence of the stress that she was experiencing. Most likely, the stress related to her transition to working in a new and unfamiliar environment with a new role and different uncertainties, as well as her struggle to work independently while incorporating the different '*usual practices*'. Her stress might also be related to the high expectations she had for herself, as well as her strong sense of not wanting to burden her colleagues. She used to feel scared about handover and relied on her piece of draft paper, which records everything the preceding colleague said during end-of-shift handover. In later interviews, after working for about nine months, I was glad to learn that Agnes had stopped relying on the draft paper, since she was familiar with her one to two assigned patients. She could hand over confidently and simply refer to the information on the computer system.

After the first interview, I returned to my full-time study and part-time work life, while Agnes also began her busy work-study life, as she had enroled in a part-time master's programme. Agnes and I maintained contact via email between interviews. One day I was very pleased to receive an email from Agnes telling me how her efforts were being appreciated by her senior colleagues and that she was gaining an increasing sense of belonging to her unit. I hope the appreciation contributed to relieving her sense of being a burden to others while she was learning and struggling to be a competent nurse in the highly complex and specialised N/PICU.

> It [is] really very busy in the past few months as every staff in our ward only has one day off every week. It is really tir[ing]. Luckily, there are many (eight, and will be ten) new staffs coming to our ward (eight of them are new graduates). Actually I think that it is a kind of pressure that I need to upgrade and become more competent now. Sometime I even need to help the new staffs.
>
> In these past few months, I usually take ill case[s]. And most of the time I have to go off duty late in order to get everything done. But all my seniors come to help me; actually I felt I was not performing well. But the other day, one nursing officer told me that many staffs appreciate my effort. It was the first time others felt proud of me. I am really happy about that.

> Now, after working for nearly one year, I finally start to feel I am one of them and have the sense of belonging.~
>
> Share with you more later~ (Original Email from Agnes, 17 September 2011)

The literature found that the feeling of being valued by the health care team is important to new graduates, their job satisfaction, and their intention to stay (Clark & Springer, 2012). Meanwhile, it is important to note that the nurse attrition problem does not seem to have been alleviated based on the large number of NGRNs who were employed in 2011 to fill the vacancy. The incoming younger generation seemed to increase Agnes' self-expectation of her competence, because she had a new responsibility to support the others.

8.10 Learning from a medical incident

Unfortunately, Agnes shared a medication incident in her next email. Every medication administered in the N/PICU had to be counter-checked by two nurses. The incident took place when Agnes counter-checked with another NGRN one year junior to her and both of them were unaware that it was the wrong doctor prescription. A larger amount of dextrose was given to their patient. Agnes attributed her mistake to the fatigue resulting from her busy work-study life, in which her only weekly day off was used to attend lectures and finish assignments. Her lowered 'concentration' seems to have decreased her readiness to question the rationale for the prescription, With her self-mentoring capacity reduced, she simply followed the doctor's prescription.

Fortunately, the patient condition remained stable. Nevertheless, I was concerned about the potential impact of the medication incident on Agnes' growing confidence and wondered whether she was supported or scolded during and after the incident. But in contrast to the scolding and blaming commonly experienced, the experience became a positive educative one under Agnes' self-mentoring and her WM's opportunistic mentoring. Agnes was not scolded by anyone after the medication incident, but instead her WM noticed her need to be mentored and initiated a personal debriefing. The debriefing, together with Agnes' self-reflection, was educative in helping her to learn from her mistakes and reassuring her that she could

still be a professional nurse and exercise her own judgment. The educative experience shaped Agnes' future practice of staying vigilant toward the doctor's prescription, remembering the normal dosages of some common medications, and counter-checking against the medication reference whenever she was in doubt. It also seemed to shape her stories to live by, of speaking up to advocate the safety of her patients in another story that will be discussed in a later section. The incident was also shared anonymously during handover as a learning experience for all other nurses in the unit.

8.11 An additional unwritten rule from the ward manager

However, further discussion about the above medication incident revealed another layer of the complex storied experience, which seemed not purely educative. Agnes' WM asked her not to counter-check medication with other junior nurses. The WM seemed to adopt a system-based rather than personal approach to mistakes (Reason, 2000), by identifying the weakness of current counter-checking procedures. However, this 'instruction' was not announced to every nurse and became another unwritten rule that put Agnes under more stress.

> Unwritten rules: 'No counter-checking medication with junior nurses'
> I was conflicted when my WM advised me during a personal conversation not to counter-check with junior colleagues. I [would have] preferred that the 'rule' be clearly stated to all colleagues during a handover session. There are times, especially at night, that we have only one senior, who may be heavily engaged. When a junior staff is preparing her medication, should I counter-check with her? If not, it [makes it] seems that I am unwilling to help. (Agnes, second interview)

This medication incident revealed a widespread and prevalent failure of communication and management style: giving advice at a personal level without clear dissemination of the rules and their rationales to every staff member. Since the rule was not clearly stated, Agnes' co-workers implicitly expected her to counter-check with any colleague, both juniors and seniors, whenever she saw someone preparing medication. If Agnes avoided counter-checking medication with junior colleagues, she may be misunderstood by others as being unwilling to help or irresponsible. This put Agnes in a dilemma, trapped between conforming to the WM's instruction and meeting co-workers' expectations. It was a dilemma

exacerbated by the staff shortage and imbalance between seasoned and junior nurses. This incident recalls Agnes' conflict when she was weaning a neonate off CPAP to a nasal cannula and was expected to conform to the 'hidden' or 'unwritten' rules. While the rule could improve patient safety, the ambiguity created tension and disempowerment instead.

I wondered why Agnes' WM did not state the rule clearly, and thought that she was perhaps concerned about feasibility and the workload of senior nurses. This led me to think of what an APN participant shared in a focus group interview: her WM also identified the weakness of the current counter-checking procedure and made changes that were effectively communicated and implemented. In the past, counter-checking by two nurses was needed when administering any intravenous fluid or medication, or validating any doctor's medication prescriptions when they were newly prescribed or transcribed from the old medication record to a new one. However, many medication incidents occurred despite counter-checking, because junior nurses were unable to recognise mistakes in prescriptions, such as conflicts with the patients' allergy history or even wrong transcriptions with incorrect medications, dosages, and frequencies. Therefore, this APN's WM ordered junior nurses not to counter-check each other, but only with an RN with more than six years' experience. This new regulation was highly effective in ensuring patient safety and minimizing medication incidents in the surgical unit, which also suffered from a severe senior-junior nurse imbalance and inadequate mentoring. Surprisingly, not every stakeholder in the focus group was prepared for the new regulation, despite its effectiveness in ensuring patient safety, as they were highly concerned about the heavy workload of senior nurses. This shows the irony of continuing to allow NGRNs to counter-check with each other, despite complaints about their incompetence and numerous medication incidents. While the counter-checking procedure available to NGRNs with the seniors can be viewed as an opportunity for mentoring and for patient safety, the perceived workload from the seniors' perspective remained an issue. The question is, how are NGRNs to be mentored in medication administration through this counter-checking practice? It is not simply a task, but requires detailed knowledge about the medications and their effects on the particular patients involved.

8.12 Speaking up but not being heard and supported

The medical incident influenced Agnes' story of good work in the midst of her busy work-study life. She had been attempting to live a consistent story of good work, emphasizing rationale and critical thinking rather than 'merely following the doctor's prescriptions'. However, Agnes was situated in a unit where the culture emphasized conformity to the instruction of both senior nurses and doctors. She observed that many of her senior nurses noticed problems of patient safety, but chose merely to gossip in secret rather than bring the problems to the attention of a higher authority. Agnes demonstrated her intention to pursue good work in nursing by speaking up to the doctors about patient safety and reporting early-warning signs of deterioration. Her voice, though, was not heard by doctors, resulting in many miseducative experiences which made her feel powerless to transform her professional identity in practice and make changes.

> Regarding disagreement with the doctor's prescriptions, nurses merely gossip behind the doctor's back while continuing to follow the doctor's instructions. There were also times when a baby had been receiving the same type of antibiotic for a long period of time without any improvement. You had suggested the doctor to consider other treatment but they didn't listen. There were times when you informed the doctors about a distended abdomen, which could indicate an intestinal obstruction, but they didn't take you seriously. I felt helpless seeing the neonates deteriorate, to the point where they needed surgery, and sad about the limited power of those in my profession to help patients and influence the treatment regimen. (Agnes, first interview)

The social dimension was also miseducative, because there was no role-model for speaking up. Alarmingly, these miseducative experiences shook Agnes' faith in her professional identity and diminished her passion to pursue good work in nursing.

> I do hope to pursue good work in nursing. At the beginning I had a passion to do this and that. However, in reality I could not achieve them and could not make any changes. This is because of the nursing culture. You must follow your seniors' instructions. Otherwise people perceive that you are wrong and scold you. You have to withstand the stress. As this is so stressful and unhappy, *why don't you just let it be, just follow their way and integrate and socialise with the*m? This is much easier than doing something deviant from the culture and making changes. (Agnes, first interview)

The power of hospital hierarchy came to light in another example. An influential figure in the unit, the nursing officer Miss A, wrongly scolded Agnes for not using the humidifier with a tracheostomy patient, who already had a thermovent. Despite

the scolding, Agnes spoke up for her patient. But she was ignored. The wrong connection caused harm to the patient, as his oxygen consumption increased tenfold. An APN (of same rank as a nursing officer but with a shorter tenure) witnessed the entire exchange, but remained silent. It was not until Agnes was recounting the incident to another NGRN in secret while Miss A was absent that this APN indicated that Agnes' comment was correct. The connection was finally removed by Agnes' preceptor, also an APN, who spoke up for the patient and Agnes. Focusing on the outcome, the experience seemed to be educative for Agnes in learning to speak up, as her preceptor proved to be a good role-model as a patient advocate. At the same time, it was miseducative, as the support of someone in power and authority was required before anyone paid attention to Agnes' advocacy. Agnes, who had once been committed to being assertive, experienced a strong sense of powerlessness as an NGRN, and her sense of professional identity was further shaken (Agnes, second interview).

8.13 Need of mentoring and support to sustain the shaken stories of good work

In the midst of miseducative experiences, NGRNs can be empowered to speak up both through mentoring by others and engaging in self-reflection. These two actions also reaffirm their shaken professional identities and sustain their story of good work in nursing. Agnes discovered a persistent patient safety issue in another incident, even after consulting with the junior doctor. This can be seen as self-mentoring, as she was guided by her knowledge of the neonate and her vigilance in checking a prescription that seemed to conflict with the neonate's condition. Agnes intended to bypass the junior doctor and seek further clarification from the senior doctor, but because of her past experiences of being ignored, she hesitated. Her preceptor raised questions that encouraged her to think critically about the situation and brave the hospital hierarchy, and reassured her that she was correct in speaking up for patient safety. This can be viewed as a general example of opportunistic mentoring, which is important for encouraging NGRNs to speak up, thereby sustaining their shaken stories of good work. NGRNs face many error traps that always put patient safety at stake, as evidenced in the following story.

> A hypernatremic neonate further developed metabolic acidosis. When I called to report the abnormality, a junior doctor verbally ordered normal saline bolus [1st error trap]. I was surprised by the order, which contraindicated for the neonate's condition. I consulted the night in-charge, who was my mentor, and she asked me to get clarification. The junior doctor insisted on her verbal order of normal saline for metabolic acidosis, without much concern for the underlying hypernatremic status of the neonate. That worried me. This junior doctor arrived at the NICU soon after my request for clarification to write her prescription. Nevertheless, instead of writing the normal saline bolus, the junior doctor wrote Lasix [diuretics]. I think she might have made an error by carelessly copying Lasix from the previous prescription on the medication record [2nd error trap]. Fortunately, I only had a few patients and I was familiar with each of their conditions, otherwise it would have been a tragedy if I followed her [Lasix] prescription straight away. I made another clarification with the junior doctor before she left, and she rewrote her Lasix prescription to normal saline bolus [3rd error trap]. I was then in conflict and wanted to call and clarify with the senior doctor. I hesitated and consulted my mentor again. She reassured me by asking the question, 'Are you going to follow through with the prescription?' I reflected and was reassured when I realised that I was calling the second doctor to safeguard the patient. He said on the phone '**Do not give the normal saline bolus. Don't give anything until I come.**' (Agnes, third interview)

8.14 Different layer of the story of speaking up for good work

The story above reveals the complexity of nursing, which involves the iterative process of critical thinking and speaking up to ensure patient safety and requires knowledge and vigilance to identify common 'error traps'. This was not an isolated incident and there were many other 'error traps' often set up by some careless and seemingly irresponsible medical counterparts that would have jeopardized patient safety without the counter-checking and reminders from nurses. Nevertheless, listening to these stories and thinking about NGRNs often assigned to work alone beyond their competence and left to self-mentor, I worried about patient safety. Agnes agreed with me, because she also perceived NGRNs often do not have the experience or personal practical knowledge needed to identify the many 'error traps' and distinguish abnormalities that require immediate intervention or deserve further observation. Such inexperienced NGRNs may simply follow doctor's prescriptions straight away. The following story revealed that without addressing the root cause of the mistakes, all these counter-checking and reminding activities were ineffective to ensure patient safety. They seemed to become another sacred story disempowering

nurses from pursuing good work. The time consumed in complex nursing coping mechanisms can be better spent on caring patients and families.

> One morning, my patient's serum bilirubin was at a marginal level that might or might not need phototherapy. The doctor affixed the chop of his name to the laboratory result during the doctor round and said verbally that the baby didn't need phototherapy, but without documenting his decision on the computer system. I handed this over to the incoming nurse, who was my classmate. Miss A was the afternoon shift in-charge and thought the patient needed phototherapy. My classmate told her the situation. However, Miss A said 'The name chop doesn't mean that he has read the result. You should ask the doctor once more!' The doctor changed his mind and prescribed phototherapy for the baby. However, I felt that nurses are responsible for everything. Even when the doctor has chopped his name it doesn't mean that he has read the result and I have to ask again whether phototherapy is needed! Then what is the purpose of name chopping? I think my responsibility as a nurse is to report any abnormal result. Doctors should be responsible for deciding their management of the abnormality. The branch was taken for the root [Chinese: 本末倒置]. That's not the first time. There are many traps at work. After some doctors put the blood label of a patient to another patient's file, two nurses are needed to counter-check the blood label with the patient before blood collection. It's difficult to find another colleague for counter-checking sometimes. This is disturbing, unfair and dissatisfying. It was the mistake of the doctor, why don't they ask doctors to change, instead of asking us to change our practice? The nursing managers conveyed a feeling that *we can do nothing if the doctor didn't check, but merely counter-check by ourselves*. [Since adopting the new protective measure] it seems doctors have no responsibility, but push it onto nurses. (Agnes, second interview)

The above story seems to convey the sense that Agnes was unwilling to speak up for her patients, which was inconsistent with her story to live by. In view of her many miseducative experiences and cumulative sense of powerlessness to speak up as an NGRN for her patients and be heard by others, she was looking for a change in the current pattern of speaking up. Agnes yearned for her seniors, those occupying the management and leadership positions, to speak up on behalf of the nursing profession and patients and to negotiate with the medical professionals to make some real underlying or radical changes for patient safety. However, they seemed to conform, seeing no possibility of making changes and simply giving up their voices. Agnes wondered why nurses had to compromise in changing their practices to counter-check everything done by the doctors. This was consistent with a larger study exploring the problems of undiscussed errors among colleagues and the silence

from management that led to avoidable medical errors. The authors identified that led to avoidable medical errors. The authors identified that both nurses and nursing managers hesitate to speak up or confront staff who are careless or incompetent, but merely counter-check their work (Maxfield et al., 2005; Maxfield, Grenny, Lavandero & Groah, 2011). NGRNs in Ireland had similar experiences, saying that these non-nursing duties leave them no time for nursing (Mooney, 2007). It is time to rewrite the story of nursing, making changes to better mentor NGRNs and empower them to speak up for patient safety and benefits.

8.15 Increasing intention to leave

Even though Agnes' NICU had a desirable nurse-to-patient ratio, it also had many conflicting stories of good work, emphasizing conformity and hierarchy. Perhaps because of this, Agnes repeatedly mentioned her intention to leave the NICU throughout the research process. She looked forward to her next rotation to another specialty and had a particular interest in the AED. That was why I shared my perspective and experience at the AED with her in our first interview. (Later Agnes changed her mind, and although she did not enjoy her work at the N/PICU, she did not make a request to leave. Instead, she intended to stay in order to accumulate two more years of experience, which would be well recognised in the future as better professional development.) In our second interview, Agnes continued expressing her intention to leave and planned to make a request after completing her two-year master's programme. She lived in constant conflict with Miss A, the influential nursing officer of her unit who frequently abused her position of authority. Agnes experienced a lot of unfair treatment. Miss A scolded or criticised her in public, interfered with Agnes' participation in an important meeting between her patient, his mother, and the doctor and made her do something less urgent and important, and gave her conflicting instructions about scheduling seminar presentation dates. Agnes seemed to be Miss A's target. When I followed up with more questions, Agnes said she felt that she was being bullied by Miss A. Before our final interview, I received two emails from Agnes that caused me to worry about her and about her shaken stories to live by and stories of good work.

As for good nursing, I have been really confused about it lately. Some nursing officers think that they are a golden standard and juniors should follow their practice. But for our training nowadays, I believe that there should not be only one practice in the world. I would only listen to them if they have a well-supported rationale. I was sometimes forced to adjust my practice in order to suit our senior's order, but I believe that it was not a good practice. So, 'good nursing' nowadays still seems to be following your senior, and critical thinking is still not being appreciated.
Just feel frustrated about my work~ (Original email from Agnes on 26 June 2012)

I finally applied to be transferred to AED. I don't think I am escaping from the pressure but I do think that I don't want to stay in a place which makes me feel unhappy. It has been my wish to work in AED since my graduation. I just want to give myself a chance, even though the transfer application may not be accepted. Haha~ (Original email from Agnes on 1 July 2012)

I was very worried about Agnes since I believed something must have happened to trigger this final decision. I asked further about her stories in our final interview, which took place at the end of her second year of clinical practice as an RN. Initially, Agnes would have been the first participant I met in the final round of interviews. She again suggested meeting on a day off, as we had for our first interview. I greatly appreciated her contributing her precious time from her busy work-study life to the interviews. However, I had to postpone our scheduled meeting for a week because I developed a sudden onset of gastroenteritis and was later admitted to my own AED for observation. I felt very sorry to postpone the meeting and was glad that Agnes understood my condition. She sent me messages to extend her heartfelt sympathies and suggested another day off for our final meeting. We met each other during lunch time instead of tea time. I wanted to invite all my participants to lunch or dinner to acknowledge their contribution to my study, as well as to celebrate their two-year contribution to nursing.

Our final meeting took place at a Chinese restaurant near Agnes' home. It was a small place with only a few customers, which was quite satisfying for conducting interviews and enjoying Chinese dim sum. I began our conversation by asking, 'How are you?' Surprisingly, Agnes immediately replied 'Not good!', instead of the usual 'I am fine, how about you?' I learnt that the conflict and tension between Agnes and Miss A had intensified and escalated since our second interview. Miss A had been targeting Agnes continuously. Agnes told me three incidents that occurred in three

consecutive shifts in which she felt unreasonably and unfairly nagged by Miss A. These incidents finally triggered Agnes' decision to leave the N/PICU. The pattern of being forced to follow the '*usual practice*' and then scolded continued the patter from the first incident. Miss A had a conflicting standard for the position of a new light source in phototherapy, vacillating between whether it should be in a horizontal or inclined position, and found fault with Agnes for not setting it up properly. In the second incident, Agnes was taking care of the most critically-ill patient in the shift. She needed to switch the patient to another ventilator machine, a procedure that requires a doctor and two nurses. Miss A, even though she was a senior nurse and the shift in-charge, did not offer assistance, but merely complained that they had taken a long time with the procedure. Agnes was disappointed to know that Miss A had intentionally withdrawn her assistance from a junior before the patient was settled, which could have jeopardized the patient's safety.

The long story climaxed with the third incident, when Miss A criticised Agnes, saying unfairly and unreasonably that she had no team spirit because she had failed to help another colleague, despite the fact that Agnes was once again taking care of the most critically-ill patient. In the midst of all these conflicting demands and miseducative experiences, and feeling powerless to sustain her own stories to live by, as well as being the target of Miss A's bullying, Agnes experienced these three incidents as the final straw. They catalyzed her decision to make a request to leave the N/PICU and transfer to the AED.

A sense of powerlessness and having no voice is indeed one of the top reasons nurses resign from their clinical positions (Webster, Flink & Courtney, 2009). Agnes' decision to leave her current unit can be seen as getting a new opportunity to pursue her stories of good work and taking the initiative to transform miseducative experiences into educative ones. Leaving the unit with all of its conflicts can keep Agnes from losing her identity and help her maintain her professional integrity.

8.16 Being asked to tolerate problems rather than make changes

Nurses need to learn to speak up not only for patient-related issues, but also to protect themselves. The confusion that Agnes displayed in her email might be

because others advised her to tolerate Miss A's uncivilised behaviour and attitude passively, rather than helping her to call out the injustice. These 'others' included Agnes' nursing colleagues and her deputy WM, who shared experiences of being targeted by Miss A when they were green and coped passively by tolerating Miss A's unfair treatment. Their advice, ironically, demonstrates yet another layer of conformity and pressure to be silent rather than speak up.

> My colleagues reassured me and said 'Let it be! This is the way of Miss A. If she dislikes someone, she will always find fault with them.' My WM also asked for my reason for applying for internal transfer so suddenly. I told her my conflict with Miss A. My WM said 'Miss A picks on everyone. I was picked on by her before.' She asked me to tolerate Miss A. I told her that I couldn't tolerate anymore. (Agnes, third interview)

It is discouraging to note that the deputy WM and many other senior colleagues acknowledged the problem of Miss A and the occurrence of workplace bullying, but instead of speaking up to effect change, they chose to ask Agnes to tolerate the intolerable. Miss A seemed to overpower the deputy WM, who was presumably at a higher level of the hospital hierarchy (although her deputy position may have also led her to avoid making problems before securing her promotion). The deputy WM showed no intention to make changes to alleviate the problem of Miss A's nagging and workplace bullying, but allowed the vicious circle to perpetuate. New graduates from South Florida also reported that nurse leaders in their units often tolerated horizontal violence, even while the leaders of the organization claimed to have zero tolerance (Dyess & Sherman, 2009).

I saw Agnes' open-mindedness and resilience as she faced all kinds of criticism and unhappiness in her two years of clinical practice. She never cried because of any issues at work. However, Agnes did cry with a great sense of being unjustly accused when the WM said that Miss A criticised her as having no team spirit. This revealed psychological distress she experienced.

> Then my WM said that Miss A had criticised me for not helping the other colleagues. I felt powerless. At that moment, I could not tolerate it anymore and I cried when my WM mentioned that point. I said, 'I think I am competent. If I have time, I always help my colleagues. She [Miss A] didn't help indeed. When she was the in-charge nurse, she always sat at the nursing station and did nothing. When we have new admissions at the PICU, she went

> to the NICU and vice versa. All the other colleagues know this. I don't think she can criticise me.' (Agnes, third interview)

8.17 Being ask to tell cover stories rather than speaking up

When the deputy ward manger knew that she would not succeed in retaining Agnes, she asked Agnes to tell a cover story to the administrator of the Nursing Service Department.

> My deputy WM said, 'We have too many people leaving [resigning or requesting to leave]. I don't know what you will tell the administrators. I still need newcomers [to fill the vacancies].' That means she doesn't want me to say too much (Agnes, third interview)

This was the second time that Agnes was implicitly asked to tell a cover story instead of the truth. The first time was a reminder made during handover by the WM that staff should report any opinions to their seniors rather than to any visitors outside their unit. The WM gave the reminder by sharing an embarrassing situation in which an NGRN at the medical unit had expressed his opinion to a higher official during a ward visit.

> An incident was shared during the staff handover session. There was a time a higher official visited a unit, probably a medical unit. This higher official asked whether the staff were encountering any problems. A junior staff expressed that he was very confused with the different colours of the cleaning cloths, which were coded to differentiate their uses for different tasks [cleaning of body fluids such as blood, general housekeeping, and washroom service]. Everyone stood in awkward silence, embarrassed, since nobody had expected this junior would voice such a thing during the visit. By sharing this story, the WM reminded us to raise any of our concerns to the seniors at our own unit first. I perceived that the seniors think that the junior was wrong in jumping in and expressing his ideas directly to the higher official, because it had caused them all to lose face. However, I think expressing ideas and views is not wrong. I learnt that all the problems or feelings officially presented at the meetings were fake. They were prepared and polished. The higher official could not see the reality. I don't think that we can fight for any resources [to improve the situation] with this approach. This is meaningless. (Agnes, second interview)

When seen in conjunction with the need to speak up for both patient safety and nurse safety, both of the above stories were clearly miseducative. They discouraged frontline nurses from voicing their concerns and opinions to outsiders, while their voices were not heard by insiders occupying the higher echelons of the hospital

hierarchy. The experiences further diminished Agnes' trust in higher officials and increased her hesitation to share her thoughts and opinions genuinely. She also witnessed her department manager dismissing another NGRN's concerns out-of-hand, simply refuting the concerns and defending the status quo, during an investigation initiated to examine high nurse attrition in the department. What kind of mentoring is that? Can patient safety and nurses' working environment really be improved when such a mentality of silencing concerns and covering up errors persists? These storied experiences of being asked to tell cover stories further confirm the social significance of this narrative inquiry, which aims to create a new space for NGRNs to voice their concerns and needs.

8.18 The assigned preceptorship evolved into mentoring relationship

Agnes intended to seek advice from her preceptor prior to apply for internal transfer to the other department, but after the three incidents described above, she could not wait for the opportunity before submitting her request. The following story shows the trust they had already established in their relationship. Agnes' preceptor did not occupy a large portion of her storied experience, but she held an important position. From the story of using thermovent with humidifier showed that Agnes' preceptor was different from the other senior colleagues and deputy WM, who emphasized conformity. She dared to advocate for patients and speak out for Agnes, disregarding any hierarchical issues. This was a characteristic attitude that Agnes and her preceptor shared, which probably contributed to the rapport they built with each other. In retrospect, their growing relationship can be recognised as a mentoring relationship, because it included the important psychosocial component that is often absent in a preceptorship (Bennetts, 2002).

> When I was considering applying for internal transfer to the AED, I wanted to seek my mentor's advice. However, I couldn't wait until I had a chance to discuss it with her before submitting my application. But even after I submitted it I continued to ask her whether she thought it was a good idea to leave the N/PICU. It seemed that I was leaving because of my low endurance threshold and other minor matters. However, I also added that I couldn't tolerate any more. My mentor said, 'I can see that you are unhappy working at the N/PICU. I don't think there is a problem in leaving. However, you have to be aware that every unit has these kinds of people and you have to prepare yourself to handle them.' My mentor added, '*If you leave, I will miss you very much*.' (Agnes, third interview)

I had the same concern as Agnes' preceptor. Each unit has co-workers like Miss A who may criticise others unreasonably and are difficult to work with or tolerate. Agnes was aware of this possibility and thought that she might be able to tolerate them better if she was working in a specialty that she was interested in, like the AED. She also looked forward to her next rotation, because she would be broadening her horizon for professional development rather than confining herself to one particular specialty.

8.19 Shaping by others or retelling a different story of mentoring?

I was interested in knowing if Agnes' mentoring experience changed under the influence of her ongoing miseducative experiences. When Agnes was still in her first year of practice, she hoped senior nurses would support the young generations by reflecting on their past 'miserable days' of being scolded or ignored. Agnes wanted to share what she knew with the incoming NGRNs and teach them patiently, but she was hesitant about teaching in the presence of other senior colleagues. She worried about being perceived as arrogant by teaching when she had only one year of experience and was not fully competent. Agnes could only support her younger generations comfortably by teaching indirectly and helping with their other cases. The following quotation about peer mentoring from an APN in the focus group interview might help to further understand Agnes' hesitation to support the NGRNs in public.

> Some new graduates have only upgraded for one to two years. They perceived themselves as smart and became the 'elder sisters' in *teaching* the incoming new graduates. However, the senior nurses became very angry because they were teaching wrongly. (NEURO, APN 10, FG 2)

I understood Agnes' hesitation as well as the anger of the senior nurses. However, from their 'conversation', it seems that a positive learning environment was not being cultivated. Instead of treating the peer mentoring as another opportunity to find the knowledge deficits of the junior nurses, the senior nurses perceived it negatively as disturbing the learning of the youngest generations. One possible explanation is that they already had an overwhelming workload preceptoring multiple NGRNs,

newly rotated nurses, and other nursing students, and did not want to spend more time fixing the mistakes of less experienced nurses.

By the end of Agnes' second year of clinical practice, she was telling a different story about mentoring her younger colleagues. Her hesitation to teach had lessened. She liked to share her experiences with the young professionals, particularly about 'error traps' she had encountered in the workplace. The duration of preceptoring had doubled to two months for the new graduates of 2012 (5 weeks in the N/PICU and 3 weeks at the PICU). This led Agnes to have higher expectations about the NGRNs' performance, but she was disappointed. She learnt later that although the NGRNs and preceptors worked in the same shift, they did not have reserved time for preceptoring as she had had. The preceptor was occupied with her primary other responsibility as the shift in-charge and did not have time to supervise the NGRNs closely. Instead, they worked on their own performing all kinds of unfamiliar tasks, resulting in many mistakes that could have jeopardized patient safety. Agnes was able to gain some perspective from the senior nurses. She recognised the difficulty of being a preceptor, based on her observation and discussions with other senior colleagues who had been assigned preceptoring responsibilities. Agnes told the following story that is very pertinent to the need to mentor NGRNs to manage emergency and uncertainty.

> A senior colleague escorted the patient to the radiology department for an MRI investigation with the two new graduates [two years junior to Agnes]. The situation became chaotic later. The portable ventilator had an air leakage and the doctor had to ventilate the patient manually via resuscitator. The blood pressure of the patient deteriorated on their way back to the N/PICU. The arterial line was blocked and we couldn't assess the blood pressure. Several doctors were busy finding sites for re-insertion of arterial line. However, the two new graduates just stood there helping the doctor to hold the baby's hand, even though the patient was sedated and would not move at all! Other colleagues helped by inputting vital signs on the computer system for documentation and preparation of medication and equipment. At that moment I wondered why they just stood there instead of finding tasks where they could help. I wondered whether they didn't know what to do or whether it was something else. Then another colleague at level similar to me asked angrily 'I don't know what they are doing there?' I replied 'I didn't know either', and added '**Maybe we were the same in the past**.' [*Bernice: Do you think it is similar to your experience [in the first year] that you don't know where to position yourself when newly admitting an intubated neonate?*] Yes. They are at a stage where they need direct instruction from the others. In such

> a busy and chaotic emergency situation, nobody is free and it is difficult to instruct as we need to address the work on the task quickly whenever they are being identified. Maybe they need to be familiar with the routine. When I see that the doctor is finding a position to insert the A-line, but the required equipment is not ready yet, I rush to push the trolley forward. They are unfamiliar with what is happening and cannot anticipate what is expected of them. (Agnes, third interview)

The above emergency situation echoes the ones Agnes described in our first interview. Initially, Agnes seems to have adopted the perspective of her seniors, who were disappointed with the NGRNs' lack of support. But compared to her peer, Agnes seemed to have a higher awareness of the NGRNs' experience, because of the reference to her past experience. She also seemed to be more reflective in wondering what led the NGRNs to perform unsatisfactorily.

In the temporal dimension, how can we resist being influenced by our past negative mentoring experiences without repeating the same stories with the younger generation of nurses? In the personal-social interaction dimension, how can we resist being influenced by others' conflicting mentoring methods, and how can we shape others positively while sustaining our stories of mentoring?

8.20 Need for ongoing self-mentoring and good work communities

During her interviews, Agnes focused on the three important aspects of her first two years of clinical experience, particularly the psychological aspect. At the end of our final interview, she shared a newly identified weakness she had in caring for the family of her dying patients. This identification of weakness was brought about by her reflection on her recent experience taking care of several paediatric patients who were healthy but suddenly deteriorated before admission. Upon seeing their crying parents, Agnes reflected on her weakness in providing family or bereavement care. This revealed that Agnes' professional development was a continuous process along with her ongoing experience, which did not stop after she gained two years of clinical experience. Once again, this self-mentoring process guided Agnes to seek opportunistic mentoring from her nursing colleagues. In this case, she initiated a conversation, but was unsuccessful in acquiring the knowledge she sought.

> Recently there were several patients with sudden loss of consciousness of unknown origin at the PICU. Seeing them caused me to reflect. I could see not much hope of recovery. I saw the children's father crying. I didn't know what exactly to say and I couldn't help much. I could neither discourage the father, nor could I give him some false hope. That's difficult. I could only give very superficial support. For a boy who was taken care of by his grandma, I was most concerned that the grandma might blame herself for the late discovery of the incident. I tried to remind the crying father that 'Nobody can predict what will happen, it is important that no family member blames himself.' I reflected that if I needed to gain practical nursing knowledge, I could accumulate experience and become more familiar with the work. However, I didn't know what to do in family care. I tried to initiate a discussion with my colleagues and told them that I didn't know how to reassure the crying father. However, my colleagues simply replied that the boy would not recover. We seldom discuss how to provide family support. My WM always invites the patients' family to have a private discussion in the conference room. Therefore, I couldn't learn from her about bereavement care. I was not taught at the university about any of this. (Agnes, third interview)

Previous literature also identified death and caring for the dying as uncomfortable and even stressful experiences for new graduates (Casey, Fink, Krugman & Propst, 2004; O'Shea & Kelly, 2007; Qiao et al., 2011; Yeh & Yu, 2009), but they focused only on the patients and did not mention their families. The narrow focus may be related to their study design, which is limited to an investigation of the new graduates' first year of clinical practice. But new graduates at that time may have a relatively narrower perspective about nursing and focus only on their patients, rather than holistically include their families (Schoessler & Waldo, 2006).

In fact, I had a similar experience. I found that caring for the dying and their families was not an 'interesting' topic among my nursing colleagues. When I think about the possible reasons behind such behaviour, I do not know whether they did not see the meaning and significance of bereavement care or whether they were exercising an emotional coping mechanism in handling such a psychologically distressing event, or whether they also felt uncertain themselves and wanted to avoid the discussion. On one hand, I reassured Agnes that her support, which she perceived as 'superficial', could make a difference and that she should continue trying her best in taking care of the patient, their parents, and even the guilt-ridden grandmother not at the hospital. I remembered the differences in my experiences caring for the families of patients who were dying gradually at the neuroscience unit, compared to those of patients who

died suddenly at the AED. Based on my experience, I found that therapeutic touch might not be effective on some patients' families, whose relatives had died suddenly or committed suicide. They need space to express their emotion and bereavement with other family members.

These stories opened up a discussion about caring for dying patients and their families. We discussed the use of 'It is a great relief to the patient' to reassure the family of the importance of good death without prolonged suffering, and the effectiveness of that phrase in conveying our empathy. This approach puzzled another NGRN participant (see Chapter 11). We also explored the possibility of supporting a family with sick or even dying children by creating an album or any form of artwork in remembrance of their loved ones. Agnes and I did not arrive at a conclusion, but our conversation stimulated awareness and helped us discover different possible ways to improve our family and bereavement care. Our conversation also stimulated me to attend a workshop about breaking bad news to gain some inspiration for ways to provide better patient and family care. Our inquiry into providing better family and bereavement care and the meaning of good work continued even after the research interview ended.

Reflecting on the conversation with Agnes, I saw the potential importance of a knowledge community (Craig, 1999) or a good work community of nurses with similar values and beliefs for sharing their self-mentoring and engaging in dialogue for exploring new possibilities to sustain good work with other nurses. When I suggest that there is a need for ongoing mentoring and support for NGRNs to sustain their good work, especially because they are in a context with many conflicting stories, people may challenge the feasibility and potential of providing a long-term structured programme when there is such a severe nursing shortage. As the problem with nursing shortage is ironically linked to the issue of NGRN's attrition as they could not live out their professional identities without the needed caring support and mentoring. So it begs the question whether the sacred phrase of 'severe nursing shortage' can be used to perpetuate an uncaring environment for the NGRNs and other senior nurses. There needs to be a clarion call for institutional support for the ongoing need of mentoring throughout the NGRNs' professional development that can provide an authentic cultivation of open and safe spaces for nurses at different

levels to share, reflect on, and question their practices, to analyse contradictions, and to explore, implement and evaluate new possibilities for improvement and growth. For lack of a better term, I will call this a 'good work community'.

8.21 Leaving in the midst yet remembering Agnes because of a song

After the final interview, Agnes and I no longer had a participant-researcher relationship, but we continued to encourage each other to sustain our stories of good work. Our stories grew in similarity when Agnes finally rotated to the AED. Even as I was finishing this chapter, I was looking forward to visiting her new sweet home the next week. Agnes could not think of any metaphors to describe her experience, but one night while I was watching the movie *Unbeatable* at the cinema and listening to the woman singing the song 'The Sound of Silence', the story of Agnes came to my mind. I use some of the lyrics from the song to close this chapter and hope it resonates with you as you read them. They are significant not only for Agnes' experience of being silenced, but for emphasizing the importance of the kind of mentoring that led her to sustain her stories to live by, and retell her stories of mentoring and good work in the new workplace.

The Sound of Silence (Simon & Garfunkel, 1963)
And in the naked light I saw
Ten thousand people, maybe more.
People talking without speaking,
People hearing without listening,
People writing songs that voices never share
And no one dare
Disturb the sound of silence.

'Fools' said I, 'You do not know
Silence like a cancer grows.
Hear my words that I might teach you,
Take my arms that I might reach to you.'
But my words like silent raindrops fell,
And echoed
In the wells of silence

And whisper'd in the sounds of silence.

8.22 Postscript

Agnes sent me the reflection below when she was member checking over this chapter. This exercise not only assures the chapter's trustworthiness, since past experience and emotion were evoked, but also reaffirms once again the significance of this narrative inquiry. Many of the problems that disempowered Agnes from learning and sustaining her good work in nursing had not improved over the past three years since our final interview. NGRNs are still left to self-mentor with inadequate support and expected to guard against the mistakes of doctors that put patient safety and care quality at stake. Looking back to just after her registration, Agnes initially yearned for autonomy to exercise her judgment. However, she had to compromise under the hospital hierarchy and conform to the 'usual practice'. Later, she seemed to see the possibility of successfully sustaining her stories to live by. Nevertheless, Agnes' use of the term 'small potato' below reveals her sense of powerlessness to make changes, who was forced to adopt the 'usual practice' if she wanted to survive and maintain harmonious collegial relationships. The emphasis on conforming to 'usual practice', that is, rather standardized care, not only kills creativity and blinds us from taking multiple other possibilities for better care quality, but also leaves in doubt the provision of individualized patient/family centred care. It is important to reflect once again and ask, What kind of 'mentoring' have we created? What kind of 'mentoring' are we going to create?

> I think your dissertation was very well written. It reminds me of a lot that I had nearly forgotten. When I read through your paper, I reflected a lot and still have a sense of unhappiness about my experience in N/PICU. I feel proud that I could get through that time with the support of my mentor and peers. Even now, when I chat with the N/PICU colleagues sometimes, I find things haven't changed much. The hierarchy, the 'usual practice', the careless doctor prescriptions and the traps are still common. I feel much more happy and relaxed now in AED [with improved collegial relationships]. I am satisfied now, even though AED is not a perfect place in nursing care. It is because, being a small potato, I can't initiate any changes, but just adapt the usual practice as long as it is not too different and doesn't violate our nursing standard. I can say of my 5 years of nursing experience, that what enables us to survive is adaptation. (Original email from Agnes on 29 June 2015)

CHAPTER NINE

EDWIN'S STORY - AN NGRN IN A MIXED SURGICAL UNIT

9.1 Introduction

This chapter is about Edwin, my seventh participant, a nurse working in the surgical unit. Our paths intersected long before the establishment of our participant-researcher relationship. I know Edwin personally. Nevertheless, I did not recruit Edwin myself, and we recognised each other as a coincidence at the beginning of the study. Edwin found himself in a unit where the seniors often scolded and blamed the NGRNs for not seeming to meet the seniors' expectations.

Edwin self-mentored often in his unit throughout his first two years of clinical practice. After I finished writing the other chapters and re-read my interim text about Edwin, I found that what I had written was still at a descriptive level. I was able to gain a better understanding when my chief supervisor, Angela, identified and commented on my interim text. Reflecting now, I wondered if I had become too involved in the experience and my relationship with Edwin, to the point that also took the same things for granted and adopted the same standpoint as he did. This might be the relational tension inherent in being a narrative inquirer that Clandinin and Connelly (2000) discussed. Nevertheless, I was glad to have an ongoing discussion with Angela and a cooling-off period afterward when I could step back and distance myself from my writing. I reflected critically on the different experiences which both Edwin and I had had in the complex health care landscape. The process of writing and re-writing gave me a more in-depth understanding of those experiences from a more holistic perspective. I further explored my research puzzle by asking the questions 'Why?' and 'So what?' about the meanings and significance of these experiences. My goal, as always, was to understand the meaning(s) of mentoring the NGRNs, to aid them in transition and to foster their good work in nursing. The following interpretive account is written chronologically because it is the way Edwin wanted to present his experience - beginning with when he was still a temporary undergraduate nursing student (TUNS), to his transition,

which he underwent with intense frustration, to his eventual growth, where he finally experienced an increased sense of comfort, satisfaction, and ability to apply his accumulated practical knowledge to practice. His storied experiences observing and working with the next generation of nurses in his second year of clinical practice are included, since they are relevant to understanding whether his experience of mentoring was relived and retold.

9.2 Our stories intersected long before our narrative inquiry

Edwin was nominated to be an NGRN participant in my research study by one of his former professors, based on his excellent academic achievements in his undergraduate nursing education. He was invited by the professor via email, to which the professor had attached an information sheet. Edwin replied with an intention to participate. However, the information I received was just Edwin's full Chinese name, his email address, and mobile number, without any other information about his current workplace. I hesitated to contact him at first after receiving his agreement to participate, because I had only received approval from some hospitals verifying the ethical nature of my research and I was still waiting for the time-consuming ethical approval procedures from the other hospitals, without any guarantee of their arrival. I had never expected that I would be referred someone I knew. But I did not recognise that it was Edwin, since I only called him by his nickname. While I was anxiously waiting, Angela reassured me and told me to 'embrace uncertainty'. One night something surprising happened that I later recorded in my field notes

> *Last week (31 May 2011), when I felt a bit anxious about the time-consuming ethical approval procedure, I thought about contacting Edwin to figure out where he worked. If he was at to a hospital where I had difficulty acquiring the approval, I could let him know about my situation and inform him that, to my regret, I couldn't include him as one of my participants. When I reviewed his contact information, I realised from his email address that he might be someone I knew. I double-checked my personal contact list and realised that he was actually a friend of mine, as well as an NGRN employed at a hospital where I had ethical approval! I called him and told him the story behind my delay and asked if he was still interested in participating in my study. He said he recognised my name as the investigator right away when he had received the email. It was because of me that he agreed to help.* (My field notes, 5 June 2011)

I still feel grateful for Edwin's great contribution and support. This was how we began our participant-researcher relationship.

9.3 Beginning as an NGRN at the surgical unit from a TUNS

Edwin had been employed as a temporary undergraduate nursing student (TUNS) at his current surgical unit since his third year of study in a four-year baccalaureate undergraduate nursing programme. When he was a TUNS, Edwin was not assigned a preceptor, but merely received some general unit orientation from a senior nurse. He began to work on the routines that were commonly performed by nursing students who were employed as TUNS or working on a clinical practicum without close supervision. These TUNS routines include basic nursing care such as vital-sign monitoring, wound and catheter care, gastric tube feeding, and patient admissions.

After working at the unit as a TUNS for about a year, Edwin was occasionally given opportunities to take care of one to two patients who were very stable, to help him learn the routine work performed by an RN. These RN routines include carrying out doctor's prescriptions, making the correct documentation, and receiving and delivering end-of-shift handover. Edwin was learning experientially, rather than systematically, from one particular nurse. How well Edwin learnt the RN routines depended on his own awareness of his knowledge deficits and how much he took the initiative to ask. His learning also depended on his senior nurses, who had to take the initiative to teach. This echoed my past experience working as a TUNS, in which my learning depended on my clinical exposure and my interactions with others. For instance, I learnt about wound and stoma care from two different wound specialists that I occasionally worked with on the same shift. They taught me after noticing my desire to learn, since I was paying attention to the ways they cared for and communicated with patients. I took the initiative to ask at other times when the unit was less busy and my TUNS routines were all completed. I call these learning opportunities opportunistic mentoring, because they have an eclectic and sporadic nature. They are highly dependent on the NGRN's developing realisation of his or her own knowledge deficits, as well as the unit situation.

The previous two years of TUNS experience seemed to have prepared Edwin with the psychological readiness to practice. He was not scared, but felt comfortable with and peaceful about transitioning from a TUNS to an NGRN in a familiar environment. He was acquainted with the setting, its frequent patient admission and high patient turnover, and his colleagues, including the senior nurses, the nurse manager, and the health care assistants. Nevertheless, he still perceived himself to be not competent enough to shoulder the more advanced RN roles and responsibilities, which included many things that he had not encountered before professional registration. Meanwhile, he was reassured by his colleagues that they would offer him support and his transition would be a simple one. This story about TUNS seemed consistent with my expectation that TUNS would be beneficial to the NGRNs' competence, confidence, experience, and socialisation with co-workers. In fact, these are the favourable learning outcomes reported in the research literature (Coakley & Ghiloni, 2009; Hoffart, Diani, Connors & Moynihan, 2006; Lott, Willis & Lyttle, 2011; Starr & Conley, 2006; Stinson & Wilkinson, 2004). However, further examination of Edwin's story shows that these assumptions may be too often taken for granted.

9.4 Initial transition in changing to the RN uniform in the same place

Despite Edwin's two years of TUNS experience in the same surgical unit, his initial transition from the TUNS to the RN role was not without stress and frustration. To begin the interview, I asked an open-ended question, 'How is your experience in transitioning from a nursing student to a registered nurse?' Edwin began to tell the story below, which conveys the complexity of his initial transition experience.

> The transition from a nursing student to an RN was very fast. This may be related to the staff shortage at my unit and the length of time that I had been working at my unit [as a TUNS]. I found mentorship [use interchangeably with preceptorship colloquially] was inadequate to support the fast transition and wondered whether it was due to the staff shortage. They [senior colleagues] had high expectations for me and didn't seem to think that new graduates have to be trained <u>progressively</u>. It was extremely stressful and demanding in the first month [post-registration]. They said, 'Impossible! You have been working here for such a long period of time, you don't know about this [RN routines]!?' I wondered why the others were giving me so much stress, I mean having such high expectations for me, which I found a bit unreasonable.

> [*Bernice: What do you mean by 'high expectations'? Are there any examples?*] As a TUNS, I mainly work on the student [TUNS] routines. I didn't know some of the admin stuff [operational knowledge of some procedures]. For instance, I didn't know how to book an appointment, a colonoscopy, or an OGD [oesophago-duodenoscopy]. They said, 'You have been working here for such a long period of time, it is impossible that you don't know how we usually manage that [RN routines]?' and 'It's impossible that you haven't assisted this procedure before [RN routines]!' and 'It's so simple and you don't know?' There were times when I found their words were very hurtful. There was a week in my first month that someone kept finding fault with me and scolding me [Chinese: 俾人啄得好緊要]. I felt frustrated and unhappy in the first month [as an RN]. I found everything was fleeting and happening quite suddenly. (Edwin, first interview)

The short excerpt above reveals multiple layers of Edwin's storied experience. In the temporal dimension, his initial transition experience was inadequately supported. Rather, he received comments and criticism far different from what he had expected to receive according to the reassurances others had given him before his professional registration. This was captured by his use of 'fast', 'fleeting', and 'happening quite suddenly'. Thinking in the spatial and personal-social interaction dimensions, Edwin was in the hospital supportive programme and expected support from his assigned preceptor, but he seldom worked with her on the same shift and rarely received much support from her. Edwin believed that the inadequate preceptorship was related to inadequate human resources and his prior years of TUNS experience. His experience was also shaped by his ward manager's perception of preceptorship and these TUNS experiences. The ward manager (WM) was responsible for all duty arrangement and did not arrange for Edwin to work with his assigned preceptor. His WM seemed to assume that Edwin could adapt to the new role on his own with just the support of the other senior colleagues working on the same shift. This included an implicit expectation that Edwin would mentor himself by referring to his past experience and engaging in opportunistic mentoring with others. Hence his WM's attitude and the unit's story of a nursing shortage seemed to prevent Edwin from receiving the expected support from his assigned preceptor. Regrettably, Edwin was receiving 'hurtful' comments and being subjected to 'high expectations' from the very colleagues who had promised support. Such comments often occurred when Edwin realised a knowledge deficit in his experience and took the initiative to ask his senior colleagues or seek opportunistic mentoring. In addition, some seniors defined 'routines' ambiguously. Their expected routines were not the kinds of routines

performed by TUNS, but were the routines of an RN. Their comments and criticism also seemed to be based merely on the length of time Edwin worked as a TUNS rather than his clinical exposure, as well as his pursuit of opportunistic mentoring. In contrast, other NGRNs who had had TUNS experience from different units or hospitals did not receive such comments when they sought opportunistic mentoring or even made minor mistakes initially. The seniors had a higher tolerance and lower expectations for them because they lacked prior TUNS experience in the same unit. In the three-dimensional narrative inquiry space, Edwin's years of TUNS experience in the same unit seemed to create an illusion for some senior nurses. They expected Edwin to know how to perform tasks beyond TUNS routines and to have become familiar with the RN routines automatically over time.

Since Edwin was not the only NGRN participant who had experienced such 'high expectations', usually because of prior TUNS experience, I brought this issue to my four focus group interviews with the preceptors and other stakeholders. Similar to the seniors in Edwin's story, but contrary to the NGRNs' view, all preceptors and stakeholders in the focus group expected former TUNS to be ready as team leaders earlier than those without TUNS experience in the same unit, and said they tended to provide less support to them. Meanwhile, all of these preceptors and stakeholders except for one advanced practice nurse (APN) found it difficult to accept the NGRNs' aforementioned perception of higher expectations. This APN told a different story which seemed to increase the awareness in the focus group of how much stakeholders took NGRNs' skills for granted and held differing expectations and gave differing support for NGRNs with TUNS experience.

> A new graduate was upgraded at the opposite unit after working as a TUNS for two years [indicating satisfactory TUNS performance]. However, every colleague and the WM were disappointed with her RN performance. She came to my unit. We trained her like a new RN [gave her sufficient teaching and time]. She has been working successfully for more than two years. (SURG, APN 8, FG 2)

The reactions of new graduates transitioning from the academic setting to their first job as a professional nurse in the hospital, has been likened to shock, has as reported by Kramer (1974) and developed by Duchscher (2009) and termed reality shock and transition shock, respectively. However, there is limited in-depth understanding of

the impact of externships or TUNS programmes on the post-registration experience of newly graduated nurses in the same unit. Most studies were conducted prior to the professional registration of externs or merely focused on the retention rate of externs after graduation (e.g. Coakley & Ghiloni, 2009; Lott, Willis & Lyttle, 2011; Ruth-Sahd, Beck & McCall, 2010; Trice, Brandvold & Bruno, 2007). Therefore, this narrative inquiry's social significance lies in emphasizing the temporal, spatial and personal-social interaction dimensions of the NGRN experience, revealing the potentially negative and otherwise complex effect of pre-registration experience working as an employed nursing student on the post-registration experience in the same unit. This effect has not yet been identified in the literature. Edwin also mentioned **fault-finding and scolding**, which open up another layer of the story.

9.5 A dreadful week of fault-finding and scolding

Edwin recalled one particularly dreadful week, which left an indelible impression on him. It was either the second or third week of his stressful and frustrating first month of transition, and he found himself the target of criticism. He gave an example of being scolded badly for minor mistakes he made unintentionally in the documentation, which incidentally did no harm to the patient. It was Edwin's first time discharging patients connected with the non-emergency ambulance transfer service (NEATS) and he was unfamiliar with how to fill out the discharge checklist. That the seniors scolded him for minor mistakes conveyed their view that no mistake was tolerable or acceptable. As mentioned previously, they might have thought this way because they took his TUNS experience for granted. Even though the mistakes were not minor from the seniors' perspective, they did not seem to be able to allow space for Edwin to learn from his mistakes in a positive way, perhaps by evaluating and reflecting on the experience in guiding future practice. After being scolded, Edwin was left to self-mentor. The seniors seemed to expect Edwin to have immediate practice readiness as a technical nurse. They wanted him to have the ability to 'hit the ground running', rather than understanding that Edwin was still going through the developmental process of becoming a professional nurse (Wolff, Pesut & Regan, 2010). In the second example, Edwin was even accused of making mistakes and scolded badly before anything was actually proven or investigated. Once again, the seniors did not try to understand the reason behind any 'mistakes',

while Edwin, because he occupied a lower echelon of the hospital hierarchy as an NGRN, did not have the assertiveness to advocate for himself and clarify the misunderstanding. It is important to note that the cumulative effect of all the fault-finding**,** scolding, and misunderstanding was so overwhelming that after the incident Edwin immediately started crying. The following story further shows the negative impact of scolding on Edwin's performance.

> I encountered the most impressive experience the second or third week after registration. I became the target of criticism. I was assessed in different aspects, particularly administering oral and intravenous medications, which were tasks that I did not perform as a TUNS. Someone assessed my drug knowledge and found me unacceptable because I failed to give her the correct answers about some medications that I hadn't encountered before. This person became fastidious and started finding fault. Minor mistakes became intolerable. For instance, we had a discharge checklist and one of the items is removal of the patient identity bracelet. That was my first time handling a patient discharged home by NEATS. [The identity bracelet is usually removed upon discharge except in the cases of those patients who are discharged home by NEATS, for doing a further identification check. Edwin was right in not removing the bracelet.] However, I had ticked 'yes' instead of 'no' on the checklist. Someone noticed this and I kept being scolded for it.
>
> Another incident occurred when I was administering eye pre-medication for a patient before eye surgery. I was not the responsible case nurse and was merely helping during her tea break [Two nurses are required for counter-checking and administering any eye medications in Edwin's unit]. Someone had prepared some eye medication in a kidney dish on the counter in front of the cubicle. It was time for administration. A senior colleague approached the cubicle before my arrival. This senior lifted up the kidney dish and placed it bluntly on the counter again in front of me and started scolding.
>
> 'Why don't you check carefully? Nobody will take pity on you if you make a mistake. You don't even know about the simple three checks and five rights? Don't you check carefully?'
>
> There are two different eye medications which look very similar. The patient required medication B but the kidney dish contained only medication A. This was the reason I was being scolded. However, I had just arrived at the cubicle and I was not the staff person who had prepared the medications in the kidney dish. I know about the three checks and five rights, but I hadn't started checking yet. I wondered how she could be so certain that I was the one who had prepared medication A. After being scolded and after the patient received the eye drops, I went to the washroom and cried. I was there merely to offer help. I felt very aggrieved and strained, particularly over what I had encountered that week. I felt very depressed and unhappy each day after work. I wondered why the week was 180-degrees different from what I had expected. Before registration, my colleagues reassured me that they would

> offer help when I became an RN. After registration, the support they provided was different from what they promised. Why I was expected to know everything once I became an RN? I am not a superman. I worked mainly on the routines when I was a TUNS, not all the paperwork or the routines of an RN. I think I was being pushed too fast.
>
> [*Bernice: How did you get through the week?*] I isolated myself within my assigned cubicles each shift. I kept checking everything many times. I was very scared about making any mistakes since I knew I would be scolded, which would lead to further fault-finding. I kept checking and rechecking repeatedly. I became very 'psy' [psychotic]! I kept thinking and worrying about missing something and making mistakes even after work. I couldn't sleep well throughout that week. The stress was overwhelming. That's how that dreadful week went. (Edwin, first interview)

Edwin used the terms 'someone' and 'a senior staff member' when he was telling his story in the first interview, which gave me the impression that the incidents involved several senior nurses. It was in the second interview, when Edwin was sharing the experience of the next generation of 2011 NGRNs in transition, that he disclosed that all the incidents in this dreadful week involved only one female nursing officer, Miss E. This telling of the secret story showed me that we were developing greater trust in our participant-researcher relationship.

Neither Edwin nor I could identify the reason behind the dreadful events of that week and the purpose of scolding, especially when only negative rather than positive effects can be observed. Edwin was distressed and kept making simple mistakes, despite his attempts to alleviate his distress by not committing mistakes that would trigger scolding by checking and rechecking the kardex as well as all the related documentation. These negative consequences on the target occurring as a result of workplace aggression have also been reported in the literature (Farrell, Bobrowski & Bobrowski, 2006; Hutchinson, Vickers, Jackson & Wilkes, 2006; McKenna, Smith, Poole & Coverdale, 2003). Physically, Edwin suffered from insomnia. Psychologically, he experienced distress, frustration, depression, and a sense of being wronged after being scolded. These psychological stressors influenced his work performance the next day when he had to work with the same senior again. The use of criticism, scolding, and finding fault create stress, affect performance, and increased the potential to commit mistakes and errors. They seem ineffective as methods for mentoring NGRNs for good work.

9.6 Pushed to take care of critically ill patients and caught in a dilemma

After the second month post-registration, Edwin was assigned by his WM to take care of patients at the central cubicle near the nursing station, where the more critically-ill patients with more complex problems and conditions were placed. Prior to such a patient assignment arrangement, Edwin's WM had initiated a 'discussion' with Edwin. (The quotation marks convey my uncertainty). He had verbalized his practice unreadiness and his inability to take on more advanced responsibilities, such as taking care of critically-ill patients. One particular worry was that he might overlook any early signs of deterioration. He was concerned about failing to identify his knowledge deficits through self-mentoring and address them through opportunistic mentoring, which might end up doing harm to the patients. However, his WM did not listen seriously to his concerns about unreadiness. She might also have assumed Edwin was at a state of semi-readiness in which he could recognise his knowledge deficits and seek necessary help. She claimed that there was no alternative, due to severe staff attrition. A total of six new joint staff had just been found to fill the vacancies, including four new graduates, both RNs and enroled nurses [ENs]. This situation seemed to repeat the pattern he had experienced in his first month, in which the unit's story of a nursing shortage once again prevented and disempowered Edwin from receiving the expected and promised support, or preceptoring. Edwin's WM claimed that she would ask other senior colleagues to support Edwin and told him to seek help whenever necessary. The story was complicated further when some other senior colleagues assumed Edwin had reached practice readiness because he had been assigned as a central cubicle team leader. It is unlikely that the promised communication between the WM and other senior colleagues actualized. The following story shows how Edwin was caught in a dilemma and experienced great tension, and how the promised 'discussion' and 'reassurance' were nothing more than empty rhetoric.

> I was assigned to work at the more central cubicle beginning in the second month post-registration. My WM found me and had a discussion with me [about this] once. I had voiced my worry that I couldn't manage and recognise the cues [early signs of changing and deteriorating conditions], which ultimately would harm the patient. Both patients and I would suffer. My ward manger said, 'There is no alternative. We only have limited

> manpower. We may not be able to provide you with the support that other new graduates have. I let you have your own team [of more critically-ill patients] and I will find other staff to support you. Speak up if you encounter any problems [Chinese: 有啲咩嘢就出聲啦].' However, I was not sure if my WM actually asked the other colleagues to give me more support. I found that the perspectives of some colleagues were different from that of my WM. Some nursing colleagues said, 'That the WM assigned you to be the team leader indicates that you have attained the necessary competence. Why can't you perform satisfactorily?' I was caught in a dilemma [Chinese: 夾咗係中間]. I felt very stressed and worried. I felt that I was being continuously coerced and pushed [to shoulder heavier responsibility] [Chinese: 好似俾人屈，擺上枱咁]. I did consider leaving my current unit at that moment. I wondered whether others in a new ward would treat me as a new graduate, by providing more protection and consideration. In the end, I chose to stay, because after such a long time I had developed a sense of belonging to the unit. There were still some nice colleagues who offered me support. However, some others had high and unreasonable expectations of me. (Edwin, first interview)

Edwin expressed a great sense of helplessness about being forced and pushed to shoulder heavier responsibility that was beyond his practice readiness, especially in the absence of the 'promised support' he had expected from his seniors. Such ineffective communication and Edwin's expectations did not match the created tensions might have diminished his trust in his WM. They created a feeling of betrayal that led to his intention to leave his workplace. It is consistent with the literature that a clear outline of role expectations is a crucial factor in making a positive transition experiences for new graduates' and cementing their intention to stay (Zinsmeister & Schafer, 2009). Meanwhile, the feeling of being 'pushed' is similar to the sense of being 'rushed' reported by NGRNs in another study, who had to live up to very high expectations and eventually felt frustrated and overwhelmed (Thomas, Bertram & Allen, 2012). In the end, Edwin chose to stay, since he had made connections with his current unit and received support from some other nursing colleagues.

9.7 The meaning of support that enhances intention to stay

While Edwin had an intention to leave because of the high expectation that he would work beyond his practice readiness and competence, the support provided by some senior nurses was crucial in influencing him to stay, limited though it was. This led

me to invite Edwin to share the following story about how grateful he felt to be supported by his senior colleagues. The following storied experience shows how Edwin's idea of support includes protection and advocacy in situations where he was likely to be scolded by senior doctors, teaching, creating space to learn from mistakes without scolding and fault-finding, and working - and even resting - as a team.

> There were times when I made [minor] mistakes, such as forgetting to sign the care plan. At least some colleagues would not photocopy the documentation immediately or report/publicize me for [minor] mistakes [Chinese: 唔會篤你出黎]. Some seniors were very nice and supportive. For instance, a senior saw I was scared to call the senior doctor to clarify something. She picked up the phone and dialed straightaway despite the potential risk of being scolded by the senior doctor. She didn't mind and apparently was helping me. Some others were supportive in teaching me when I didn't know something. When my colleagues were free after finishing their work, they asked if I need any help. They didn't mind helping with the bedside care or even documentation. We were covering for each other. I can still remember a busy shift when I had no time for tea break. Miss E helped me to write the kardex so that we could have our tea break together. At that moment I felt really glad that she didn't abandon me to enjoy the break herself. There were also times I missed something or made mistakes, which were discovered during handover. They [those supportive senior colleagues] wouldn't scold me straightaway or complain that I left work for them to follow up. They understood that I didn't know something [and made the mistakes unintentionally]. They said 'It's ok! I'll help you manage. If you encounter a similar situation in the future, remember to confirm with the doctor.' This approach was more comfortable, yet I found that the experience made an impression on me and that I would remember it in the future. Although someone who scolds might still help me afterward, I still feel discouraged because I had done so many things right and had only forgotten one. When they scolded me, I was worrying so much about whether I had made other mistakes that I didn't listen. (Edwin, first interview)

It is interesting to note that Miss E, the nursing officer responsible for much of Edwin's dreadful week, offered help to Edwin when he was busy. This made an impression on him. It shows some of the complexities of Edwin's experience: some seniors had a low tolerance of mistakes and tended to scold him whenever they discovered them, but they were also willing to help when the NGRNs were overloaded. There were some other colleagues who were also supportive and helpful, as well as willing to teach and allow NGRNs to learn from their mistakes. The scolding and fault-finding culture likely influenced Edwin when he compared both approaches. He found that the supportive approach of using gentle reminders was a more effective way of teaching and preventing errors as compared to scolding and

blaming**.** Two of the stories told above - about not photocopying documentation with his mistakes as well as risking being scolded by the senior doctor when making a telephone clarification - revealed the complexity of the scolding and fault-finding culture in both intraprofessional and interprofessional collaboration.

9.8 Scolding instead of opportunistic mentoring

In Edwin's unit, whenever the senior nurses and doctors discovered mistakes, they immediately scolded the person whom they thought was responsible, even though it might not be the appropriate person. For instance, Edwin felt bad for another new graduate who made a mistake and forgot to book the OGD for a patient who required re-insertion of the nasogastric tube for tube feeding. The graduate was scolded by both surgeons and senior nurses until she burst into tears. Although she had made a real mistake, Edwin wondered whether the senior nurses had taught her the comprehensive procedures of booking the OGD and preparing the patient, before she was being pushed to work independently on her entire team of patients. Edwin disagreed with the senior nurses' and the surgeons' use of scolding, but understood that the senior nurses should also have the responsibility to oversee the work of new graduates. There were also times that documentation containing mistakes, such as giving the wrong intravenous fluid, was photocopied and passed around within and even across different surgical units. The nurses would then gossip about the documentation to a point that the new graduates were stigmatized. Edwin said, 'It seemed that no chances were given to new nurses [to learn from their mistakes]' (Edwin, first interview).

Edwin's storied experience made me ask several questions about the use of scolding. 'What is the purpose of scolding?' Is it for patient safety or nurse education, or is it merely the expression of emotions? Scolding, without identifying the reason for the mistake and without providing the necessary opportunistic mentoring, is ineffective for preventing future mistakes. Rather, it puts patient safety at risk. This use of scolding can be viewed as the 'person approach' rather than the 'system approach' of responding to mistakes (Reason, 2000). Edwin seemed to advocate a system approach to mistakes that identifies the root causes of the problem. NGRNs were being 'pushed' to work beyond their practice readiness, with inadequate orientation,

teaching, and supervision. Also, the opportunistic mentoring that NGRNs needed to ensure patient safety, sustain good work in nursing, and learn from mistakes, was not provided.

Another layer of the system problem was revealed when Edwin continued by telling two stories, recorded below, of receiving hand over from the other new graduates and he was being scolded immediately for missing work or mistakes made in that previous shift. Scolding Edwin and the nurses who were taking care of the patients at the moment the mistake was discovered, rather than finding the responsible party, was once again a person approach instead of a system approach. The involved NGRNs did not have the necessary opportunistic mentoring to learn from their mistakes. Very likely, they would simply repeat the same mistakes and jeopardize patient safety again later. This not only makes the nurses feel as though they are treated unfairly, but can damage peer and collegial relationships. Furthermore, it has not been shown that self-mentoring is adequate to ensure good work when NGRNs are 'pushed' to take on responsibilities beyond their practice readiness and competence. It was also uncertain whether peer mentoring can take place effectively when NGRNs are handing over to each other. It is easy to miss important information and jeopardize patient safety. Following are some examples.

> <u>Scolded by the nurse in-charge for another's incomplete work</u>
> Occasionally, I felt very depressed at work and I wondered if it was related to too many new graduates [four] at my unit. I received a handover at the beginning of my afternoon shift from another new graduate. Our handover started at 2pm and was completed at 3pm. The handover between the shift in-charge nurses had finished earlier than ours and the afternoon in-charge started checking my team's kardex. She realised there were many incomplete tasks and missing things. For instance, the diet of the patient had changed, but the corresponding signage wasn't. Blood investigation was prescribed; however, no blood label was available for the phlebotomists, which they needed to collect blood. She accused me and thought the mistakes were my fault, since they were identified in my shift. I felt very unfairly treated, since I hadn't even had a chance to follow-up from the handover.
>
> <u>Scolded by the surgeon for another's fault</u>
> There was another time I was scolded by a surgeon at the beginning of another afternoon shift. He threw the kardex of a patient on the table, which made a loud bang, and demanded, 'Why hasn't the blood been collected?'
>
> I checked and realised that no blood investigation had been requested and no blood label was available for blood collection. I intended to ask the house

> officer (HO) to collect the blood immediately. The surgeon shouted: 'What is the point of collecting the blood now? I am off-duty now. Who is going to interpret the laboratory results? What is the point?' He made another pound on the table again and left.
>
> That's the problem when there are too many new and inadequately supported graduates. Someone is ultimately going to suffer. I wondered if it was possible to prevent new graduates from handing over to each other, although I know it was unlikely. If a junior hands over to a senior, at least there is an extra layer of coverage. Perhaps the missing part will be identified and resolved by the senior colleague. Otherwise, some information is certainly going to be missed in a handover between new graduates who are less vigilant. Patients are going to suffer. For instance, one patient had a medical consultation during hospitalization and a medical follow-up was offered to the patient after discharge. If a new graduate is in charge of it and does not know how to book a follow-up with another department, the patient will miss the suggested medical follow up. This can be prevented by simple double-checking, so long as the kardex is not thick. However, some patients with a long stay can have a kardex with more than 290 pages. How can I know important information without a clear handover, when the prescription may have been written ages ago? The staff member who discharges the patient and signs the discharge checklist will be accused of making the mistake. However, it is unfair to accuse the case nurse at the moment when the mistake is discovered, rather than finding the original reason for the mistake. This is another problem of having too many new graduates and too few seniors to cover them. (Edwin, first interview)

The continual use of scolding, without providing any opportunistic mentoring, creates issues for patient safety. Equally important is how the nursing shortage, which is the default situation for most units, has prevented NGRNs from getting the necessary mentoring for good work. NGRNs are being pushed to work beyond practice readiness with inadequate preceptoring. They are even handing over to each other, which decreases the chances of getting opportunistic mentoring for good work from the senior nurses. NGRNs are left to self-mentor or peer-mentor, with the result that they remain unaware of their knowledge deficits.

9.9 The WM's practice of tolerating violence and using scolding

As seen earlier in the section discussing Edwin's ideas of what support should be, it was not uncommon for Edwin and even his senior nurses to be scolded by the surgeons when they were asking for clarification or reporting abnormalities related to patient care and safety. This was quite similar to the experience of new graduates reported in the literature (Dyess & Sherman, 2009; Etheridge, 2007; Thomas,

Bertram & Allen, 2012). The following story not only shows the problem of uncivilised communication between some doctors and NGRNs, but also how the WM was aware of their scolding and yet implicitly tolerated them. The surgeons' scolding seemed to be an acceptable way to communicate. This led to another unit story about how the WM disempowered Edwin from clarifying or speaking up for patient safety. The WM might have wanted to empower Edwin to speak up for patient safety, saying 'Our surgical department welcomes jumping calls [to inform the more senior doctors].' However, her 'reassurance' was again mere rhetoric. She did not actually teach him with whom to inform or clarify with or when to do so, and left Edwin with more uncertainty. Edwin was once again dependent on his senior colleagues and his own initiative to get opportunistic mentoring. It was up to him to learn about analyzing the situation and patient's condition to determine the urgency, severity, complexity, potential risks of rapid deterioration, whether a HO or surgeon was needed to manage the situation, and whether to inform the doctors. This need to self-mentor was especially acute in the first few months after professional registration. The communication style between nurses and surgeons is highly dependent on context rather than explicit and direct statements, in order to attain interpersonal harmony. This style has been identified as part of high-context cultures, which are commonly found among Chinese and other Asian cultures (Xu & Davidhizar, 2004).

> At the beginning I had difficulty working and communicating with the doctors. I didn't know their preferences, while they did not welcome further clarification. However, there were times I needed further clarification. I remember there was one time an intravenous antibiotic was newly prescribed at 8pm. The prescribed frequency was every eight hours and the hospital guidelines stated that the time for administering intravenous medication should be scheduled at 12am, 8am and 4pm. The medication order was prescribed in the middle of the usual medication time, and I could not administer it one hour after the scheduled time. Therefore, I had to clarify with the doctor to see if he wanted to give the antibiotic late at 12am or whether a stat prescription was needed. When I asked the doctor, 'Would you like to give a stat dose? Would you like this stat dose to be treated at 4pm or 12am [intended to clarify with the doctor for his preferred time for the next regular dose]?' He exclaimed, 'Hey! Ridiculous! [Chinese: 有無搞錯] You have to ask me about this? You don't know how to manage it yourself?'
>
> There were times I faced a dilemma in reporting abnormalities, for example, if a case changed condition, I wondered, 'Who should I inform, the HO or the surgeon?' Sometimes, the surgeons may think the problem is simple and that

> it was unnecessary to inform them. ‘That’s only a slight drop in blood pressure. You ask the HO to manage it. You don’t have to inform me. I am busy at the operating theatre now!’ At other times, they scolded ‘Ridiculous! [Chinese: 搞錯呀!] The case is in shock, in obvious septic shock. Why didn’t you inform us? Why did you inform the HO only?’ A blood pressure drop could have different causes and I don’t know how to manage them and whom to inform. I always faced such a dilemma. There were times we perceived that a patient needed immediate attention, while the surgeons didn’t. My WM always reminded us that our surgical department welcomes jumping calls, even to the COS [Chief of Service – the department head]. She asked us to feel free to make a jump call. She even asked, ‘Are you scared to be scolded? Even if you made the call wrongly, you will only be scolded. You will not die!’ However, they [the surgeons] would remember! Some mistakes couldn’t be made. I was told [by my WM] to do something one way, but I believed that it would be wrong to follow it. As a junior without adequate support, I wondered whose ‘right’ was right. I was quite dependent on my senior at the beginning. When I felt any uncertainty, I consulted my seniors for their advice. If I was still feeling uncertain, I asked others for a second or third opinion. In case I really called the wrong person and was accused, at least I [could explain that I] had consulted my senior’s opinion. Then I would not be accused of making decisions and acting on my own [Chinese: 自把自爲]. (Edwin, first interview)

I continued reviewing the hospital document about communication between nurses and doctors. In order to reduce human errors and foster a culture of patient safety, the Hong Kong Hospital Authority (HA) (2014c) has adopted the Crew Resource Management (CRM) programme, which originated in the aviation industry. It is a one-day interdisciplinary classroom-based programme that teaches CRM concepts and outlines three safety tools for health care professionals of varying tenure, seniority, and specialties. The key concepts emphasized in CRM include communication, teamwork, situational awareness, assertion, problem solving, and decision making (Table 9.1).

Table 9.1 Components of the CRM programme piloted in Hong Kong HA (2014c)	
A one-day interdisciplinary classroom-based CRM programme teaching about CRM concepts & three safety tools for nurses, doctors & other allied healthcare professionals of various tenure, seniority & specialties.	
Crew resource management (CRM)	Originated from the aviation industry, to reduce human error & foster patient safety culture. Emphasized key concepts: communication, teamwork, situational awareness, assertion, problem solving & decision making
Modified early warning score (MEWS)	A bedside clinical scoring system that is based on data derived from four physiological readings (systolic blood pressure, pulse rate, respiratory rate & temperature) & one observation (level of consciousness) to identify patients at risk of deterioration & urgent need for active intervention & enhance communication between healthcare professionals for safe & effective patient management with excellent outcomes.
ISBAR	A standardized team communication approach, (i.e. identify, situation, background, assessment & recommendation for patient management) to facilitate handover of patient's conditions in a multi-disciplinary setting in a succinct & concise manner.
Assertion model	Get person's attention (Make eye contact, face the person & use person's name); Express concern (Focus on the common goal i.e. patient safety & quality care); State problem clearly & concisely Propose action (Understood by all parties); Reach decision (Escalation by jumping rank if necessary)
Note: MEWS is taught to all staff but it is not used in some specialties	

Though new graduates may need concrete guidelines at the beginning of their clinical practice (Benner, 1982), it is important to emphasize that the CRM programme and the three other safety tools would not have taught Edwin what he needed to know about reporting abnormalities related to patient safety, such as what symptoms to spot, when to report them, and to whom. Also, the standalone one-day training tended to oversimplify the complex and ingrained scolding culture among doctors (Fawcett & Rhynas, 2014).

Besides CRM, another strategy that might improve interprofessional collaboration and eliminate scolding and other uncivilised behaviours is interprofessional education. Reciprocal teaching might open up avenues of mutual respect and communication, allowing professionals to see problems from the perspectives of other professions (Reeves, Perrier, Goldman, Freeth & Zwarenstein, 2013). This would also open up space for further inquiry.

The scolding culture of Edwin's unit was influenced by his WM. She acted as a negative role model by scolding all of her subordinates, including nurses and HCAs. Meanwhile, the practice of photocopying documentation that had mistakes for the purpose of finding fault was prevalent not only in Edwin's unit but the entire surgical department.

Edwin recounted an incident about his unit which he was not personally involved in. His unit was being accused by another unit for administering the wrong intravenous fluid, with the photocopied documentation form presented as evidence. After receiving the accusation, Edwin's WM scolded all the nursing staff during the afternoon handover session for making the mistake. However, Edwin's senior colleagues soon discovered that the accusation was false, because the patient had already been transferred out to another department at the time the wrong fluid was supposedly given. The WM did not apologize for scolding her staff before thoroughly investigating the charge. This irresponsibility on her part diminished the trust between her and her subordinates. The practice of scolding whenever mistakes were discovered was miseducative and shaped the scolding and fault-finding culture in Edwin's unit.

9.10 Ambiguous feedback from WM

Edwin's WM used to have regular discussions with him and other new graduates to evaluate their performance. She advised Edwin to follow proper practices instead of skipping steps and cutting corners [Chinese: 散手]. Edwin did not know exactly what she was referring to and asked for further clarification. However, she could not give any concrete examples to substantiate her criticism and asked Edwin to reflect on his own. This was one more example of ineffective communication between Edwin and his WM. In most of these situations, the opportunity for learning and improvement was wasted and Edwin was left with more uncertainty and frustration. His uncertainty led him to believe that his WM was judging him based on three incidents that had happened within the previous two weeks, during his fourth or fifth month post-registration, in which he was misunderstood, wrongly accused, and scolded. This made Edwin feel unfairly treated. One of the incidents was the one mentioned above when his WM scolded all the staff for a mistake involving the intravenous

fluid made by another unit. In the second incident, Edwin was wrongly accused and became a scapegoat when a patient's documentation was found missing after a blood transfusion procedure. He was scolded badly on the telephone after his night shift and was targeted merely because he had contributed a paragraph to the nursing documentation while helping the busy night in-charge. He was not allowed to explain the situation. In the third incident, Edwin was scolded publicly at the nursing station and wrongly accused for forgetting to sign on a Dangerous Drug Administration (DDA) record book. The accusation was merely based on the oral report of the shift in-charge. However, since Edwin was a male nurse, it was impossible that he would have been giving an intramuscular injection of medication to the buttock of a female patient as part of the hospital policy. Just like the WM, the senior nurses who wrongly scolded Edwin did not apologize for the false accusation and left him feeling aggrieved. Overall, Edwin was very concerned about how the gossip and false accusations in these incidents would affect his reputation and his competence as a nurse. He worried that others would lose trust in him in their subsequent collaboration and gain a negative view of his personal image and professional identity.

> Criticised as acting 'improperly' by the WM without concrete evidence
> At times my WM called us for a discussion. This time she asked me to be more proper and not cut corners [Chinese: 散手]. She said, 'I am not very strict. Don't try my patience!' When I tried to clarify by asking her what particular incident she was referring to, she replied, 'You should understand what I mean… You should reflect on your own.' I prefer more direct communication. I wondered whether she was falsely accusing me again, and whether she was referring to three incidents, the blood transfusion, DDA, and IV fluid incidents, which were not my fault! I felt that I was being treated very unfairly. I felt worried that, as a new graduate, I was being treated as a scapegoat [Chinese: 硬食]. (Edwin, first interview)

9.11 Lack of support and appreciation and merely blaming and scolding

Edwin shared two further concerns about making mistakes in general. Although these stories are not about his direct experience, they show the importance he placed on receiving proper support and appreciation instead of blaming and scolding, especially when the mistakes in question were not directly attributable to any NGRNs or nurses. The first story is about a patient fall incident that took place when

Edwin and some other colleagues were resuscitating a different patient in another cubicle. The second is about a medication incident in which an NGRN administered a medication to a patient who had a history of being allergic to that particular group of medications, since the NGRN was following a prescription that the doctor had made incorrectly. The stories not only convey Edwin's stress as he perceived a sense of unfairness that a nurse is to take full and sole responsibility for all mistakes made, even when the medical profession is also involved, but also his story of mentoring.

> <u>Rescuing one patient's life, but being blamed for a nearby fall incident</u>
> It was common in my unit for documentation [with mistakes] to be photocopied and used to criticise colleagues behind their backs. This increased resentment and paranoia [Chinese: 人心惶惶] among my colleagues and morale became very poor. I found this very wearisome and stressful. No matter how well I was doing, I was *not appreciated*. All mistakes were [presumed to be] my responsibility. I always imagine a situation that could one day happen to me. If a patient falls while I am resuscitating another patient in another cubicle, [if] I [were] the case nurse, I will be blamed for the fall incident and responsible to report the incident. It's my mistake for not keeping a close observation of the patient, that's why he fell. I am blamed for every mistake, without consideration of how hard I had been trying to save another patient's life. 'Busyness is not an excuse' is what I was frequently reminded of by a senior. I know busyness is not an excuse, it is a *fact*! I am *not appreciated* for rescuing the life of one patient. Everyone focuses on the other patient who fell. (Edwin, first interview)

> <u>Can't you think critically? Why follow the doctor's prescription?</u>
> The responsibilities of a nurse are too overwhelming. I felt unhappy and unfairly blamed as a nurse. We are responsible and are blamed for any mistakes made by doctors or by other unlicenced supporting staff. A nurse made a mistake and administered a medication that the doctor prescribed, but it was a medication that the patient had an allergy to. However, it [the scolding] made it seem as though the doctor had made no mistake by prescribing the wrong medication. 'It is the doctor's prescription, but it's not necessary for you to follow it. Can't you think critically? Why don't you clarify?' It was all the nurse's fault for administering the medication. (Edwin, first interview)

Scolding, blaming, photocopying documentation with mistakes, gossiping, and stigmatizing staff who make mistakes, both within and across units, have only negative impacts. NGRNs and seniors do not engage in opportunistic mentoring to learn from and prevent future mistakes. The use of scolding and other disruptive behaviour merely creates extra stress and even panic, and perpetuates a poor workplace atmosphere, which increases the likelihood of committing mistakes and

affects patient safety and care quality. Edwin discovered this during all the stressful experiences he had being scolded by Miss E, especially during the dreadful week when he made many mistakes despite rechecking his work multiple times. Such effects have also been reported in the literature (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). Furthermore, errors in the health care landscape usually involve system breakdowns and have multiple responsible parties within the health care team. They are rarely caused solely by individual providers (Bell, Delbanco, Anderson-Shaw, Mcdonald & Gallagher, 2011; Reason, 2000; Sharpe, 2000). A system approach to error should be used along with collective accountability, which means accountability should be shared by the whole health care team, instead of finding individuals accountable and then addressing the problem only through scolding, as mentioned earlier. Scolding and individual blame, in fact, happens contrary to the directives of the Hong Kong HA, which advocates a non-punitive and non-blame response to error and values learning and continual improvement (HA, 2010b; HA, 2011b). Further inquiry might be valuable for exploring how to learn constructively from mistakes in a more positive and appreciative way.

9.12 Mentoring myself

Edwin was aware of and had verbalized his practice unreadiness because he knew might not recognise problems with prescriptions and signs of patient deterioration. However, he was not heard by his WM, who pushed him to work beyond his capability. It is doubtful that adequate support, teaching, or preceptoring was provided for Edwin and the other NGRNs to give them the 'critical thinking' they needed to recognise the many 'traps' in the workplace. Edwin indeed found that nursing was difficult enough that he could not depend solely on the teaching of others in the health care landscape to learn it.

Edwin had been mentoring himself in different ways in learning to be a good RN, as evidenced by his various storied experiences. First, to prevent making mistakes and being scolded by others, Edwin maintained a high state of vigilant and always took a crucial pause in the frantic workplace to think before taking any action. He used an image of a yellow traffic light signal, the few moments between red and green lights,

to describe such a pause. This tactic is further discussed in a later section when he expounds more on his story of mentoring.

> I would check everything carefully. I don't want to be disqualified or lose my licence. I felt very worried and scared at work. I would always stop and think before doing anything, like thinking at a yellow light. (Edwin, first interview)

Our second interview followed up on Edwin's development of high vigilance to recognise any cues of changing or deteriorating patient condition. He perceived that his motivation to learn and improve was driven by his intention to get through the transitional period and work as a nurse. He also attributed it to his empathetic practice of putting himself in the shoes of the patient or their relatives, who would not want his family to receive substandard care. This shows how much Edwin used self-mentoring in pursuit of good work.

Documentation and handover were two other challenges in Edwin's initial stage of transition for which he did not receive any teaching from his own preceptor. The second way he self-mentored was by referring to the documentation made by his senior colleagues, especially those who were regarded as 'professional' by other senior colleagues. He analysed them to identify the acceptable format of writing documentation for each of his patients in each shift of work.

Since Edwin's experience with delivering the end-of-shift handover had been limited through working as a TUNS, he was still very unfamiliar with the process. He could not identify the main points among all the information that must be handed over to his colleagues, especially because he was still unfamiliar with the management of the various kinds of diseases. In a third strategy of self-mentoring, he paid attention to the prescribed treatment of each of his patients and compared and contrasted the treatment of patients with the same diagnosis in order to learn about standard disease management processes and pathways at his unit. Edwin also saw the benefit of spending extra effort remembering all these standard treatments. He took almost six months to accumulate the necessary practical and experiential knowledge to understand what was happening to his patients. He was also able to deliver a clearer handover by anticipating and connecting the diagnosis, investigation, and treatment efficiently. (Edwin, second interview)

After accumulating such a significant amount of personal practical knowledge over six months about managing different situations, Edwin gained so much confidence that he exclaimed, 'I finally feel I am working like an RN.' He felt very confident giving his rationales for his actions and no longer worried about being scolded. He could distinguish emergency from non-emergency situations and could recognise critical incidents for which he ought to notify the surgeons instead of the HOs. He recognised signs of deterioration and felt confident and secure about reporting abnormalities and collaborating with his medical counterparts. This transition neatly followed the process of learning to think like a nurse identified by Etheridge (2007). It is interesting to note that Edwin perceived the doctors' attitudes becoming more positive toward him. They had a higher tolerance level for his questions. Evaluating this observation in the dimension of personal-social interaction dimension, Edwin thought that his confidence may have been apparent in his tone of voice on the telephone, which made the surgeons have greater trust in his judgment and reporting. He also thought that the change could be related to the length of his stay: his face was now recognisable to the surgeons as a member or an insider of the surgical department. Edwin's two years of TUNS experience did not make much of a difference in that respect, since his TUNS routines were mainly basic nursing care. He had rarely interacted with the surgeons then, and the rotation system meant that HOs and surgeons were always moving among different units (Edwin, first interview).

9.13 Telling and retelling his nurse story with patients

As he gained more personal practical knowledge and confidence, Edwin's interactions with his patients changed gradually as well. He recounted many satisfying and memorable experiences caring for his patients and making differences in their lives. These educative experiences, together with his reflections on his experiences, served as a kind of mentoring in restorying his nurse story and sustaining good work in nursing. As Edwin recounted his nurse story with his patients, he seemed to be reliving and retelling the story and discovering new possibilities for patient communication, psychological care, and the unique influences that nurses can have as part of the health care team.

Patient communication

Before restorying, Edwin perceived patient communication and education to be difficult, and he perceived himself as disappointing different parties when he minimized interactions with his patients. He gradually changed to become more willing to communicate and provide appropriate education to his patients, and his relationships with them evolved as well, which led to further educative experiences.

> I found it difficult [to take care of patients] at the beginning, when I had a knowledge deficit. Even something as simple as nasal bleeding after an operation, I wondered whether there were any nuanced differences from the general management of usual nasal bleeding not after surgery. I didn't know about surgery and its complications, the reasons for and common sites of bleeding, and ways to stop nose bleeding. The patient kept waiting for my care and didn't realise that I was a new graduate. My seniors expected me to be able to manage it because I had some years of experience [working as TUNS]. I felt anxious and I disappointed everyone. There were also times I didn't know how to respond to patients' questions. I wanted to answer but I was worried about giving the wrong answers. I hesitated to talk too much with patients, because I worried about eliciting more complex questions that I couldn't answer. Sometimes I simply asked [the routine question], 'Is there any problem?' and [hoping that the answer would be 'no'] I walked away if they had no complaint. I was scared because I had inadequate knowledge. I didn't have any confidence in conducting patient education.
>
> After almost half a year, I gained more confidence at work. Patients could also sense my confidence in our interactions and my explanations [in response] to their questions and they would be more willing to talk with me. The [patient-nurse] relationship became closer rather than superficial. (Edwin, first interview)

Although the importance of patient communication is always emphasized, it is not uncommon for nurses in both local and overseas hospitals to complain about all the documentation, paperwork, and other non-nursing work that take up their time – time which could be better spent caring for patients and understanding their needs and concerns (Choi, Pang, Cheung & Wong, 2011; Mooney, 2007; O'Shea & Kelly, 2007). I observed nurses who pushed the cupboard containing all the patient kardexes to the nursing station to complete the necessary documentation, avoiding contact with patients and relatives, and minimizing interruptions. I agree that excessive paperwork acted as another element in the surgical unit's story that disempowers nurses from performing good work in nursing. In contrast, I was glad

that Edwin and I share a very different nurse story, as both of us made good use of our time to chat with our patients while completing our routine work, such as documentation or wound care. Both of us were interested in our patients' conditions, feelings, and needs at the moment, and we found that our leisure conversation soon extended to our patients' histories, families, and work. While he could not avoid the unit story, Edwin saw the time for documentation as a protected time and an opportunity for undisturbed conversation rather than an obstacle to communicating with his patients. When I considered patient communication from the place dimension, I realised we both were comfortable finishing our work in the in-team place, that is, with our patients, rather than choosing to do so in the out-of-team place, that is, away from patients, which creates distance from and a boundary with patients and their relatives. Edwin's ability to multi-task, including finishing documentation while having a conversation with his patient, also demonstrates his level of competence (Edwin, first interview).

Edwin continued recounting his stories of how he established close and rewarding patient-nurse relationships. He felt very happy about and was impressed by the fact that many of the patients under the specialty of ear, nose, throat who were discharged a long time ago and readmitted later still remembered him by name when they did not remember the names of other nurses in the unit. Edwin was quite proud of himself. He perceived that patients remembered his name because he was a good nurse. Appreciation from patients had unequivocally influenced him to relive and retell his nurse stories. Appreciation was very important to Edwin, as he had commented earlier about his need for appreciation and support from his WM and senior nurses. The following two stories are about two patients, one in a long and the other in a short hospitalization. Edwin made a difference in their lives, and so they remembered his name. Although the stories are a bit long, they reveal the importance of having patient conversations and communication to build relationships, meeting the holistic needs of patients, as well as bridging the communication gap between patients and doctors. These two stories also reveal the good work that Edwin performed by accompanying and supporting his patients while they were most vulnerable, and contributing to their decision-making process leading to big differences in their lives. The strong satisfaction, motivation, and empowerment that

he gained from the patient interactions were important in sustaining his passion to continue performing good work.

A happy story of making a difference

Some of the patients may be newly diagnosed with cancer and have no hope initially. They looked very down and wondered whether to proceed with the operation. Recently, we had a patient who was readmitted. He is about sixty and had a sudden onset of stridor and shortness of breath one day. His larynx became so narrow there was only 3mm of space left. He was then diagnosed with cancer of the larynx. He refused surgery because he thought it would cause too much suffering even though he probably would die [without it]. He had no intention of surviving and suicide prevention measures had to be taken. I kept chatting with him during this time. I learnt that he had many children. His main concerns were about being unable to talk and dying after the operation. He was told by the doctor that he wouldn't be able talk after the total laryngectomy and tracheostomy. He became very pessimistic, since nobody had educated him about other ways of communication. He also had very traditional [outdated] perceptions and thought that people died from surgery very easily. You only had to show him that the reality was very different - and there was the solution. I reassured him that although the operation carries a degree of risk, it is quite frequently conducted. I referred him to the patient support group. After interacting with patients who had had a similar experience, he realised gradually that people could talk after surgery with the use of different devices. He worried about financial problems and I referred him to the medical social worker. Gradually he realised that the outlook was not so bleak and that there was more hope after the operation. He would most likely survive for a longer period of time. After ongoing repeated discussions, he finally agreed to the surgery. After the operation, he told me something. I don't know if it is true or not, but I smiled and was happy from the bottom of my heart. 'I kept thinking of you during the operation!' he said. Every time I met him afterward, I felt very happy. He was readmitted later for consultations with the speech therapist and placement of a provox [speaking device]. He told me after the placement of the provox that he named his cat the same name as my nickname. Seeing him recover without a recurrence of the cancer, changing from a person without hope and requiring suicide prevention measures to a happy person with everything settled, changing from a pessimistic to an optimistic person - made a deep impression on me. The effort was worthwhile. (Edwin, first interview)

Another satisfying story of making a difference

[This patient] was in his mid-forties and his chief complaint was hemetemesis and per rectal bleeding. He was diagnosed with hepatic cell carcinoma with gastric and esophageal varices. His conditions were so complicated that I didn't want to handle him initially. He knew that he needed both a blood transfusion and an embolisation to stay alive, but he refused any treatment. I started chatting with him [hoping to persuade him]. He told me that he had no relatives or friends in Hong Kong, but had returned for a short visit. He had owned several restaurants in Canada before, but had lost them all during the financial crisis. He found no hope in living. I was very worried about him. On

> the one hand, I understand that he would suffer if the varices ruptured. On the other hand, I was thinking selfishly, worrying about how difficult it would be to manage such an emergency situation [because I had no resuscitation experience]. After some persuasion, he agreed to have a blood transfusion. Our understanding increased with more communication and we found a chaplain to counsel him. After about two days, he changed his mind and agreed to the embolisation. I believe he realised there was still hope. When I received him from the operating theatre and transferred him to another surgical unit, he said 'Thank you very much. Without you, I guess I wouldn't do this.' He held my hands and we said goodbye to each other. When I returned to my unit and saw his empty bed, I felt very emotional. I helped this person and ensured that he would be safe afterward. I felt happy seeing him glowing with health and radiating vitality after the operation. It is enough to see a simple smile. (Edwin, first interview)

Psychological care

Edwin's narrative history indicates that he was attracted to nursing by its stable salary and helping nature. However, he had never imagined how much he would be able to help as a nurse and the kind of satisfaction that it would bring to both the patients and himself. He learnt about psychological care at the university, but the teaching seemed to be merely talk to him (Chinese: 紙上談兵). He found it difficult to grasp and apply in practice. His ongoing educative experience interacting with his patients influenced him to relive and retell his story of nursing to realising the power of communication in nursing to address psychological needs and make a difference in his patients' lives. (Edwin, first interview)

9.14 Preceptorship is important but also abstruse, vague, and insubstantial

I continued to explore Edwin's stories of good work in making a difference in his patients' lives and focused on his perception of good work in nursing. Edwin saw that the workplace culture and positive role models were important in motivating all health care workers, both nurses and doctors, to do good work and treat their patients well. Edwin also recognised the importance of preceptorship, but regrettably in reference to his own experience, he used two Chinese idioms: 'abstruse, vague, and insubstantial' (Chinese: 虛無縹緲) and 'in name only' (Chinese: 有名無實) to describe his experience of inadequate preceptorship. Edwin was aware of the hospital's story of preceptorship, which he described as well-stated on the hospital document in 'black and white' (Chinese: 白紙黑字). The official document shaped

his initial perception and expectations. According to my document analysis, the hospital authority expected preceptorship to be an individualized teaching/learning arrangement in which the preceptor is immediately available in the clinical setting to act as a role model and to provide guidance to the NGRNs (HA, 2006).

Three layers are embedded in Edwin's stories. In the first layer, Edwin perceived the preceptorship as a relationship in name only because he rarely worked with his assigned preceptor, even though he was being pushed to quickly take a role as team leader beyond his practice readiness. His preceptor was not 'immediately available', as required on the hospital document. From his storied experiences, he was mentored through the teaching of several different senior colleagues at his workplace, through educative experiences with his patients, and by teaching himself during his transition and learning to sustain good work in nursing. He appreciated all of his colleagues' effort, teaching, tolerance, and contribution to his learning. However, he said twice in the second interview that he disagreed with his assigned *preceptor*, who seemed to take the credit for his learning, satisfactory role transition, and good performance.

The second layer was related to his vision of an ideal role model for good work in nursing. Although his preceptor was willing to teach and share her knowledge with him, Edwin had issues with her overemphasis on work efficiency and her expectation that her co-workers follow her pace when she worked as the shift in-charge. The following story shows that his preceptor treated the patient admission procedure as a task to be completed as quickly and efficiently as possible. This is in contrast to Edwin's approach, which was to utilize the procedure as an opportunity to understand the patient at an interpersonal level, especially since admission is the initial contact with the patient. This also leads me to wonder whether nurses who work in extremely stressful environments are being cared for when they are expected to stay vigilant and perform at maximum competence all the time.

> My mentor and I both value the importance of being efficient, but we are different in one important aspect. I understand that one needs to be highly efficient when managing critically-ill patients. However, when the patients are stable, I wonder why we have to finish the patient admission procedure in *two minutes*. Right after we received the fax from the AED, she has filled out all the admission forms and documentation. She simply fills in the vital signs of the patients after their arrival. I wonder whether such efficiency is

necessary. (Edwin, second interview)

The following story also revealed that Edwin was disappointed with his preceptor's overreaction and disagreed with her way of practice, yet still followed her pace and work style to minimize interpersonal conflict and maintain a harmonious work relationship. He and his colleagues tolerated his preceptor's low emotional quotient and her tendency to lose her temper easily whenever the ward was messy and she was overloaded with work. Edwin's way of coping, practicing tolerance and seeking harmony, has also been adopted by new graduates in Taiwan (Lee, Hsu, Li & Sloan, 2013). This kind of conflict management might be influenced by the values and ideology of Chinese society (Xu & Davidhizar, 2004). However, his preceptor's displays of temper might not only be due to her stress levels but might also have been indicative of her limited trust in Edwin. This, combined with the stories of their repeated conflicts, shows why a nominal preceptorship does not easily evolve into mentorship, much less friendship (Mills, Francis & Bonner, 2007, 2008a, 2008b). Such a relationship has the potential to shape Edwin's future experience with mentoring as well, in emphasizing the importance of self-mentoring.

> I know everyone was very busy yesterday. My patient had just been discharged and a new patient was admitted who was being assigned to the same bed. I said, 'The bed has not been tidied yet!' as the HCA was busy with the napkin round at about 3pm. My mentor [also the shift in-charge] shouted, 'Do I have to help you in tidying the bed? Can't you push [the patient] aside for the admission procedure first?' Everyone went silent. That's her character. Whenever she is busy, she loses her temper. I felt very hurt [because of her response]. I dislike it [her temper and personality]. We [Edwin and his preceptor] have known each other for such a long time, and if I was unwilling to work everyone would know it. Then, a HCA said, 'Just ignore her! I will help you tidy it.' Everyone knows that's her character and way of practice. She feels dissatisfied if we are not following her instruction and pace. However, I really do not think her instruction was so urgent that I needed to put aside my unfinished work. Anyway, I am used to that now. I do whatever she likes, otherwise she will put on a long face if she is disappointed. I don't want the disharmony. (Edwin, second interview)

The third layer to Edwin's story of preceptorship is its abstruse, vague and insubstantial nature, revealed when considering it in the temporal dimension of the narrative inquiry space. Even though his preceptorship was not confined to his assigned preceptors but included other seniors as well, he was not receiving the expected 'guidance' as stated in the hospital document. Working within the unit's

story of a nursing shortage, Edwin and other new graduates seemed to self-mentor most of the time and received only sporadic opportunistic mentoring, while they were pushed to work beyond their practice readiness with high expectations to work competently without making any mistakes. Otherwise they would be scolded, without even opportunistic mentoring afterward. This might be the important layer of mentoring that had been taken-for-granted in leading to NGRNs' stressful and overwhelming transition experience, as well as their high attrition rates

9.15 Perpetuating abstruse, vague and insubstantial preceptoring

My second interview with Edwin was intended to track his ongoing experience beyond his first year of practice and examine any change in perspective since our first interview at six months. At the beginning of the interview, Edwin said that the unit atmosphere had worsened, with increased scolding since the incoming of next generation of nurses, new graduates in 2011. He and his colleagues were disappointed with the performance of all but one of the four new graduates. All four had been scolded, not only by Miss E but by other senior nurses and APNs as well, in the previous seven months. Edwin was afraid that the seniors' frustration, anger, and stress would also lead them to scold him. In order to avoid being scolded, he tried to stay out of their way by keeping himself in his cubicle. However, the experience was like the dreadful week he had experienced earlier. The following four bullet points summarize Edwin's story of one of the new graduates. She was described by Edwin and his colleagues as having 'no common sense' and being scolded for putting patient safety at stake with unsafe practice.

- Miss E asked if she [the new graduate] would give the ACEI [an anti-hypertensive drug] to a patient with systolic blood pressure lower than 110 [borderline]. She [the new graduate] intended to give it. Further questioning revealed that she was confused about hypertension and the use of an anti-hypertensive drug and was unaware of the potential risk of triggering a further drop in blood pressure that could lead to life-threatening situation.
- She intended to withhold a laxative from a patient admitted with fecal loaded bowel after bowel opening twice, with only soft stool instead of watery stool.
- She had been giving IV fluid and local application medication to the wrong patients. While some incidents were stopped in time, others were not that had to be reported to the incident reporting system.
- She simply waited for the HO to book an urgent computer tomography scan without checking closely, which in fact delayed an urgent investigation.

These stories of substandard and dissatisfactory performance by careless, irresponsible, and ignorant NGRNs are not unique to Edwin's story, but were frequently reported by other NGRN participants, as well as preceptor and stakeholder participants in all the focus groups. They experienced great frustration, tension, and stress trying to mentor NGRNs about patient safety, especially when they were often working and overlooking one to four NGRNs per shift. This seemed to be the dominant discourse of NGRNs, not just in the local context but reported in overseas literature as well (e.g. Chernomas, Care, McKenzie, Guse & Currie, 2010; Clark & Holmes, 2007; Duchscher, 2009; Feng & Tsai, 2012; Wolff, Regan, Pesut & Black, 2010). However, the crucial question is: are substandard and dissatisfactory performance simply attributed to NGRNs only?

Are problems within the system simply being taken for granted? It is interesting to note that Edwin initially found the preceptorship in 2011 had improved by making sure duties between preceptors and preceptees matched. One of the preceptors was an APN, newly rotated in, who demonstrated high motivation to teach and support his preceptee. Edwin also perceived an improvement with newly designed guidelines for NGRNs, though he later noticed that the guidelines only added some RN routines, which were meaningless for the complex transitional needs of NGRNs. Edwin expected the guidelines to include information such as the knowledge he had been receiving from supportive seniors and learning through his own mistakes and reflection, such as detailed operational knowledge about managing different procedures, ways to recognise signs of deterioration, and the usual management of different diseases. But they did not.

From a long-term perspective, the complex mentoring experiences of Edwin and the following generation show how they were disempowered by 'preceptoring' conducted within the context of the unit's story of a nursing shortage while being 'pushed' to work beyond their practice readiness. This was especially true of those with previous TUNS experience in the same unit. Meanwhile, opportunistic mentoring was limited when management assigned NGRNs to hand over to each other and using scolded whenever mistakes were discovered. Edwin was mentored for good work in a variety of ways: from his preceptor and other colleagues, through educative experiences with patients, and on his own via opportunistic mentoring and

self-mentoring. Therefore, it was doubtful that improving the preceptorship programme merely by matching duties and securing motivated preceptors would have been enough to support further generations for good work in nursing.

One important and positive point to note is that Edwin and his colleagues seemed to recognise the need for changes in mentoring for good work after seven months of scolding the three new graduates in 2011 for their unsafe practices. They were aware of the system problem of pushing them too fast to work beyond their practice readiness and competence that contributed to their dissatisfying and substandard performance. However, their WM continued to live and tell her unit's story of nursing shortage to disempower NGRNs from mentoring for good work. When another new graduate was employed after the first seven months of scolding, Edwin and all his colleagues spoke up collectively and negotiated with their WM to consider providing better support and a progressive transition. Fortunately, this new graduate was given time and supernumerary status to learn with her preceptor progressively and comprehensively, before being allowed to take on her own patient assignment. This was the story of mentoring that Edwin had been looking for throughout our inquiry. This approach may take more time but it reduces mistakes that would otherwise put patient safety at risk. I was glad to learn that this new graduate, who had been given a progressive preceptorship and support was not 'pushed' to work beyond her practice readiness, had a successful transition. Also, later NGRNs coming to the unit were no longer pushed to work beyond their practice readiness and take care of critically ill patients in the central cubicles during their first year of practice. This further shows that the unit's story of a nursing shortage can also accommodate NGRNs' needs to be mentored in good work. However, the use of scolding still seems to be an unrecognised system problem.

9.16 Being shaped or transforming miseducative experiences into educative ones

As I considered the temporal dimension, I wondered to what degree Edwin's way of mentoring younger nurses himself for good work would be shaped by his past experience being scolded and his former TUNS experience of having his knowledge taken for granted. My concern was heightened by research on the influence of one's previous mentoring experience (Darling, 1985b; Darling, 2007; Mills et al., 2008a)

and the likelihood of repeating negative preceptoring practices on later generations (Deppoliti, 2008). Would Edwin's stories of mentoring NGRNs for good work be shaped by others' stories of scolding? And to what extent would he be influenced? The story below shows that Edwin did not scold an NGRN who was unaware of her knowledge deficits and had made mistakes that could have harmed a patient. Edwin seemed to take the perspective of the NGRN and provided opportunistic mentoring by sharing his personal practice knowledge with the hope that she could learn from the mistake and manage future situations better.

> Wound without packing
> The post-operation note said to pack the wound with one ribbon gauze after I&D [incision and drainage]. She [an NGRN one year junior to Edwin] told me during handover that she could not and did not pack. [A mistake that would likely have resulted in scolding by Edwin's seniors, since the doctor's prescription was not followed.] I asked her, 'Why don't you consult the wound nurse [working on the same shift]? If the wound heals only on the superficial level, leaving a hole underneath, the patient will need another surgery.' She asked me to redo the wound dressing and packing for her before the patient was discharged home. I did not feel entirely at ease with her response [a response that was again, likely to have resulted in scolding by Edwin's seniors, since the NGRN showed no intention of taking remedial action herself. Nevertheless, Edwin tried to understand the situation from her perspective as an NGRN and her need to rest before her night duty eight hours later after handover]. When I handed over to her at night, I told her that the wound could be packed provided that the patient was placed on the side or in the prone position. (Edwin, second interview)

Edwin shared another mentoring story, included below. While support and communication were emphasized at the beginning of relationship, he found that he had to use discouragement and scolding for one particular type of NGRN to make them be more vigilant.

> Traffic signal metaphor: Different approaches for different mentees
> People who are over-confident always assume it's green light all the time. They think that everything is alright. They think they know everything and have no intention to learn. They are in danger when they act without realising they are indeed standing at a red light [indicating that they may do harm to patients and themselves]. But it is not good to always assume it's a red light either. A person will feel scared and hesitate to do anything, but when he does nothing, he will become very depressed and negative. Therefore, I think a new graduate should think with a yellow light [pause for deliberation before an action], which I had talked about previously [in our first interview].

> [*Bernice: What will you do if one day you become the mentor of these three different types of new graduates?*] I think support is important and I will begin as a nice mentor before I know which light they think with. Otherwise it is difficult to communicate. For new graduates who are green light thinkers, I would not be a nice mentor [who doesn't scold]. This type of person has to be warned harshly at an early stage, otherwise he will [wrongly] perceive the place is safe without cars and cross the road in a disorderly manner. I would hit him with a car to give him a minor injury, to help him realise the risks. I will take the position of a villain even though he will hate me for it. I will also scold him harshly even when he has made only minor mistakes [related to patient safety]. The scolding is to increase his awareness. I don't want him to get involved in any crucial events. For those who are red light thinkers, I will be a nice mentor. I will allow him to work on his own without helping him in order to let him realise his ability, but I will be available and help him if needed. This type of person cannot be censured too harshly, otherwise he will become even less confident in his care [of patients]. It's simple for yellow light thinkers. Making friends with them is adequate, as they are cautious enough. However, I realise that graduates now are often in either one of the extremes and are seldom yellow light thinkers. (Edwin, third interview)

Meanwhile, Edwin also recounted a story about one of his peers whom he perceived as over-confident and a 'green light thinker'. This NGRN improved considerably after being censured and harshly scolded [Chinese: 俾人啄得好緊要] by other seniors. Edwin's use of scolding in mentoring seemed to be shaped by his past experience. However, it seemed to contradict his experience being scolded by Miss E during the one 'dreadful week', which caused Edwin into considerable distress and affected his performance. At that time, he continued making minor mistakes, despite checking and rechecking many times. Upon member checking, Edwin articulated that his prior negative experiences motivated him to strive to provide better support to his younger generation. He also identified one of the ways he was different from Miss E, who assumed that every NGRN would benefit from continual and indiscriminate scolding, even scolding for minor mistakes that would have done no harm to patients. The key was not the tone of her voice but the lack of on-the-spot mentoring that made the experience very negative and not conducive to any kind of educative learning. In contrast, Edwin might use a *serious* tone or scold *but* in context. He emphasized increasing his mentee's vigilance to ensure patient safety, through communication, discussion, reassurance, and support. Though his professional development led him to identify the substandard care provided by the younger generations, by thinking differently and taking the mentor perspective, he retold a different story of mentoring for good work with his empathy and reflection.

The following story shows how Edwin once again self-mentored in transforming a miseducative experience into an educative one. He focused on learning how to be a better mentor and support NGRNs without taking their former TUNS experience for granted.

> I am glad that I didn't perpetuate my negative experience on the new graduates. I was scolded throughout my transition and did not receive mentoring, and I wish that new graduates didn't have to grow in such an environment. [*Bernice: You are not only a good nurse but also a good mentor!*] I hope so. Empathy is needed to be a good mentor, by setting aside one's identity as a senior and thinking from the perspective of new graduates. I can do that by reminding myself of my past experience. For new graduates with former TUNS experience in the unit, I wouldn't expect them to have knowledge beyond the TUNS routines and provide less support. I understand that they might not have encountered the RN routines. Thus I would teach them without assuming they know RN routines based on their years of TUNS experience. I think all new graduates not only need teaching, but the willingness of others to understand their needs. Whenever I finish my work, I take the initiative to see how I can offer help to them. I think simply asking 'What can I help you with? You are welcome to ask any questions, even stupid questions, and I won't laugh at you' can enhance their sense of security at work. I also take the initiative to teach them something that may be interesting for them to learn.

The above stories captured how Edwin makes sense of mentoring based on his experience. It is important to note that his meaning of mentoring for good work is beyond task orientation or functional relationship, hence beyond preceptoring as defined in the literature (Billay & Yonge, 2004; Hodgson & Scanlan, 2013; McCloughen, O'Brien & Jackson, 2006; Meier, 2013; Mills, Francis & Bonner, 2005; Morton-Cooper & Palmer 2000; Stewart & Krueger, 1996; Yoder, 1990). Edwin emphasized relationship building and psychosocial component in his stories of mentoring with the use of 'not only teaching', 'communication', 'understand their needs', 'empathy', 'support', and 'enhance sense of security'. These are attributes of mentoring (Mills, Francis & Bonner, 2005; Morton-Cooper & Palmer 2000; Stewart & Krueger, 1996; Yoder, 1990). It might be time for hospital administrators to pay attention to the needs of mentoring among NGRNs and search for possibilities to foster mentoring in the complex and dynamic health care landscape. This may not only enhance NGRNs competence, but also their satisfaction, sense of belonging, and intention to stay, and even more affirmed professional identities. All these may ultimately lead to better patient outcomes, not merely physical patient safety, but a

more holistic one (Fawcett & Rhynas, 2014). Furthermore, not only good work for the benefit of patients and their families now, but also in the future by helping to retain nurses who are committed patient advocates to mentor future generations.

Edwin also believed that there was a gender issue in mentoring NGRNs, since some female senior nurses tended to scold, make malicious photocopies, and gossip about the NGRNs more than the males. In fact, Edwin said that the prevalence of malicious photocopying had decreased, which might be related to the addition of two new male APNs. His story of gender issue is as follow.

> [*Bernice: Scolding, malicious photocopying, and gossiping were rather prominent in your unit. Is that related to the admission nature of your unit? Patients are later transferred to other units, so are mistakes in documentation more likely to be exposed?*] I don't particularly think so. But perhaps it a gender issue related to some female seniors, as the two new male APNs won't [do those things]. (Edwin, text messages on 23 June 2015)

Similar gender issues were reported in another research study, which concluded that the presence of male nurses made the ward environment more balanced and less bitchy and malicious (Kelly & Ahern, 2009). This opens up room for further inquiry into the relationship between scolding and mentoring for good work, and gender. While gender may be part of Edwin's story of how the seniors related to the NGRNs, I still wondered if the transfer nature of the unit may have contributed to the seniors' rigorous attention to the documentation and performance of the junior staff, as reported by Edwin, since the patient care they provide and their reports would be reviewed by the units receiving their patients. Hence how much the institutional story is at play in the image of the unit as perceived through staff performance in the unit and others' stories of the unit remains an issue.

Edwin's retelling of how he mentored NGRNs for good work reveals another important factor to consider when preparing mentors, an endeavour which should not be limited to skills or learning styles (e.g. Hatler, Stoffers, Kelly, Redding & Carr, 2011; Owens et al., 2001). It was important for mentors to transform past miseducative experiences into educative ones, by reflecting and seeing situations through the perspectives of others, and see new possibilities to relive and retell a different story of mentoring NGRNs for good work. While Edwin had a great

capacity for self-mentoring to retell his stories, and thus an advantage in mentoring others himself, other nurses might not have the same capacity and might be more likely to be shaped by miseducative experiences, especially when they do not have the opportunity for conversation and reflection with others. It is important - given the complexity of mentoring NGRNs for good work via preceptoring, opportunistic mentoring, peer mentoring and self-mentoring, and given that fact that NGRNs with only one year of experience are expected to mentor their younger colleagues - that preparation of mentors for good work should begin at the end of the formal hospital supportive programme.

9.17 Continuing to walk upstairs for a brighter future

By the end of our final interview, Edwin had demonstrated some changes. He was even more motivated to learn, and was open to and positive about new challenges and uncertainties. The changes were shaped by two main educative experiences. The first one was related to studying a part-time master degree programme. He articulated satisfaction and excitement in applying his knowledge to his clinical practice by helping a new graduate recognise early signs of deterioration in abnormal cardiac rhythms. He felt pride when he shared his newly acquired knowledge with his younger colleagues, who raised questions that many senior nurses did not know. This further reveals the mutual benefit of opportunistic mentoring. The second educative experience was a successful resuscitation drill for which he received important appreciation from his seniors and colleagues. He continued self-mentoring for further professional development and made use of his communication skills and empathy to make a difference in his patients' lives. With increased personal practical knowledge and confidence, he felt more comfortable handling greater responsibilities such as being both a night and daytime in-charge nurse and welcomed the uncertainty of rotating to other specialties. He used the following metaphor of walking upstairs toward a brighter future to capture the sense of his ongoing professional development, which is a fitting close to this chapter.

> Walking upstairs is a good metaphor. So far, I am moving smoothly upward step by step with growth. I hope that by the end of the steps there will be a bright path. I think I was quite depressed when I met you for our first interview. I believe you could observe that I become more and more positive as time went on, changing from being unwilling to do [anything] to motivate

> to do and learn [everything]. After two years, I am happy and satisfied. I want even faster development, maybe an exponential growth curve. I hope everything will be smooth and successful. (Edwin, third interview)

9.18 Postscript

When Edwin read over and member checked this interpretive account of him as an NGRN, he agreed with my writing and then, as a nurse who now had five years of experience, shared some reflections about patient appreciation. Though he continued self-mentoring to sustain his stories of good work in the midst of other miseducative experience, his retelling of the stories of patient appreciation seemed to reveal another layer of his self-mentoring, further growth, and professional development. Edwin developed firm stories to live by and no longer depends on appreciation from patients and other seniors to buttress his nurse stories. He mentors himself for good work in nursing. He has gained increased confidence in self-mentoring guided his conscience and internal values. His comment below also shows that, even though the narrative inquiry ends while the NGRNs' careers continue to develop, the inquiry itself opens up space for further exploration into the different uses of self-mentoring. It encourages NGRNs to sustain good work in nursing, both for themselves and for others, as they continue beyond their first two years of clinical practice.

> You have captured everything I want to say. Reflecting on the past, I think I am more mature now and can do as my heart desires [Chinese: 做嘢隨心咗]. In the past, I felt a great sense of satisfaction whenever patients appreciated my care. I needed the recognition as a novice. Now, I think that it is my responsibility to take care of patients, whether I receive their appreciation or not. Provided that I can really help them, I feel no qualms upon self-examination. (Edwin, text message on 19 June 2015)

CHAPTER TEN

NANCY'S STORY – AN NGRN IN THE SPECIAL CARE BABY UNIT

10.1 Introduction

Before my alarm had rung, I was awakened by the hot sunshine streaming through the window beside my bed. While I giving my audio recorder, information sheet, consent form, and interview guide a final check before my first meeting with Nancy, an NGRN of the SCBU [special care baby unit], I flashed back to my experience in paediatrics. When I was in kindergarten, I used to spend my school holidays, Christmas, and Easter at the hospital. My right hand was always connected to a line that caused me pain. A bag of fluid hung over a stand, and I could only play with my toys using my left hand. When I was in secondary school, I visited my younger brother at the paediatric unit. He was frequently hospitalized for asthma. When I was a nursing student, I had less than a month of clinical experience at the paediatric unit. During that time, I came across with children suffering from cardiac, respiratory, digestive, or epileptic disorders. But what does the SCBU looks like? How can a new graduate adapt in such a specialty with the limited paediatric knowledge learnt from a three-month module in an undergraduate nursing programme? Will her experience be very different from that of my other NGRN participants? Without much experience in taking care of newborns, will I experience any difficulties in understanding her stories? Will this affect the building of a relationship between us? On my way to the hospital where Nancy works, I kept thinking about all of these questions… It was almost the scheduled time. I received the phone call from Nancy. 'I am at the entrance to the hospital', she said. 'Me too!' We then recognised each other as people who had actually been waiting at the entrance for a while. We laughed and started walking towards a private meeting room outside her workplace.

Since our first interview at noon before her afternoon shift, Nancy and I have had many interactions. Nancy was the eighth NGRN participant whom I met in the first round of interviews. She was referred to me by a senior RN who had assumed the leadership and supervisory role as a shift in-charge at the paediatric unit. When our interview or dialogue began, I soon realised that Nancy was articulate, reflective, and highly motivated to learn and improve herself. My questions and worries were soon relieved. Nancy became one of the NGRN participants with whom I had the most frequent email conversations between our half-yearly interviews. She even shared some of her writing on weblogs. Through our email conversations about ongoing events in which she was involved, which were apparently not parts of the regular

flow of life and which triggered many of her reflections, we gradually established a close and trusting participant-researcher relationship. This chapter is an interpretive account of Nancy's ongoing educative and miseducative experiences (Dewey, 1938), reconstructed chronologically in her preferred way of telling her stories and reproducing her chosen metaphor. Thinking narratively about her stories, which were shown to be shaped by the competing or even conflicting stories that others lived through and related to the health care landscape that might help us to discern new meanings and possibilities for mentoring NGRNs in transition, for the pursuit of good work in nursing.

10.2 The sponge metaphor

Reflecting on Nancy's past experiences in transitioning from a university nursing student to an NGRN, it is apparent that she recognised that she was learning and growing. She used the metaphor of a sponge to describe her first two years of clinical experience. A sponge, with its characteristic of absorbency, is a metaphor of her strong motivation and positive attitude towards learning. The reason why Nancy became a sponge for learning seems to have been due to her narrative history and the awareness of her limitations of clinical experience and knowledge that she had accumulated in the four years of her undergraduate nursing programme using mainly Chinese as the teaching medium and her clinical practice was primarily at private hospitals. However, she emphasized that, unlike a sponge, she did not absorb everything indiscriminately.

> I think I am quite similar to a sponge sometimes. I am very willing to absorb. However, I am not absorbing just anything [unselectively]. I learn the good things from others. Also, I modify [what I learn] to find what is most suitable for me. [*Bernice: I also think that you have a very good attitude towards learning and an open mind.*] This is likely because I know that my knowledge is too limited… There were also times when I felt arrogant and thought that I knew a great deal, although this didn't last long. I was grateful to be told by others, including you, when I was acting in an arrogant manner. [*Bernice: Did I?*] Your email caused me to brainstorm and further improve. (Nancy, third interview)

I am glad that Nancy acknowledged my contribution to her growth and learning, or reliving and retelling of her story, by the end of the one-year study period. She had been learning like a sponge or absorbing selectively of the 'good things from others'.

However, how did she define ‘good things’? To her, did these ‘good things’ refer to good work? Who were the people from whom she had been learning selectively and who were potentially shaping her nurse stories and stories to live by? The above short excerpt seems to reveal some swinging from being humble to being arrogant. What happens during this swinging or process of awakening? These questions might be addressed by learning about her narrative histories.

10.3 Being a sponge since her time as a TUNS

Nancy had been a temporary undergraduate nursing student (TUNS) at SCBU since year three. The SCBU was situated within a paediatric unit (paediatrics for short). While the paediatric unit admits patients aged between one month to less than 18 years old, the SCBU admits newborns and pre-term babies under the age of one month. Therefore, nurses who work in the two units of the same ward require different kinds of specialised knowledge. During the time of our first interview, they were rarely rotated to the other unit to work, even though the two units were managed by the same ward manager. This was also the experience of Nancy and the other seven TUNS, who had been staying at their assigned unit before registration. To my surprise, Nancy asked that the eight TUNS be rotated between the SCBU and paediatrics every half year. Although her request was not accepted by her ward manager, her initiative and assertiveness as a TUNS or nursing student in ‘giving a try in asking’ for more learning opportunities impressed me and led me to think of her sponge metaphor. Nancy’s story, which revealed her strong intention to learn as a TUNS, seemed closely related, but also contradictory, to her intention to leave the SCBU after professional registration.

10.4 Intention to leave the TUNS unit

Nancy intended to leave the SCBU, but preferred to work at another adult specialty for her first RN workplace. The hospital preceptorship programme stipulates that NGRNs are to have a clinical rotation or to work at two different specialties in the first two to three years after they are hired. I myself had worked at the neuroscience unit for about 23 months and then rotated to the surgical unit. However, if Nancy had worked as an NGRN at the SCBU immediately after registration, she would have

anticipated that her clinical rotation would be an adult specialty such as medical, surgical, or orthopaedic nursing. She perceived a huge gap between paediatric and adult nursing, and was concerned that the knowledge that she had gained in taking care of patients under the age of one in the SCBU would have limited transferability in her next rotation. Hence, she feared that she would have difficulty adapting to her new rotation. Before registration, Nancy had experienced difficulty in shifting between her part-time work as a TUNS in taking care of newborn babies at the SCBU during weekends and taking care of adult patients at other specialties in her clinical placement during weekdays. Her worries were also shaped by stories told by senior nurses of difficult rotations between paediatrics and other adult specialties.

Despite her strong intention to leave the SCBU and the paediatric unit, Nancy was tense from worrying about the stories that other people were telling about her and about how their attitude might change once they discovered her intention to leave. Therefore, she had been telling her nursing colleagues a cover story. She only revealed her strong intention to leave the SCBU to her ward manager and the board of administrators during the job interview that she was given when she was applying for the position of an RN at her current hospital. When Nancy was told to stay at the SCBU after registration, her ward manager told her that the reason or this was 'Difficulty in human resource arrangements'. Once again, it seemed that Nancy's voice was not being heard by her ward manager, just as it had not been when she was still a TUNS and had suggested that she and her fellow TUNS be rotated similar to between the SCBU and the paediatric unit. After receiving the 'bad' news, Nancy was extremely upset. Despite discussing her worries about her next rotation with many friends, her concerns remained unresolved. It was not until after reading a letter that she received in reply from her former university teacher that Nancy was able to see new possibilities and to regard her first RN workplace in a different light. The following story could have had a considerable influence in shaping Nancy's nurse stories and her stories to live by considerably in having a positive attitude toward learning and contains the 'sponge' metaphor.

Retelling stories about the SCBU

My former university teacher shared her years of experience in working at a home for the elderly. She learnt about management, especially when some HCA [health care assistants] intentionally created conflicts by urging the relatives of the residents to make complaints. She also provided health education to the residents' relatives. She even engaged in further studies and obtained a doctoral degree. She said 'I could learn so much at a place where it was perceived that there was nothing to learn. Why you are so worried about learning nothing at paediatrics? Attitude is the most important thing.' Ah-hah! [Enlightened] Finally I accepted the fact and determined to learn to be an RN at the SCBU. (Nancy, second interview)

Nancy's intensely negative feelings when she was struggling to leave her TUNS unit echoed my own feelings in a highly similar past experience (see Chapter 6). I, too, had voiced my intention to leave to my TUNS ward manager, the administrators, and even to my nursing colleagues, telling them about my dream of working in the accident and emergency department (AED). However, as with Nancy, my voice was not heard, and a shortage of nurses and human resource arrangements were used to explain the failure to meet our needs. Thus, NGRNs either fit in or resign. Meanwhile, TUNS are being used by ward managers as a tool to recruit and retain graduated nurses to return to the same unit whose TUNS' performance was satisfactory without much regards to the NGRNs' aspiration and nursing career path. This understanding may further silence the voices of NGRNs, and seemed to contradict the story of support for the NGRNs from the hospital support programme. It is hard to know to what extent these experiences and the feeling of powerlessness that they engender might have affected the satisfaction of NGRNs, their sense of belonging to the units, and the trust that they feel towards their superiors, all of which might be related to the problem of retention and to the undesirable patient outcomes (Aiken et al., 2002; Bae, Mark & Fried, 2010).

Nancy also said that her view of the hospital management and administrators as ignoring the needs of the frontline staff, which had been shaped by the mass media, had been reinforced. Our experience can be regarded as miseducative, as it hindered us from developing a relationship of trust with the management and administrators under a top-down management approach. Nevertheless, in sharing her story, Nancy's university teacher had revealed a new possibility to transform a miseducative experience into an educative one through authentic dialogue. This kind of dialogue or opportunistic mentoring (see Chapter 8) could be of importance in mentoring

NGRNs in transition and in sustaining good work, by guiding NGRNs to think from broader and different perspectives.

10.5 Mixed feelings when putting on the RN uniform

Putting on the new RN uniform the next morning in the same place with the same people, instead of the old TUNS uniform, gave Nancy a sense of being reborn. On the night before, she shared her excitement on Facebook. *'My first day as an RN earning an RN's salary!'* However, putting on the RN uniform also caused her to worry a great deal, feel a greater sense of responsibility, and have higher expectations of herself. Her expectations of the knowledge that she should have about what constitutes a normal condition caused her to develop the ability to identify signs of deterioration and improvement closely related to the treatment plan. This revealed her to be a nurse who felt that she should not merely follow a doctor's prescription, but should have her own knowledge to make clinical judgements.

> When I arrived there [the SCBU], even at the same setting with the same people, I had the sense of casting off my old self [Chinese: 少少脫胎換骨既感覺]. I had a strong feeling that 'I am an RN now!' Nevertheless, I felt a greater sense of responsibility and stress. I had a high expectation of myself and was nervous about not doing well. For instance, we have many neonates with jaundice who need phototherapy. The light of the phototherapy machine can be switched off at a certain number [the normal range of the serum bilirubin level]. I became nervous and forced myself to remember all of the numbers within a short period of time, whereas in the past [before registration] I had merely followed the [prescription on the] kardex. (Nancy, first interview)

10.6 The ideal preceptoring, but not a mentoring, experience

After registration, when Nancy knew which RN her ward manager had assigned to be her preceptor, she pulled a long face and was displeased. From her years of TUNS experience, she knew that her preceptor had a difficult personality, and was someone who loved delegating the responsibilities of her job to others (Chinese: 點人做嘢) and **gossiping**. Nancy was even expecting to hear **gossip** about herself from her preceptor. Nevertheless, both Nancy and I found that her preceptor's style of teaching was an ideal one in that it provided the NGRNs as much certainty as possible in a complex health care landscape filled with uncertainty.

> My mentor [here used interchangeably with 'preceptor' without Nancy's awareness of the conceptual differences in her colloquial use] worked as the shift in-charge on my first day of work [as an RN]. I was assigned to work at a room with the most stable and simple to care for newborns, such as those with neonatal jaundice or simple feeding problems. My mentor taught me that I have to be cautious, and about the various kinds of management required in each case. Although everyone might know how to manage neonatal jaundice, she still wanted to teach me once… Soon I was assigned to take care of more complicated cases, such as babies with breathing difficulties, cleft palates, or social problems, and patients who usually need to have multiple appointments for investigation and consultation. My mentor allowed me to carry out the required tasks on my own. She evaluated my performance afterwards and reinstructed me if necessary. Then, I was being **pushed** to take care of the most complicated patients who were usually transferred out from the NICU [neonatal intensive care unit]. I trembled when I was in the room. Again, my mentor taught me about the things I needed to be careful of on a case by case basis. For instance, [if a neonate has a] Ryle's tube [nasogastric tube], we have to check the markings on the tube to ensure that the tube is in place. She also taught me how to prioritise by identifying which patient is at a high risk of death and requires immediate attention when the monitor alarm sounds. This was her style of teaching on a case by case basis and identifying the important points to pay attention to. This was the mentoring that I had been looking forward to but had not found in my previous clinical practicum [as a nursing student]. (Nancy, first interview)

The preceptoring experience was recognised as ideal because Nancy's preceptor was teaching quite systematically on a case by case basis and imparting the practical knowledge necessary to operate in a clinical setting, and also going progressively from simple and fundamental cases to more complex ones. Her preceptor did not make any assumptions about what Nancy might have learnt from her previous clinical experience as a nursing student or a TUNS. What Nancy found difficult to learn with guidance, and which was emphasized by her preceptor, was recognising the salience of the situation and prioritising. Teaching for a sense of salience was also advocated by nurse educators and researcher when teaching NGRNs (Benner, Sutphen, Leonard, Day & Shulman, 2010). Thinking along the temporal dimension, Nancy's perception of what was ideal had been shaped by her narrative histories. She had received limited support and supervision from the hospital staff and her former teachers from the university throughout her clinical practicum mainly at private hospitals since her second year in the programme. Her clinical exposure and learning were limited. She regarded it as a matter of luck if the hospital staff allowed her to observe some special procedures. Most of the time, Nancy was assigned by the

hospital staff to perform basic nursing care such as monitoring vital signs, emptying urine bags, or transferring patients within the hospital. That was why the progressive and systematic process of teaching and learning had been the ideal preceptoring that Nancy had been looking forward to.

Nancy yearned to develop a close and trusting relationship with her assigned preceptor – one with psychosocial components that resembled mentoring as described in the literature (Billay & Yonge, 2004; Hodgson & Scanlan, 2013; McCloughen, O'Brien & Jackson, 2006; Meier, 2013; Mills, Francis & Bonner, 2005; Morton-Cooper & Palmer 2000; Stewart & Krueger, 1996; Yoder, 1990). Although the teaching that she received was ideal in that it was systematic and progressive, the building of a relationship between them was hindered by her preceptor's difficult personality, particularly by her tendency to gossip, which made Nancy uncomfortable. While her preceptor seemed to be clear when teaching the knowledge, skills, and thinking required of nurses, it was important to note that she was not explicit about many of her expectations of Nancy, which were conveyed indirectly through the mouths of other nurses. However ideal the teaching was, in the absence of trust or other psychosocial components, the relationship seemed to be merely about orientation and work-related teaching. Nancy shared two stories in which she ran into conflicts and had difficulty understanding her preceptor's implicit expectations.

> Asking is a way of showing respect
> I realised that my mentor had suddenly pulled a long face. I didn't know why until the other nurses told me about her expectations. She expected me to ask her instead of the others if I had any questions [if we are working on the same shift], otherwise she would be disappointed. She thinks this is a way of showing my respect to her. I felt very unhappy when I realised the level of respect that my mentor expected from me. When I was a TUNS, I used to ask questions of any nurses who were available. (Nancy, first interview)

The story above revealed that Nancy and her preceptor told different stories of a preceptee. Nancy's expectations were shaped by her past experience as a TUNS in the same unit, where she had developed the habit of asking any available senior nurses whenever she had any questions. Nancy was not aware that her preceptor had different expectations, and she continued her habit of asking anyone when she wanted to learn something. In contrast, her preceptor apparently had a different

expectation. It is possible that her preceptor interpreted Nancy's act of asking questions from other colleagues as reflecting poorly on her preceptoring; alternatively, she was unwilling to answer the questions raised by Nancy. Nancy's preceptor might have thought that she had lost face, causing her to become angry with Nancy and to 'pull a long face'. Nancy was fortunate to have been enlightened by her nursing colleagues; otherwise she might never have understood the reason behind such behaviour and her preceptor's implicit expectations. Once again, this reveals the importance of open and direct communication between the preceptor and the NGRNs to minimize conflicts and misunderstandings and to build better relationships.

The story below involves a formal medication assessment, which with supervision and evaluation could have been a learning opportunity for Nancy; however, it seems that such a formal space for learning was not being provided.

> Causing the preceptor to be scolded
> [When administering medication, nurses are expected to adhere to the principles of three checks and five rights (patient, drug, dose, route, and time). First and second checks: before and after taking the medication out from the container, respectively. Third check: Final checking of the medication against the container before disposal (HA, 2005). All medications have to be counter-checked by two nurses in the SCBU.] One day, a nursing officer assessed me in administering a vaccine by intradermal injection. I was nervous about the assessment. At the time that I intended to give the injection to the patient, the medication had not yet been withdrawn into the syringe but was still in the vial. This revealed problems in the medication checking and preparation procedure that I followed with my mentor. I was **scolded** by the nursing officer. However, she **scolded** my mentor even more harshly, **'How do you check medications with her?'** My mentor was very angry and **gossiped** about the incident, with the new hatred piled on the old [Chinese: 新仇舊怨] against me. Other nursing colleagues defended me, 'Nancy is not normally so careless.' It is a fact that I made a mistake, but she had added a great deal of her discontent to the **gossip**. Other nursing colleagues told me that my mentor expected me to counter-check with her when she was the shift in-charge, although I could actually counter-check with any available RN. She would not directly tell me her expectations, but always did so through the mouths of others. I felt bad and embarrassed. (Nancy, first interview)

There are three layers of story to the above incident. First, the nursing officer resorted to **scolding and blaming** when Nancy performed in an unsatisfactory manner during the medication assessment. It is unclear whether she scolded Nancy in order to teach her patient safety or to express her emotions. Nevertheless, the use of **scolding** seemed to reveal that Nancy was provided with no space to learn from the

process and her mistakes. The nursing officer seemed to view practice readiness as the tangible end product of a nursing education and preceptorship, rather than as a process of development, whereby a person evolves by learning from experience (Wolff, Pesut & Regan, 2010). Second, it can be seen that **scolding and blaming** could have negative impact, potentially affecting the NGRNs' transitional experience and confidence, as well as the reputation of the preceptor and the relationship between the NGRNs and their preceptors. Third, once again, her preceptor's use of **gossiping**, was an ineffective way of communicating her new expectations, but further hindered the development of a close and trusting relationship with Nancy. Ironically, other nurses seemed to be more accepting of Nancy's mistakes and to have more trust in her. Their opinion of Nancy was not affected by the **gossip** or the incident. They even advocated for Nancy and helped her to understand the shifting expectations of her preceptor. This may be why Nancy felt so grateful for the support provided by her nursing colleagues throughout the period of her transition. Their support has enabled Nancy to learn from her preceptor on how to be a nurse in the SCBU and to live through her first month post-registration.

Nursing duties in the SCBU involved taking care of neonates with different conditions, who were assigned to three different rooms. In the morning and afternoon shifts, three nurses were often assigned to the three rooms. However, during the night shift, only one member of the nursing staff took care of all of the patients in the SCBU, while in the paediatric unit there were two such nurses. In fact, working in the SCBU at night is full of challenges and uncertainty. There might be more than twenty neonates to look after. After those in the afternoon shift hand over their duties, the nurse who takes over is expected to familiarize herself with all of the patients and to give a brief report to the night nurse who patrols about 1.5 hours later. Each night, the nurse also conducts an audit on matters ranging from hygiene and infection control (such as whether the rubbish bins had been well covered) and whether the babies were wearing identification and security bracelets on their wrists and legs, to even nursing documentation. Therefore, apart from taking care of a large number of patients, a nurse has to tidy up everything in the unit in preparation for the audit. This added more stress on Nancy, who had had no prior experience in working at night in the SCBU despite her years of TUNS experience, and who was still unfamiliar with the night routines (feeding, changing napkins, administering medications, and

continuously monitoring the large number of patients). Furthermore, her routine work was frequently interrupted by new patient admissions.

10.7 Lack of practice readiness to work alone at night since the second month

Nancy was assigned to night duty two months after her registration when she had completed the paediatric Advanced Life Support (PALS) course on managing paediatric emergencies and resuscitation. She began to work on her own at the SCBU immediately after two night shifts of working as a supernumerary (counted as additional staff) while learning from her preceptor. As Nancy was without the close supervision and immediate support of her preceptor or another senior nurse, her ward manager made a special arrangement to provide 'more distant support' to Nancy, who was working alone in the SCBU. A senior nurse from the SCBU was assigned to work in the paediatric unit, not as a supernumerary, but as one who could offer help if necessary or handle complex emergencies that Nancy had never encountered before. As this SCBU nurse had her own roles and responsibilities to fulfill at night, the support that she offered was therefore a 'more distant' one. How much support she gave Nancy depended on whether Nancy and/or the senior were aware of Nancy's knowledge deficits in providing the necessary opportunistic mentoring. The following story revealed Nancy's lack of practice readiness to take a leadership role with a bed assignment. She made the decision to focus on caring for one patient, while overlooking the interests of other patients. Also, she was unaware of her knowledge deficits in seeking opportunistic mentoring from her senior in the paediatric unit, while without close supervision her senior was unable to realise that Nancy had a knowledge deficit. In the end, Nancy learnt from her mistake, which was identified by the night nurse, and through further self-study.

> <u>Dilemma of the bed assignment</u>
> I didn't know how to manage some cases at night. For instance, something as simple as admitting a baby from the AED with tachycardia and sneezing. I thought, 'Oh my God! Which bed should I assign this baby to? If I place him in a corner bed, I wouldn't be able to closely monitor his tachycardia.' Finally, I placed him near the entrance of the room for closer observation. The night nurse disagreed with my decision and worried that the baby's sneezes might be infectious and spread to the other newborns. I didn't have adequate knowledge about the issue. I could only search on the internet afterwards to validate the decision of the night nurse. *[Bernice: I believe that you have to learn gradually, because we studied little about paediatrics during the four*

> *years of nursing study.]* Yes. I learnt much of what I know only after encountering some cases and searching for information about how to manage them. (Nancy, first interview)

Nancy learnt from her experience and mistakes and saw new possibilities or gained personal practical knowledge (Connelly & Clandinin, 1988) on how to manage future situations by assigning patients to a corner space while turning up the volume of the monitor alarm. However, her experience was consistent with the problems experienced by new graduates as reported in the literature. They also experienced difficulties in finding the information information in their workplace that they needed to support their clinical judgement (Parker, Giles, Lantry & McMillan, 2014).

In contrast to Nancy's two nights of preceptoring, other new graduates or those of previous years could work with their preceptors or seniors for more than one and three months respectively, before being assigned to work independently at night. Therefore, Nancy perceived that her previous years of TUNS experience had caused her ward manager to have higher expectations of her ability to work independently at night with the 'distant support' provided by another senior nurse working in the paediatric unit. Her ward manager seemed to regard Nancy as being in a state of semi-readiness to practice, and as one who had the ability to realise her own knowledge deficits and to seek help from the 'distant support'. However, the above incident revealed that Nancy still lacked practice readiness, and might not realise her knowledge deficits. Patient safety might be jeopardized when NGRNs are pushed to assume responsibilities beyond their practice readiness with inadequate support, or are left to learn on their own or by chance.

Nancy had also worried about the possibility of failing to manage complex emergency situations that might be expected to occur at the SCBU – particularly those involving a baby born before arrival (BBA). Although Nancy had read the relevant guidelines and protocol, and different senior nurses had taught her how to manage BBA cases, the teaching seemed to be quite scattered and she felt that she could not consolidate what she had been taught. For new graduates, managing emergencies is a common stressor (Teoh, Pua & Chan, 2012; Yeh & Yu, 2009). The following story shows the difficulties that Nancy experienced in interpreting and constructing her practice knowledge in this area. It shows the importance of

experience and observation in the learning of such knowledge, which allows one to prioritise the various tasks that must be carried out. This kind of knowledge echoed with Perkins' (2006) identified troublesome knowledge.

> Stunned when admitting her first patient born before arrival
> Although there is a protocol and guidelines, and I had read and even revisited them once before the patient was transferred to our unit from the AED, I had forgotten everything when the baby arrived. I was stunned and my mind went blank, so that I didn't know what I should do first. The senior at the paediatric unit took the lead in managing the case and I provided assistance. After observing how the senior had managed the case according to the protocol, I had a better understanding of what I should do. (Nancy, first interview)

Her learning seemed to take place only after she had observed how her senior managed the BBA case, which happened almost four months after her registration. Managers and seniors should not merely make assumptions about competence based on the length of time that an NGRN has worked in the setting, because clinical exposure varies. The above story revealed that learning through observation might help NGRNs to gain a better understanding of a situation and give them more certainty to manage uncertain yet expected situations. While the Hospital Authority (HA) has promoted simulation learning in recent years (HA, 2014c), further research might be needed to explore the effectiveness of this approach for learning to deal with difficult situations specific to each unit or other NGRNs' common troublesome knowledge (Perkins, 2006) that requires practice.

10.8 Beginning to have a sense of adaptation

After experiencing her first BBA at night and getting through a busy time with high admission rates and a heavy patient load, Nancy grew to be able to manage four new admissions per night. It was not until four months after registration that Nancy began to have a sense of adaptation or a sense of comfort and certainty about her ability to manage future similar situations. At the same time, Nancy had no social life and work-life balance. She had lost ten pounds since registration. After the busy night shifts, she remained hyperactive for some time; however, once she was able to fall asleep, on her day off she slept for hours like one unconscious. I could see the psychological stress that Nancy was under. She presented psychosomatic symptoms during the time of transition, which was filled with uncertainty. I was glad that

Nancy had persevered during the toughest period of transition. However, I wonder whether better support can be provided to NGRNs so that they do not have to experience such overwhelming stress and so that the NGRN attrition rate can be minimized. Most importantly, how can patient safety be ensured? Is the shortage of nurses being used as an excuse to prevent better support from being given to the NGRNs? Are the management and administrators listening to the voices of Nancy and other NGRNs, instead of taking their previous years of TUNS experience in the same unit for granted? Below, Nancy articulated her learning needs and the support that she expected to receive.

> The support that Nancy expected from others
> I think they shouldn't have put me on night duty alone so soon. I didn't expect much. Four nights [with the support of a preceptor or senior supernumerary] would have been better. They [the ward manager and the nursing officer] assumed that I was familiar with everything and knew everything [given my years of TUNS experience]. However, I knew that was not the case. There are many things to learn even on a peaceful night. (Nancy, first interview)

The above interview excerpt once again prompts me to think of Nancy's sponge metaphor. However, it seems that she was not given adequate support and mentoring opportunities but had to learn from her own mistakes and reflections. Further listening to Nancy's story after her stage of transition, it was apparent that she continued to experience tensions and stress while her professional identity was still forming and that she was affected by the competing and conflicting stories of others. Several incidents, which Nancy shared in our email conversations, are presented in the following sections. They reveal the social significance of this narrative inquiry, which helps us to better understand the underexplored yet stressful stage of integration and the meaning of mentoring for sustaining good work in nursing (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013).

10.9 Meaning of night audit in relation to scolding

In an email following our first interview, Nancy shared a story of a night audit in which she was involved. This was also an example of her engaging in reflective practice (Schön, 1983) or self-mentoring to sustain good work in nursing. Nancy found night audits meaningless in themselves and a source of additional stress in her

initial transition to working alone at night from her second month as an NGRN. The auditing activities were also of little importance to frontline nurses in England as a means of assuring quality (Cooke, 2006). The night audit might be a traditional practice of the night nurses in the department for assuring quality; however, it seemed that no one had explained its meaning and significance to Nancy. Also, Nancy had used the word 'fastidious' (Chinese: 挑剔) to describe some night sisters. What the attitudes of the night nurses were while they were conducting the audit and pointing out the problems that they had identified is unknown. Also unknown is whether the night nurse had merely been focusing on the fine details of a situation without considering the Nancy's overall situation in relation to other developments. This led me to recall my experience in working at the AED, where one of the nursing officers had a habit of reminding me and all other nursing colleagues that we should record the respiratory rate of the patients on the AED form. However, given that all of our attention and effort was focused on resuscitating patients, documentation occupied the lowest priority in our mind. Indeed, his general reminder could have shifted our attention from the emergency situations. That was why I wondered whether Nancy's night nurse would stop criticising and instead help and support when she was struggling and fretting as the only staff member at the SCBU, or when she was heavily occupied by new admissions and the changing condition of her patients. Before Nancy retold her story, the night audit had shaped her practice as an NGRN, even as she had not been told of its meaning and significance. Gradually, by reflecting on her experience, Nancy saw new meanings and some positive aspects of the night audit, such as the importance of attending to details and nuances. On the one hand, her reflections of the meaning of good work might have been shaped by her participation in my research study and by the questions that I raised in our email conversations. On the other hand, they once again revealed that Nancy was learning like a sponge by continuously reflecting upon and searching for positive meanings in her practice.

> *<u>A story of the nursing life, the transition, and the pursuit of good work and mentoring</u>*
> *I was quite scared of some night nurses who were fastidious to the extent that they would blow aside the fur to find the blemish* [Chinese: 吹毛求疵]. *The uncovered rubbish bin and the bottle of normal saline that had been opened in the morning without marking the opening date were also the responsibility of the staff in the night shift. I was told that if the baby was not lying at the*

> *centre of the incubator, I had not been attentive enough [even though some babies move frequently]. Therefore, before they arrived for the night patrol, I felt stressed, as I bustled about making sure that every neonate was in place and everything was tidy. I was worried that I would be 'bad mouthed' by the night nurse and that negative stories about me would told by others.*
>
> *Sometime later, I found the positive side to the fastidiousness of the nurses. They helped me to pay attention to the details of caring and to pursue good work in nursing. Gradually, I developed the habit of checking each of my neonates and tidying their kardex after the handover. I realised that my job satisfaction increased when I saw that the neonates felt more comfortable and their parents sensed that they had received good care. I could even discover problems and take remedial action. There was the time that I found a needle near the hand of a neonate. I believe that it was left by the doctor after the doctor had set an intravenous access. Luckily, I discovered this before visiting hours.* ***Complaints*** *from the relatives would be a minor issue in comparison to being* ***scolded*** *by a supervisor, which would be a* ***big issue*** [Chinese: 投訴事小，被高層照肺事大]*!!* (Translated title and email from Nancy on 4 August 2011)

At first glance, the above experience seems to be purely one about seeing a new positive meaning to the night audit, which shaped Nancy's practice as a nurse and caused her to find the needle and prevent the neonate from being harmed. However, after further deliberation and discussions with my supervisor, Angela, Nancy's retold story of the night audit seems to have extended beyond the interest of her patients to that of her own. In a way, the story was alarming, as the NGRNs' stories to live by might be shaped by other stories, including how audits were conducted, how the complaints of relatives were handled by nurse managers, and other stories about her unit. Being scolded after receiving complaints from a patient's relatives or after mistakes had been noticed, seemed to have the potential to divert the NGRNs' attention from their patients' interests. Once again, Nancy's story reveals the importance of creating learning space, engaging in dialogue, and providing opportunistic mentoring for NGRNs to learn from complaints or mistakes in order to improve the quality of the care that they provide in the future.

10.10 Importance of communicating and empathizing with 'difficult' relatives

In another incident that Nancy shared in a subsequent email, she stated that although nurses were being criticised unfairly, the interests of the patients remained her top priority. This attitude seemed to be related to her ability to understand and empathize

with the patients and the patients' family. In the past, although Nancy would not completely avoid communicating with 'difficult relatives', her communication was superficial in order to decrease the risk of conflicts and complaints. The following story about a 'difficult' relative led Nancy to reflect on the importance of communication and empathy in understanding what had caused the relatives to become 'difficult' and in building a trusting and therapeutic relationship. Unfortunately, the relationship of trust was damaged by some misunderstanding created by the neurosurgeon. Nevertheless, I was grateful to see Nancy grow and mature. She thought from the perspective of her patient and the patient's relatives, focusing on the care that she gave the patient rather than on herself. She managed her sense of unfairness and other negative emotions well without falling into the trap of blaming others.

> *Hei Hei had stayed at the SCBU for a long period of time after her birth due to a developmental problem. Her mother was well known for being troublesome and for making many requests. She was always disappointed with the care that her child received, and was always getting into conflicts with the nurses. Fortunately, some paediatric nurses with good communication skills had an in-depth communication with her. After gaining a better understanding of her background [Hei Hei's physical condition had led to behavioural problems on the part of her older brother. Her mother then gave up working to take care of the children and her father became the only breadwinner, which led to financial problems], we began to change our view of her. Although we had frequent conflicts, we could feel that such 'troubles' were based on her love for her children. We all empathized with her and gradually become more willing to communicate with her. Perhaps she felt our care and we began to establish a better relationship.*
>
> *Hei Hei had hydrocephalous and required neurosurgery. Two days after the surgery, Hei Hei became hemiplegic and had diabetes insipidus. It was noted that some accidents had occurred during the surgery, which caused some damage to Hei Hei's brain tissue. However, the neurosurgeons had shirked their responsibility and* ***blamed*** *the paediatric nurses for not taking good care of Hei Hei. Her mother trusted the words of the neurosurgeons and became very disappointed with the paediatric staff. Before Hei Hei was transferred to our unit, our ward manager shared with us the story of the conflict between Hei Hei's mother and an PICU nurse, which was a complaint case that had been brought to the PRO [Patient Relations Office]. I found that it was highly unreasonable for the neurosurgeons to blame the nurses; nevertheless, I thought at this moment that providing good care was more important than explaining the truth to Hei Hei's mother. Every staff member felt a great deal of stress when taking care of Hei Hei, as her mother perceived any chitchat as sarcasm and continued to put forward multiple requests and to be in a bad mood. Yet we understood her situation. From this case, I saw the importance*

> *of communication skills, as well as empathy.* (Translated email from Nancy on 14 October 2011)

Nancy had been learning reflectively or self-mentoring to see the new meaning of communication and empathy in dealing with 'difficult relatives'. To my surprise, Nancy shared her story about her preceptor, in the recognition that the latter has had a great deal of influence in shaping the tactics that she uses in resolving conflicts and in developing her effective communication skills in handling difficult relatives. It should be remembered that Nancy did not establish a close relationship with her preceptor because of her preceptor's strange personality and penchant for gossiping. As time went by, Nancy realised that her preceptor had not only formally taught her hard skills such as prioritising and the knowledge needed to for practice at the SCBU, but had also informally shaped her soft skills. Nancy seemed to have learnt selectively from her preceptor, a positive role model, on how to communicate better to establish a relationship of trust with the relatives of patients. She did so without much awareness that she was learning until she reflected on her experiences.

> <u>The most significant impact of her preceptor</u>
> I grew to be able to manage agitated patients and relatives and their complaints. I used my communication skills/silver tongue [Chinese: 三寸不爛之舌] to persuade them to stay calm. My [SCBU] mentor has influenced me a lot in this respect that I haven't learnt everything that I can from her yet. (Nancy, third interview)

10.11 Need for preceptoring upon being rotated to another unit

About one year post-registration, Nancy and three of her SCBU colleagues, both junior and senior nurses, were assigned to work at the paediatric unit. They worked with patients of a wide age range, different diseases, and with different teams of doctors, systems, and practices. The rotation means that the nurses will be able to work at both the SCBU and the paediatric unit, which will facilitate human resources arrangements in the unit and might be related to the problem of nurse attrition. Nancy had made request to be assigned a preceptor, but her ward manager refused this request. The ward manager seemed to assume that preceptoring and systematic teaching were unnecessary, and that Nancy was in a state of practice semi-readiness and would be able to recognise her knowledge deficits and learn about patient safety by asking questions of any senior nurse in the paediatric unit. However, the

following story reveals that Nancy in fact lacked practice readiness, and was not necessarily in a position to recognise her knowledge deficits and to ask the right questions of the right people to get the right answers. This confusion between practice semi-readiness and lack of practice readiness was similar to the situation that Nancy faced when her ward manager assigned her to work independently at night beginning in her second month as an NGRN. Even though Nancy was aware of her knowledge deficit, the teaching of some seniors was rather contextualized and task-oriented, and could only be applied to the current situation. The knowledge gained was not transferable to future situations. With limited knowledge and inadequate support throughout her rotation, Nancy might not have recognised problematic prescriptions when she was assigned to take care of patients on her own. Nancy felt that the clinical rotation was stressful, an experience that has also been reported in the literature (Kelly & Ahern, 2009). Nevertheless, it is most important to note that the erratic learning that she encountered, which depended on luck, her self-mentoring, and the opportunistic mentoring that she received from others, could jeopardize the safety of patients. In fact, Nancy was not in need of a specific person to act as her preceptor, but in need of a systematic and comprehensive learning experience to give her the knowledge and certainty of how to provide safe patient care.

> I know I can ask any of my seniors. However, I don't want to [learn] by trial and error. I really want to know the entire procedure involved in managing the cases and the principles behind them. Others may not tell you the entire procedure. [*Bernice: They are not teaching systematically, but merely telling you what to do next?*] Yes. The shift in-charges were nice in asking whether I have any questions. However, I really didn't know what I did not know or what I needed to know. For instance, you have many things to do and parties to contact in admitting a case of child abuse. I had a child abuse form with me, but I don't know how to manage it. You are confused when you hear questions about whether MSW [medical social work] has been contacted and whether the form has been faxed to the special investigation team during the handover. I asked, and someone said that the MSW would manage everything and that we have nothing to do with the case. There was a time the mother had lost her temper and left with her son after waiting for the entire afternoon. I had to rush to the corridor to stop them. I felt really confused, as they asked why the MSW had not been contacted. It was then that I learnt that there were different types of MSW. One day, I had been searching for the protocol and guidelines for handling child abuse cases. My ward manager noticed that and stayed after work for about an hour to teach me about the management of such cases. I was grateful, yet I think it might have been better if I had been taught by my mentor or if there had been clearly written guidelines for us to follow. (Nancy, second interview)

Although Nancy's ward manager kindly taught Nancy after work to address one of her knowledge deficits, Nancy and I wonder if there are other forms of support that could be given with more certainty and less frustration to NGRNs in the new setting, especially in a context of severe staff shortages and limited systematic and comprehensive teaching. We explored the possibility of formulating guidelines specific to each unit, which would impart the necessary operational knowledge for managing various kinds of cases for the reference of NGRNs. Concrete and contextualized guidelines might enhance the capacity of NGRNs to manage uncertainties, hence ensuring patient safety. Nevertheless, we were aware that these guidelines alone might not be sufficient to equip NGRNs with the knowledge to manage complex and emergency situations such as the BBA mentioned earlier by Nancy.

10.12 Retelling the story of unfamiliarity for good work

Soon after Nancy had adapted to the paediatric unit after two months of struggling, she and her colleagues were assigned by their ward manager to work alternatively at the SCBU and paediatrics unit. The rotations were so frequent that they could be assigned to work in the paediatric unit for an afternoon shift, and the next morning be assigned to work in the SCBU, and eight hours later to again be sent to work in the paediatrics for a night shift. Most of Nancy's colleagues were disappointed with the new 'strange' duty arrangement, as it led to unfamiliarity and discontinuity of care. However, the unfamiliarity that was created as a result of the frequent rotations seemed to increase Nancy's vigilance of changes and their rationales, and to minimize any tendency to take things for granted or to work mechanically without seeing the meanings of her act (Kragelund, 2011). Therefore, Nancy began to identify mistakes that other senior nurses had overlooked. These educative experiences or events influenced Nancy in an important way, causing her to reflect and tell a different story of the frequent rotations. Nancy seemed to self-mentor in realising such unfamiliarity could also enhance good work. This further shaped her into being more open to change and to have a positive attitude towards learning.

> *There are many long-term cases in the paediatric unit, which leads to boredom and inertia after you have worked there for a period of time. Some colleagues could remember the medications and dosages of the long-term cases. This inertia can easily cause them to overlook problems and mistakes. As I had frequent rotations, I would not develop such inertia and could discover mistakes and problems more easily. For instance, the gastrotomy feeding had changed from 160ml, 5x/day (5 times per day) to 100ml, 5x/day half a month ago. However, I could not find the changed prescription on the kardex. Someone might have copied the dosage wrongly one day. I was glad that my lack of inertia had led me to realise that a mistake had been made. This is the advantage that I have discovered, although I am the only nurse in the paediatric unit who think so positively.* (Translated email from Nancy on 28 December 2011)

Thinking narratively, the importance of the dimension of place in sustaining good work was revealed. It potentially leads to familiarity and causes people to take things for granted, which can affect patient safety and the quality of the care that is given. Besides broadening one's horizons, clinical rotations can prevent nurses from taking things for granted and relying on assumptions that might jeopardize patient safety and the quality of care.

10.13 Importance of dialogue in learning to speak up

Speaking up is also an important aspect of intra- and inter-professional communication (Sellman, 2005), as it involves conveying to someone in higher authority specific information that might make a difference to patient safety (Sammer, Lykens, Singh, Mains & Lackan, 2010; Sayre, McNeese-Smith, Leach & Phillips, 2012). Nancy recounted a story that shed light on the subject of mentoring NGRNs for good work, specifically on the issue of speaking up for patient safety. Can NGRNs recognise cues indicating that patient safety might be jeopardized and have the moral courage to speak up? How are they supported throughout the process of learning to speak up? (Those on the first to third calls are the most junior to the most senior on-call doctors; therefore, any abnormalities are generally reported to those on the first call. In case the person on the first call cannot manage the situation, they will inform their seniors. However, when nurses disagree with the management of the doctors involved, they can 'jump call' to inform the more senior doctors, e.g., by going to those on the second to third calls.)

PET Incident

A doctor on the second call was ordered to conduct a PET [partial exchange transfusion] *for a patient during the staff meal time, when I was the only nurse in the SCBU. My mind went blank and I wondered, 'What is a PET? How does one do that?' I interrupted my colleague, a part-time RN* [who was dining in the pantry], to *tell her about the PET. Her strong reaction, and that of another senior RN from the paediatric unit gave me the impression that PET is a high-risk procedure. They asked the doctor to conduct the PET at the NICU, and even prepared the internal transfer form.* [However, the doctor on the second call insisted.] *Although I remained calm, I felt uneasy when I saw the doctor putting on the sterile gown and inserting the A-line* [arterial line]. *Fortunately, the procedure was carried out uneventfully.*

Two days later, my ward manager was shocked to discover that a PET had been conducted in the SCBU. She pointed out during the staff handover session that the nurse who was involved [that was me] did not strongly refuse to cooperate with the doctor. Without naming any names, she thought that the nurse involved [i.e., me] should have jumped call to see whether the doctor on the third call would agree to conduct a PET at the SCBU. I felt helpless receiving such 'criticism' from the ward manager. I merely knew that I had finished [assisting] the procedure without supervision and backup. Even the doctor on the first call didn't know how to conduct a PET. Everyone was following the instruction of the doctor on the second call. How could I 'jump to the doctor on the third call' when no such idea had entered my mind? I asked my colleagues of different levels of seniority for their opinion on the matter, and everyone said that they would absolutely NOT jump to the doctor on the third call, 'The doctor on the second call said, 'It's alright', which means that he had already assessed the risk, although conducting the procedure in the NICU would still have been the most correct choice.
(Translated email from Nancy on 11 June 2011 with the same punctuation)

The above story, involving anonymous **criticism and blaming** by her ward manager, was initially miseducative to Nancy's learning to speak up for patient safety. Her sense of helplessness was further intensified when her senior nurses agreed with the judgement of the doctor on the second call in telling a different story from that of their ward manager. The experience would remain miseducative if Nancy had not been learning like a sponge in self-mentoring and initiating an important dialogue with her ward manager about the incident. Nancy realised that her ward manager was **not blaming her,** but understood her lack of knowledge about both the PET and its complications, which was required for making the decision to jump rank. In fact, the baby's blood pressure (BP) did drop that night after the PET. An instance of opportunistic mentoring had occurred, in which her ward manager taught Nancy about the importance of speaking up to safeguard her patients and to protect herself, despite the risk of being **scolded** by doctors. Nancy felt more relieved and prepared

to manage future unfamiliar situations by being more assertive about having a discussion with the parties involved on speaking up to a higher authority. The miseducative experience became educative in shaping Nancy's story to live by and her nurse story to safeguard and advocate for her patients. The importance of dialogue was revealed once again after Nancy's conflict with her preceptor, who used indirect communication to show that her expectations of Nancy had changed.

When Nancy thought about the **criticism and blame** that she received from the ward manager for not 'jumping call', she seemed to adopt a personal approach to the incident; however, a different picture can be revealed by adopting a system approach (Bell, Delbanco, Anderson-Shaw, Mcdonald & Gallagher, 2011; Reason, 2000; Sharpe, 2000). The incident took place prior to the implementation of the five-day work pattern (see Chapter 6) for which the accumulated holidays of each staff member have to be cleared. That may be the reason why one senior nurse was called off, leaving a part-time nurse and Nancy, who had only one year of experience in taking care of 16 neonates and who assumed that nothing special would happen. However, this assumption could have placed Nancy and her patients at risk, as there did not seem to be any spare capacity in terms of human resources to manage any contingencies and uncertainties. Thinking of collective accountability (Sharpe, 2000), it was questionable whether adequate support and empowerment had been provided before Nancy was **blamed or criticised** for not speaking up for patient safety. How could an NGRN speak up by jumping rank to inform the more senior doctor when she had inadequate knowledge of procedures such as PET? Once again, had the ward manager confused a lack of practice readiness with semi-readiness? Blame and criticism without important dialogue or opportunistic mentoring did nothing to help Nancy learn to speak up and advocate for her patient, but merely diminished her trust in the management and shaped her stories of them.

> Nurses had been complaining about the difficulty of getting through the busy shifts with a poor mix of skills and a shortage of staff. However, many managers ignored these complaints and reframed their management as acceptable, since as no particular incident had occurred during those shifts. They are working in a mediocre fashion and simply letting things drift [Chinese: 得過且過]. (Nancy, third interview)

10.14 Importance of receiving support from others when speaking up for patient safety

Nancy's above educative experience in learning to speak up echoed another educative experience in which she was taught and supported by other nurses and a doctor on the second call when she spoke up for patient safety. The incident took place just after Nancy had begun to work on her own at night in her second month. Her neonatal patient needed an intravenous infusion. After several failed attempts, the first doctor, who was notorious for his bad temper, started using foul language. Nancy saw that he was doing harm to the patient by inserting the needle perpendicularly into the flesh instead of into the veins. She did not know what to do, but knew that she could not look on without taking any action. She ran from the SCBU to the paediatric unit to report the incident to her senior nurses. They were also angry and immediately suggested that Nancy 'jump call'. The doctor on the call knew that his junior had once again lost his temper. He took over the responsibility of taking care of the neonate and asked Nancy to come to him that night instead of to the doctor on the first call if necessary. (Nancy, first interview)

Though Nancy did not know how to manage the situation without prior experience of speaking up for patient safety, she advocated for her patient by refusing to remain silent, but instead seeking help from others. Her sense of uneasiness in witnessing the doctor doing harm prompted her to seek opportunistic mentoring for patient safety and to speak up. The experience was educative, as Nancy was supported when she spoke up and her voice was heard by her nursing and medical colleagues. The educative experience seemed to encourage Nancy to gain more knowledge, courage, and confidence to advocate for her patients in the future, which has been recognised as an important individual factor in the complex process of nurses speaking up for patient safety (Okuyama, Wagner & Bijnen, 2014).

10.15 Speaking up for a hypotensive neonate but not being heard

After two educative experiences, another incident occurred in which Nancy's medical and nursing colleagues seemed to care more about the documentation than about providing patient care, which caused her to reflect deeply about conscience and good work. Nancy spoke up for a neonate with marginal hypotension, which can be

an early sign of deterioration and resolved easily by inserting an arterial line and giving a saline bolus. Her voice was not heard, nor was space provided for discussion with a group of doctors. Instead of measuring the neonate's BP when the infant was calm, they continued to tap her foot to stimulate crying in order to achieve a higher and '*satisfactory*' BP for documentation without any resorting to other interventions. It was fortunate that Nancy was not negatively affected by this incident. She self-mentored in persisting to speak up. She also self-reflected so as to transform the miseducative experience into an educative one by identifying discontinuities in values, self-affirming her professional identity and the importance of conscience, and resolving to address the actual needs of patients in the future.

> *An incident about a hypotensive little baby*
> *A neonate was found to have marginal mean blood pressure, even after measurements were taken over all four limbs and the result rechecked. The problem could easily be resolved by inserting an arterial line and giving a saline bolus. I informed the group of doctors. They 'claimed' that the sphygmoanometer was inaccurate, though it was most accurate for pre-term patients [according to Nancy's personal practical knowledge]. After changing to another sphygmoanometer, instead of measuring the BP when the neonate was calm, they tapped the neonate's foot and stimulated crying to achieve a higher and 'satisfactory' BP for documentation without other intervention. Astonishingly, the incoming nurses followed the 'management' of the doctors for the entire afternoon shift. The condition of the neonate as represented in the documentation appeared to be 'stable', but this was not the case. The acts of the medical and senior nursing colleagues could not be reflected in the documentation, but were immoral. That night I kept close observation of the neonate and persisted in reporting the abnormal vital sign to the doctor. The neonate was finally stabilized around midnight after the saline bolus was administered. The incident caused me to reflect on the importance of conscience in nursing and the meaning of documentation. Since then, I have become more thoughtful about using the documentation to reveal the actual needs of patients. (*Translated title and email *from Nancy* on 12 September 2011*)*

In contrast to the PET incident, in the above situation Nancy had the knowledge to identify the issue of patient safety and the moral courage to speak up for her patient; however, her voice was not heard, nor her act supported. I could feel Nancy's pain and tension when she witnessed her nursing colleagues, who used to be her positive role models, following the 'management' of the doctors. It is possible that a personal-social dimension was involved in the interaction, as the act of her senior nurses seemed to be shaped by their perception of the doctors' intention, rather than

the patient's actual condition. This incident shows that individual conscience might be inadequate when speaking up for patient safety, especially when Nancy was a nurse on the lowest echelon of the hospital hierarchy, while team conscience is needed.

10.16 Disempowered to speak up and do good work by the doctors' sacred stories

Unfortunately, the above miseducative experience was not an isolated incident. Several paediatric doctors seemed to develop a habit of procrastination (Chinese: 拖字訣), which could jeopardize patient safety, especially as neonatal and paediatric patients are more vulnerable than other patients and incapable of protecting themselves due to age and diseases (Vaartio & Leino-Kilpi, 2005). Nancy perceived that laziness was the reason behind the habit of procrastinating even at the expense of patients. Ironically, such procrastination was implicitly encouraged by the tolerance or 'silence' of the most senior doctors in the department, the consultants. Nancy felt that these consultants were also irresponsible. In her view, they were not acting in the best interests of the patients, but enjoyed playing the 'doctor-nurse game'. Meanwhile, they advocated communicating and operating within a hierarchical structure, which disempowered Nancy from speaking up or having her voice on patient safety heard. It is important to note that Nancy expressed her *great sense of powerlessness, helplessness, and negativity* in her emails when her stories of good work kept bumping against these conflicting stories told by her medical co-workers.

One of the examples was about an abnormal condition involving milk leaking from the baby's gastrotomy site, possibly complicated with peritonitis. Nancy's colleagues noticed the problem in the morning and duly informed the doctor, but no action was taken. In the afternoon, Nancy found that the leakage had become more severe. 'Keep observing' was the only 'order' given by both the case and on-call doctors, although both of them had the knowledge and experience to change the gastrotomy tube at bedside. After the next feeding, the leakage became even more severe, which seemed to synchronize with the breathing of the baby. I was astonished when reading Nancy's email that the on-call doctor continued to not take any action. He was not busy with other patients, but merely playing games on his IPhone at the nursing

station until Nancy left for her afternoon shift, so that nobody was going to call him again. This was in fact the doctor mentioned earlier, who had thrown a tantrum over the neonates. He even complained to his senior, a consultant, that the nurse was an 'idiot' to repeatedly inform him about the leakage on the next morning during the senior doctor's round. Nancy perceived that the consultant was irresponsible person who would not advocate for the patients' best interests even though she had spoken up. She merely muttered to herself beside the consultant and the on-call doctor while writing on her kardex, '*If I don't have to inform the on-call in such a situation, when should I inform*?' Although some cues may show that the on-call doctor had not responded in a timely manner to the gastrotomy leakage, the silence of the consultant could have implicitly encouraged this doctor to continue his irresponsible and unprofessional act and attitude. The consultant's silence led me to think of a study entitled, 'Silence kills'. Conversation about broken rules instead of silence, such as the above example of procrastination in providing treatment, was identified as one of the seven crucial conversations that contribute to reducing errors and improving the quality of care (Maxfield, Grenny, McMillan, Patterson & Switzler, 2005). Finally, the leakage was stopped late when the button and tube were changed by the case doctor on the evening of the next day. Once again, this incident confirms the importance of team conscience, as individual conscience was insufficient.

The unsafe practice of procrastination seems to have been shaped by the sacred story of hierarchy and hierarchical communication, advocated by some of the paediatric consultants. This sacred story hindered direct clarification and interprofessional communication and collaboration, which potentially created more misunderstanding and led to gossip. It is important to note that under the sacred story of hierarchy speaking up for patient safety required considerable moral courage and the determination to endure the risk of being **scolded**. This caused Nancy to feel discouraged and dissatisfied. The story of these consultants was in great conflict with the hospital story, which emphasized effective communication, teamwork, assertion, and problem solving for patient safety (HA, 2014c). Their sacred story was also in great conflict with Nancy's previous two educative experiences involving speaking up for patient safety, which were consistent with her ward manager's reminder that she should jump call and ignore the risk of being **scolded** by doctors if issues of patient safety were involved. The following story revealed how Nancy was

disempowered by the sacred story in learning to speak up for patient safety and good work.

> Doctor-Nurse Game
> *There are several consultants at the paediatrics department who love playing the 'Doctor-nurse game' and have a strong class consciousness* [Chinese: 階級主義濃厚]. *However severe the problem, house officer [the most junior doctor] should be the first one to be informed. Only if the problem can't be resolved can the more senior doctor [medical officer, associate consultant, and consultant] be consulted. If you jump call without a good reason, you will be* ***scolded harshly*** *by the doctors* [Chinese: 被人鬧爆] *or regarded by the senior nurses as 'a little girl who doesn't know how the world operates'* [Chinese: 細路女唔識世界]. *With regard to the nurses, the consultants mainly communicate with the shift in-charge or even the ward manager about any mistakes or problems. That person then informs the case nurse. As the mistakes might have been made by others, such as the HCAs or nursing students, the case nurse further approach the appropriate persons. This is a strange culture. Many unnecessary misunderstandings happen and* ***gossip*** *circulates, which could be prevented if the problem had been dealt with directly.*
>
> *I was* ***scolded*** *by the consultant when I tried to clarify her written prescription. Meanwhile, I observed that she was willing to clarify the inquiries of nurses with whom she was acquainted. This apparent case of hierarchy and concept of class could discourage new graduates and lower their job satisfaction. This could even give new graduates the wrong impression that the senior nurses would negotiate with doctors if needed. Sometimes, I do think that courage is needed to withstand the risk of being* ***scolded*** *when making clarifications. However, I also remind myself that if I was doing the right thing [in seeking clarification] yet being* ***scolded****, that is the other person's problem, so I shouldn't be scared.* (Translated email from Nancy on 27 February 2012)

In sustaining her stories to live by and in learning to speak up for patient safety after being **scolded** by doctors, Nancy seemed to self-mentor once again. How can NGRNs speak up for patient safety and be heard by the health care team when they are at the bottom of the hospital hierarchy? What can the senior nurses and managers do after listening to such a story as the one told by Nancy? How can the NGRNs be better equipped and supported while living in the midst of competing and conflicting stories in their professional knowledge landscape and being shaped by ongoing miseducative experiences? Such questions led me to review a hospital document on a one-day interdisciplinary classroom-based Crew Resource Management programme that had been piloted to promote team communication, reduce human errors, and foster a culture of patient safety. An assertion model was one of the safety tools that

was taught to different members of the health care team to encourage them to speak up (HA, 2012; HA, 2014c) (see also Chapter 9). I did not intend to degrade the effectiveness of the one-off training. However, Nancy's experiences revealed that the process of learning to speak up is a complex and ongoing one, which might be shaped by ongoing miseducative experiences and therefore, requires ongoing mentoring rather than one-off training. When NGRNs speak up, they need to be supported by others. When they speak up but are not being heard, opportunistic mentoring by nurses and/or other health professionals becomes essential to guide NGRNs' reflective learning, changing the miseducative experience into an educative one. This in turn can reaffirm their stories to live by and be supported to sustain their stories of good work in the future.

The negativity that Nancy expressed in her email was also closely related to her exhaustion and lack of work-life imbalance. The above incidents took place at a time when the paediatric unit was dealing with the problem of a severe shortage of nurses, as three nurses were resigning while many others were taking sick leave in the midst of winter, when the patient load was heavy. In fact, Nancy was also leaving the paediatric unit to study Midwifery. She felt grateful that her ward manager had not limited her opportunities for professional development, as it was not uncommon to hear stories of ward managers using various methods to prevent their staff from leaving to study Midwifery. In return, Nancy promised her ward manager that she would help out as much as possible during this chaotic time by sacrificing her days off. Nancy was aware of her negativity and exhaustion. However, her experience revealed that a work-life imbalance could have limited her capacity to engage in reflection and to self-mentor by thinking positively and seeing new possibilities in the midst of competing and conflicting stories.

10.17 Becoming a midwife and sustaining good work in nursing

Since our first interview, Nancy had share with me many of her experiences and reflection through emails. Although some were highly miseducative, I was glad to see her grow through seeing new possibilities and telling stories related to good work. Our second interview was scheduled on a special day, which was her last day as a paediatric nurse before making a new start next day as a midwifery student. Her

interest in studying midwifery was in fact shaped mainly by her narrative history in working in paediatrics. She wanted to understand what happen during the ten months of pregnancy to cause babies to develop neonatal and paediatric diseases. She also saw broad professional development opportunities in becoming a midwife, as specialised knowledge in this area is demand not only at in the obstetrics unit, but in other departments such as the AED.

Initially, I did wonder whether, as a midwifery student, Nancy would be eligible to participate in my study. I considered that Nancy could continue to address my research questions on the meaning of mentoring NGRNs in the transition period and of sustaining good work. After all, she was still practicing in the public sector, and in the same hospital, and it is not uncommon for NGRNs to study midwifery in their first two years of clinical practice. Therefore, after our second interview Nancy and I agreed to continue our participant-researcher relationship. We continued our email conversations and had a third interview by the end of her first two years of clinical practice. I was grateful to share Nancy's happiness and satisfaction during the time that she was learning to become a midwife. She also enjoyed the increased autonomy she experienced as a midwife in helping her clients throughout a normal pregnancy and the relationship she had with her medical co-workers as partners, instead of the disempowering relationships that she encountered in the paediatric unit.

10.18 Conflicting stories of good work

After increasing her knowledge about obstetrics and gynaecology, particularly about breast feeding, Nancy retold her stories of good work, which seemed to have brought her new perspectives about mentoring and good work in nursing. In the past, when she was in the paediatrics department, Nancy thought that she had good knowledge about breast feeding. However, it was not until she became a midwifery student and gained more personal practical knowledge in that area that she realised successful breast feeding is a more complex process than she had thought. Nancy had been living the sacred story of the paediatrics department, in which the newborn was her main concern. She used to focus on treating neonatal jaundice as soon as possible. She was not aware that jaundice is a normal process if the mother is exclusively breast feeding, and can be easily managed with phototherapy. Breast feeding can

never again be successful if the newborn and the mother are separated, or if powder feeding or bottle feeding is employed instead of cup feeding. The mother and her newborn can be prevented from having a unique bonding experience, which could even lead to post-partum depression. In contrast, as a midwifery student Nancy was shaped by the sacred story of the obstetrics unit in emphasizing the well-being of both the mother and the newborn, as well as their bonding and intimate relationship. The conflicting stories lived and told by the midwives and paediatric RNs were revealed in Nancy's stories of her experiences, which were shaped by her narrative history as a paediatric nurse. They further reveal an important issue in the quality of care, which is the discontinuity of care between the obstetrics and paediatric units, that caused new mothers have to deal with the different practices of the two departments. As a midwifery student, Nancy could not effect any significant changes. Nevertheless, if the newborns were admitted to the paediatrics department, Nancy educated mothers about the potential conflicts between the departments and empowered them to persist in breast feeding by negotiating with the paediatrics nurses. Nancy's experiences and the personal practical knowledge that she had accumulated reveal an important space or possibility for mentoring. The two separate yet closely related departments should discuss their rationales for following different practices and through effective inter-department communication come to a compromise to provide more consistent care for the benefit of their patients and clients. This would broaden the perspective of mentoring to achieve good work in nursing. Mentoring does not need to be confined to the level of the individual, but can also extend to the level of the departmental, as the sacred stories told by each department shape the practices of their nurses. Without a consistent story across different departments, continuity of care can never be achieved, affecting the good work done in nursing. Once again, achieving good work in nursing requires more than individual efforts or interpersonal efforts between mentor and mentee within a unit. In this case, collaborative efforts between departments are needed for holistic care and continuity of care.

10.19 Awakened from the shaping of the shifting landscape

Apart from the sacred stories told by the different departments in the hospital, by the ward manager about the shortage of nurses, and by medical professionals about the

hospital hierarchy, Nancy was also shaped by the sacred stories told by society. She experienced on and off tension and dilemmas when interacting and caring for parents from mainland China who were not eligible to receive care in a Hong Kong hospital, and who spoke different dialects and had different attitudes and cultures of parenting (see Chapter 8 for more details). The tensions that she experienced were related to her multiple identities. As a Hong Kong citizen and a taxpayer, Nancy was very angry with the mainland parents who had never contributed to Hong Kong society in terms of taxation but were giving birth in Hong Kong to give their child the benefit of Hong Kong citizenship. Some parents never pay the hospital fees, while others abandon their children at the hospital if the newborns have abnormalities or congenital diseases. The bad debts and the abandoned children become the responsibility of the Hong Kong government and local citizens. Nancy regarded this as abnormal and unfair. Meanwhile, Nancy also saw the situation from the perspective of the pregnant mainland women. She understood that they were taking the risk to travel across the border to give birth so that their children would obtain the benefits of Hong Kong citizenship. As a health care professional, Nancy accepted and treated them as normal patients if they were cooperative and polite. She continued to provide her usual care by teaching them child care skills and providing the necessary referrals and education. However, Nancy was angry that some parents could not be contacted as they had given fake contact information. Some abandoned their children at her unit for an entire month while they returned to the mainland for post-partum maternity care. Nancy also felt annoyed that some mothers refused to learn anything about post-natal care, as their children would be cared for by their relatives or by babysitters that they employed. Nancy was also furious with the mainland parents who claimed that they could not understand Cantonese and asked Nancy and other colleagues to use Mandarin to communicate with them, with some even criticising the nurses' Mandarin proficiency. Yet these parents were able to comprehend the Cantonese post-natal educational video that contains important information about obtaining the birth certificate, and made no complaints of a language problem.

Through Nancy's self-reflection and self-mentoring in the personal space that she created, she gradually came to understand the conflicting stories of parenting told by the mainland parents, who came from different social, cultural, and educational

backgrounds. In the midst of vigorous daily social debates and conflicts at work, instead of feeling angry, Nancy grew to be aware of her taken-for-granted interpretation of holistic care and the cultural differences. She embraced and respected the multiple different stories of parenting and understood the unique needs of the parents, even though she might have personal disagreements with some of them. She saw new possibilities to better prioritise her limited time and to balance her emotions by assessing the parents' intention to learn about child care skills before providing further comprehensive teaching. If they showed no interest in learning, Nancy shifted her focus to taking good care of the babies and teaching other parents who were eager to learn, rather than trying to persuade these parents to change. The following was Nancy's story of what took place when she was still an RN in the paediatric unit.

> Retelling the diverse interpretations of good work
> *In the past, I believed that doing good work in nursing was about ensuring that my patient is receiving holistic care. After interacting with them [the non-eligible mainland parents], I realised that the patients and I could have different interpretations of 'holistic care'. They only wanted to be discharged with their healthy newborn within the shortest period of time (three days and two nights). Under such circumstances, I really don't have to worry about whether the mother can breast feed well or which maternal and child health centre is the most convenient for them, and so on. I seldom become furious with them now.* (Translated email from Nancy on 1 February 2012)

Nevertheless, Nancy again experienced unhappiness from interacting with these mainland parents at the obstetrics department, potentially under the influence of the sacred stories being vigorously discussed in society and by some other midwives. As both a nurse and a Hong Kong citizen, Nancy's great tension and dilemma had not been fully resolved. She felt as if she was *'serving the thief who steals from her pocket'* (Chinese: 倒要服侍在你錢包偷錢的小偷!!!!). I was surprised to learn in our final interview that I had shaped the second retelling of her story when I replied to one of her emails. In an email, Nancy told me about a senior fellow midwifery student who was being faulted by other midwives for her poor learning attitude. Nancy observed her **scolding** a mainland mother by saying, '***Don't tell me that you don't know Cantonese if you come to give birth in Hong Kong!***' (Chinese: 你黎得香港生仔，唔好同我講唔識聽廣東話). In the email that I sent in reply, I shared my different perspectives and reflections on her classmate's attitude, as well as on

the responses of others. As a Hong Kong citizen, I also resented the pregnant mainland women who were giving birth in Hong Kong. Nevertheless, as a nurse, my goal is to take care of the patients regardless of their identity or background. I understand that this involves a lot of emotional work. After reading my email, Nancy seemed to have been awakened from her 'arrogance', as mentioned at the beginning of this chapter when she was explaining her sponge metaphor and being reminded about her initial stories of nursing. In our final interview, she told a different story about dealing with mainland parents. She also said that she had an awakened understanding of professionalism, which reaffirmed her desire to treat every client equally and according to their needs, despite their identity, status, or background.

> Awakening of professionalism
> I remember that I felt unhappy during my placement at the post-natal unit, where I had served for some period of time. I felt psychologically imbalanced. I was angry with them [the non-eligible mainland parents] for taking money from our pockets, yet having multiple requests and complaints… After about ten months, I finally successfully overcame these feelings. It was the thoughts that you shared [in an email on 29 July 2012] that awakened me to the importance of not labelling the clients. I realised that I was indeed not behaving in a professional manner. I realised that I don't have to get into a blind alley [Chinese: 無必要去包拗頸]. [*Bernice: It seems that it was not that good, as I have influenced your perspective.*] It's good. You have awakened me when I was not sensible and was feeling too sentimental. You reminded me about the importance of delivering quality care. As a professional, you should provide care regardless of who the patient is, especially at a public hospital. I realised that I shouldn't forget why I work at a public hospital. Instead of feeling angry, it is better for me to concentrate on helping the mothers who are in need. I was glad that you awakened me at an early stage. I discussed my dilemma with other nurses who had also experienced the same dilemma in the past. Most of them had overcome their feelings of resentment, while some hadn't and continued to feel angry and persisted in speaking only Cantonese to the mainland parents. (Nancy, third interview)

I am glad that that the thoughts that I shared might have had some kind of peer-mentoring effect and stimulated Nancy to self-reflect and self-mentor to sustain her good work in nursing. Nancy's telling and retelling of her story of caring for mainland parents shows that the stories of NGRNs can be shaped by changing landscapes, that they can affect their transition, perception, and identity formation. This reveals the importance of ongoing mentoring, both by others like me as a peer, or by the NGRNs themselves. Thinking from a system approach, hospitals might

need to be sensitive to the changes taking place in the landscapes of professional knowledge and make changes to their supportive programme accordingly. Thinking about the conversation space between Nancy and me also revealed the importance of cultivating such safe and open spaces for nurses to share their educative and miseducative experiences, reflections, tensions, and dilemmas. Through the story-telling process and the exchange of personal practical knowledge, new possibilities can be unveiled from a miseducative experience, while the educative experiences can support and empower the nurses to sustain their good work in nursing amidst a complex health care landscape. The influx of mainland pregnant women could actually be viewed as an event with mentoring potential (Darling, 1985a) if reflection, self-mentoring, dialogue with each other had taken place for enhancing the development of cultural sensitivity and sustaining one's professionalism.

10.20 Leaving in the midst and pending opportunities for reliving

Nancy and I left the restaurant after a relaxing dinner and walked to a bus stop under the rain. We had shared stories about our personal life and our joy about the significant life events that we expected would occur. Leaving in the midst, the two of us, a midwifery student and a research student, continued to further our endeavour in the different aspects of nursing with the common goal to optimize the well-being of patients and their families. When I have finished writing this chapter on Nancy, I was very grateful that I could share her important stories about being in transition, from being a new graduate to becoming a professional nurse, and from becoming a midwifery student to becoming a registered midwife; and about how she sustained her stories of good work in the midst of other conflicting stories in a complex health care landscape. Also, I feel blessed that Nancy and I had seen each other in walking down the aisle with our second half. By the end of the research study, our participant-researcher relationship had evolved to friendship and we continue to support and mentor each other to achieve good work in nursing.

CHAPTER ELEVEN

HEIDI'S STORY –

AN NGRN IN THE PAEDIATRIC AND GYNAECOLOGY UNITS

11.1 Introduction

Heidi, my eighth NGRN participant, began working in the paediatric unit immediately after registration. Similar to the four NGRN participants in the previous narrative chapters, Heidi experienced inadequate support from her assigned preceptor and other senior nurses. The inadequate preceptoring and opportunistic mentoring seemed to be mainly with regard to orientation and transfer of knowledge to facilitate NGRNs in becoming able to function independently and care for patients. This current pattern of 'mentoring' seemed to emphasize task completion and meeting tangible goals in physical care, such as getting routine work and doctor's prescriptions done. This led me to wonder what kind of 'good work' was being cultivated under the current pattern of 'mentoring', which seems to focus merely on the physical aspect of patient safety? Where is the 'human side' of patient care mentoring that aims to promote good work with a holistic approach to patient care, which has the interrelated psychological, social, and spiritual components? In the absence of mentoring for the 'human side' of nursing, Heidi seemed to self-mentor by reflecting on her ongoing educative and miseducative experiences. In contrast to the other four NGRN participants, Heidi's stories of mentoring for good work were shaped by both personal and professional experiences, particularly her stories of her family and her clinical rotation to the gynaecological unit 18 months after registration. After her clinical rotation, Heidi retold her stories of mentoring for good work in seeing the meaning of preceptoring, instead of merely self-mentoring, and the importance of mentoring the intangible or human side of nursing, including empathy, spiritual care, and work quality rather than merely emphasizing work efficiency. The retelling might not only have been shaped by the clinical rotation, but was possibly related to Heidi's professional development from being task-oriented to adopting a more patient/family-centred and holistic perspective. As I re-read my interim text about Heidi, which dated from almost two years ago, I felt dissatisfied

with my descriptive writing in chronicle form, as well as the repetitions of lengthy passage about her transitional and self-mentoring experiences in the absence of adequate preceptoring and opportunistic mentoring. I struggled to find the best possible way to present her storied experiences in this final research text to unveil the meanings and significance of mentoring NGRNs in transition and sustaining good work in nursing. Heidi could not identify a metaphor to describe her mentoring experience, but we agreed that it was most important for her to share her four main relived and retold stories of mentoring for good work in this chapter, with the hope that NGRNs will learn to emphasize the human side of patient care through mentoring for good work in the future.

As mentioned earlier, Heidi's stories were shaped in part by her stories of her family. She decided to be a nurse under the influence of her elder brother, who has a chronic disease, and later her mother, who had cancer. She perceived that her acquired medical knowledge could better equip her to take care of her family, especially since her other siblings work in the business field. Heidi graduated from a three-year hospital-based higher diploma nursing programme. In her second year of study, she was also employed as a temporary undergraduate nursing student (TUNS) in an orthopaedic unit in what is now her current hospital, working once a week. However, Heidi did not make any request to stay at the orthopaedic unit because she was concerned about the stress received from the others in the unit, their expectations of her, and her worries about discouraging them if she performed dissatisfactorily. She seemed to be highly aware of her strengths to perform tasks efficiently by following the instructions of the staff nurse that resulted from her years of training in a hospital-based nursing programme and her TUNS experience. She was also cognizant of her weaknesses in critical thinking, prioritisation, and the other knowledge and skills that were required to take care of her patients in a holistic manner.

11.2 Meaningless preceptoring and the bewilderment of learning from everyone

After registration, Heidi expected to learn and be supported by her assigned preceptor for two to three months. In her story of preceptoring, she referred to a teaching-learning relationship with her preceptor that was shaped by the story of

having one preceptor for her continuous learning in the unit as described by the hospital supportive programme. However, there was a gap between her expectation and the actual preceptoring she experienced. Heidi recognised that she had a one-month orientation period, during which she had a supernumerary status, that is, she was additional member to the number of staff already assigned to each shift. Heidi was assigned to a preceptor by her ward manager, but they rarely worked with each other, even in the first two weeks. Heidi barely recalled the orientation and learning her preceptor gave her, which was limited to ward routines, some case management, and some limited supervision when Heidi was learning to work as a paediatric nurse taking care of her team of patients. That was why Heidi perceived preceptoring was meaningless and useless.

In the absence of her preceptor and any systematic or comprehensive teaching, Heidi's transitional experience was rather complex and filled with bewilderment (Chinese: 迷茫). Heidi was assigned to work with another senior nurse who was taking care of the largest team of patients each shift. Unfortunately, Heidi's learning to be a team leader seemed to be rather ineffective, erratic, and unsystematic. She received support if she was lucky, an experience similar to one reported by new nurses in Scotland (Horsburgh & Ross, 2013). There were times the assigned senior nurses simply asked Heidi to get all the routine work done or instructed her to perform different tasks as though she were a nursing student. Without giving her opportunity to think and work as a team leader, such as allowing her to set priorities and make decisions about reporting abnormalities, the learning seemed ineffective to better prepare Heidi and give her more confidence. It was possible that these seniors worried that Heidi might make mistakes, for which they had to be responsible. Alternatively, they might have been unready and unwilling to teach Heidi and perceived that performing the work by themselves would be more efficient. There were also times the other seniors expected Heidi to deliver the end-of-shift handover. However, she felt bewildered, as she had not had an opportunity to receive the handover from the preceding nurse or her 'partner' senior, follow the doctor round, or check the kardex herself. Heidi was heavily engaged in finishing all routine work, such as taking vital sign observations and tube feeding all paediatric patients in the unit, as well as being called to help the other senior nurses, as is expected of the most junior nurse. Without being given any teaching or time to learn how to think like an

RN (Etheridge, 2007), which means being able to integrate various pieces of information about her patients and gain a holistic picture, Heidi perceived that her handover remained at a basic tasks-oriented level in merely stating the prescription of the day and reporting whether the tasks had been completed. Heidi became aware of her weakness and need of mentoring in handover via self-mentoring by comparing her performance with that of the others. For instance, she admired her seniors' well-integrated handover, in which the reasons behind the doctor's prescriptions were identified and correlated with the patient's condition and medical history. However, judging by the basic level of her handover, her senior colleagues seemed to have given her no support, feedback, or opportunistic mentoring (see Chapter 8). Heidi could only improve by seeking peer-mentoring (see Chapter 8) from her classmates working in other units or by reflecting and self-mentoring (see Chapter 8). It took her months to gain a sense of competence in handover, which seems to indicate that the knowledge required was of a troublesome nature (Perkins, 2006, see also Chapter 10). This is consistent with the stories of handover told by all preceptor and stakeholder participants in the focus group interviews, who expected NGRNs to give a well-integrated handover, but were generally dissatisfied with their performance. The following excerpt from a focus group interview reveals the anger of one preceptor about an NGRN, who had no understanding of her own patient and made a dissatisfying handover. Instead of providing feedback or opportunistic mentoring, the angry preceptor seemed to have lost interest teaching.

> **Preceptor 3 (MED)**: A patient was taking Warfarin 6mg [high dose of anti-coagulant drug]. I asked the new graduate the reason why during handover. She said 'Don't know!' I asked 'What is the diagnosis?' She simply said 'PE!' without knowing what PE stands for [PE can mean pleural effusion or pulmonary embolism etc, while the latter one is the right diagnosis in this case]. She didn't know anything about her case, even such an important part as that. Forget it, I stopped listening.
> **Preceptor 2 (SURG)**: I guess she was not intentionally ignorant.
> **Preceptor 3:** Not intentional but she should know it when delivering handover.
> **Preceptor 4 (MED)**: They read the kardex sometimes without understanding what they are reading. (Focus group 3)

It was questionable whether preceptor 3 had taught the NGRN in question about how to hand over or how to think like a nurse and identify the relationships between the various pieces of information about each patient. In contrast, other preceptor and

stakeholder participants emphasized teaching and opportunistic mentoring about delivery of handover, a view which may have been shaped by their past experience.

> New graduates are now reading the kardex [Nods of agreement by other stakeholders]. I found that being taught about handover by a mentor benefited me throughout my life. He taught me on the first day about the meaning of handover – to let other nurses know what had happened, the reasons behind the prescribed treatment. For example, it was meaningless to read out the prescription Augment [an antibiotic]. One needs to identify the reason for its use, e.g. related to the positive result of the blood culture. (SURG, APN 4, FG 1)

NGRNs in Taiwan also perceived that delivery of precise end-of-shift handover information and using professional English terminology were major stressors to them in transition (Yeh & Yu, 2009). Thinking in the personal-social interaction dimension, NGRNs are responsible for their own learning and professional development. However, it might also be important to explore how the others could better support NGRNs by sharing and exchanging their way of thinking for better communication and patient safety. Without opportunistic mentoring by others, NGRNs might need a much longer period of time to gain a holistic understanding of their patients and be able to deliver a well-integrated handover.

After one month of 'orientation' and despite still being very bewildered and uncertain, Heidi was expected to work independently and was assigned a team of patients. She was in need of even more support and mentoring, but it was also the time for her preceptor to be rotated to another unit. Heidi was not assigned to another preceptor. Instead, she shared with me that she worked with and learnt from a senior RN, who was my ex-university classmate and the same person who recommended her to become one of my participants. This senior nurse, Heidi's referee, often asked questions during handover, which stimulated Heidi to think like a nurse and identified Heidi's knowledge deficits, which led to further teaching or opportunistic mentoring. Heidi recognised this knowledgeable, efficient, and approachable RN as her role model. She recounted an incident in which she was not aware of a potentially serious condition and learnt only after being scolded by her referee. It is interesting to note that Heidi did not seem to suffer any negative impact from being scolded, unlike the other NGRNs discussed in earlier Chapters (see Chapter 7 - 10). This might be because of her referee's good intention, tone of voice, provision of

opportunistic mentoring, and subsequent apology for the scolding. The two actually established trust in their relationship. Heidi's lack of any negative experience might also be related to the nature of the mistake. Since the incident was potentially serious with dangerous consequences for patient safety, Heidi may have focused immediately on the patient's interest rather than thinking of herself being scolded as a negative mentoring experience.

> Scolding and apologizing
> The mother said the patient had a seizure attack. However, when I went inside the isolation room only ten seconds later, I found the patient was very calm and playful. I wondered whether it was a seizure attack or tremor. I felt very confused. I thought the patient had a long-term convulsion problem and I didn't have to inform anyone even if it was a seizure attack since it subsided so quickly. I told a senior RN [Heidi's referee] what had happened during handover. She scolded loudly, 'What? How is it possible that you didn't inform the doctor? What if she really had a seizure attack? She needs an assessment by the doctor... ' After a while she apologized and said, 'Sorry, I didn't mean to scold, but it's for your benefit.' In fact, I was not aware of her scolding. I was very concerned about whether I had harmed the baby. Fortunately, I had not. (Heidi, first interview)

Heidi's bewilderment, particularly in the first few months after registration, seems to reveal the problem of inadequate preceptoring and support being provided to NGRNs in transition who are learning to be RNs without doing harm to patients. This led me to think about the lack of matched duties between NGRNs and their preceptors. Duties are often arranged by the ward manager, APN, or nursing officer (NO), hence my invitation to the stakeholder participants to explore their views in my two focus group interviews. It is interesting to note that they acknowledged that the preceptoring provided was inadequate to support NGRNs and immediately attributed it to inadequate human resources and experienced nurses, which seemed to have the quality of the sacred story. This led me to wonder about the meaning of such inadequate preceptoring. Also, the stakeholder participants seemed to have already resolved the problem of inadequate human resources, based on how often they emphasized that NGRNs could ask any senior nurses for help whenever they encountered any problems. This means that they expected NGRNs to already know about any lack of specific knowledge at hand and then take advantage of any further opportunistic mentoring, if it was available. There is thus the assumption that NGRNs can identify their knowledge deficits and take the initiative to ask the right person with the right question to get the right answer to solve their immediate

problems in a new and unfamiliar place. However, the above storied experience reveals that this assumption may not be valid, which could jeopardize patient safety. Also, not every senior nurse has the motivation to teach or the necessary pedagogy. All of these shaped Heidi to perceive preceptoring as meaningless and useless, leaving her in bewilderment and having to self-mentor to adapt to her new environment and role.

11.3 Ineffective 'training' but self-mentoring to be night in-charge

The paediatric unit had only two nurses working at night, one as the in-charge of the unit, taking care of all the patients and their documentation, while the other nurse worked as the runner and completed all the routine work and other tasks. About eight to nine months after registration, Heidi stopped working as a runner at night and was 'trained' to be a night in-charge. After five nights of 'training', Heidi was expecting to work as the night in-charge with another NGRN one year junior than her, which meant she would lose the protection of her senior nurse and would only be able seek help from the more distant night sister overseeing all the paediatric units at the hospital in case of emergency. During the five nights of 'training', Heidi was assigned to the role of the night in-charge while working with a senior nurse who took up the runner role. I have put 'training' in quotation marks to convey my doubts about calling it training, as it seemed ineffective on at least two levels in better equipping Heidi to be a night in-charge. On the first level, the senior nurses in the five nights of 'training' (a different nurse each night) were expected to but did not give any concrete guidelines or systematic teaching about being a night in-charge - not even regarding the night routines. Heidi had to self-mentor based on her personal practical knowledge, which she had gained through ongoing observation while working as a night runner.

On the second level, Heidi felt 'bewildered and confused' when several incidents and unfamiliar events occurred almost simultaneously, all of which required prioritisation and identification of abnormalities that she should have reported immediately to doctors. However, the senior nurses merely worked as night runners and did not provide the necessary and/or effective opportunistic mentoring to Heidi. Heidi struggled with her limited knowledge and whatever ongoing understanding she could

gain through self-mentoring. For instance, on her first night, when she was administering intravenous immunoglobulin (IVIG) to a patient, a blood transfusion needed to be initiated for another patient, and soon a third patient developed a prolonged seizure that required medical intervention. Another night she had to follow up on a long list handed over by her afternoon colleagues while also having to handle many new admissions and even a patient who needed a lumbar puncture. Heidi described her mind going 'blank' during these times when she was facing multiple pressures. She self-mentored by prioritising and getting through those nights but did not have the confidence to manage future similar situations. In view of the complexity and uncertainty inherent in reporting abnormalities to doctors, Heidi sought help and opportunistic mentoring from her senior. As the following interview excerpt reveals, however, her attempts were ineffective. Heidi did not gain the knowledge, certainty, and confidence she needed to make future decisions about when, what, and to whom to report when she noticed abnormalities.

> I still don't know what situations I should inform the doctor. When and whom should I call? I am still very uncertain and need to ask my senior whether I should inform the doctor in such a situation. They know the characters of the doctors and whether the doctors perceive the situations as urgent and needing immediate intervention - otherwise no intervention will be provided even if we inform them. For instance, I had a patient with slight hyperkalemia. I intended to report the abnormality. The senior RN [working as runner] said 'I wouldn't call if I were you. The doctor will not intervene for such a slight increase in potassium level.' I hesitated. 'But… the result is abnormal.' She replied, 'You are the night in-charge, it's your call to do what you want to do… you have the control.' In the end, I called. [*Bernice: But how would she have managed the abnormality?*] She did not intend to inform the doctor immediately, but would have waited until he came to manage other problems. I still cannot find the balance between calling immediately and not calling because the doctor would come later. (Heidi, first interview)

The senior's sharing of her perspective and management of the opportunistic mentoring seemed ineffective, since Heidi could not apply the assistance to her present and future situations, but continued feeling uncertain and bewildered. The senior may have made an astute judgment based on the patient's condition, anticipated intervention, and considered that the telephone call would disturb the only on-call doctor at night, who would either be busy with other patients or taking the only available time to have a little rest before another new admission. Such would be the behaviour of a proficient or expert nurse (Benner, 1984). However, it

was obvious that sharing her clinical judgment without discussing the decision making process and Heidi's concern about the issue of responsibility and liability was inadequate to address her hesitation and better equip her for future situations. Heidi's uncertainty about reporting abnormalities may also be related to her still limited understanding of how to form a holistic picture of her patients' condition. Therefore, the effectiveness of such 'training', as well as whether the assigned senior RNs are equipped with the necessary pedagogy skills to stimulate Heidi to think like a nurse is debatable. In fact, it was reported that new graduates who enjoyed the comprehensive support of the standardized nurse residency programme in the United States still require about 8 to 12 months to become competent in prioritisation, autonomous decision making, and collaboration with doctors (Kramer et al., 2012). This led me to wonder even more about patient safety and how much Heidi could have developed professionally with her limited preceptoring and 'training'. A similar situation was addressed in a focus group with my preceptor participants and one of them lived and told a counter story to Heidi's storied senior RN, which seemed to be a more effective form of opportunistic mentoring.

> The new graduate asked me whether the doctor had to be informed [about a tiny abnormality]. I asked, 'If someone informed you, would you intervene?' She said 'No, I just want to ask.' I said, 'So you are shirking your responsibility and passing it up to the doctors. You are a nurse [who should have your own clinical judgment].' They called whenever the blood pressure was high without checking the patient's overall condition. As a whole, they don't understand [how to think like a nurse]. (MED, Preceptor 4, FG 3)

The above story reveals that reporting abnormalities is a rather complex issue, which can be identified as troublesome knowledge (Perkins, 2006) to NGRNs, similar to the problem of handover. Heidi and other NGRNs generally possessed the ability to identify abnormalities, but that ability alone was inadequate. The decision to report an abnormality, especially a marginal one, has dynamic biomedical, legal, and interpersonal dimensions in relation to the patient's overall conditions. The decision must take into account protection from legal liability and consideration of the doctor's need to deal with other more important events. Heidi also identified her knowledge deficits about being able to distinguish whether the abnormality is a marginal one that can be further observed without immediate intervention, or an early sign of deterioration. Because of the severe nursing shortage in the paediatric department, Heidi brought all these knowledge deficits and bewilderment with her

into her role of night in-charge. She was assigned to work alone at night in another small paediatric isolation unit for months, and later as the night in-charge in her own general paediatric unit with another new 2011 graduate as the night runner. It was also at this time that Heidi developed palpitations that woke her from her sleep before her night shifts. The palpitations may be a psychosomatic symptom related to her stress at being a night in-charge. Heidi felt fortunate that she had peaceful nights without any 'change of conditions among her patients' or emergency situations. She did wonder how those situations could be managed without immediate support from her senior nurses, except by reporting all incidents to the doctors immediately. It is doubtful whether Heidi and the junior night runner could have learnt from or peer-mentored each other to acquire the knowledge needed to guide their practice in the future. However, it is quite obvious that this human resource arrangement was risky to all three parties: Heidi, her subordinate, and the paediatric patients. All her experiences in the paediatric unit shaped Heidi in perceiving that mentoring, referring to the preceptoring by her assigned preceptor, as well as 'training' and opportunistic mentoring by other senior nurses, was meaningless and useless.

11.4 Retelling the stories of mentoring for good work

Heidi rotated to the gynaecology unit after working at the paediatric unit for about one and a half years. She was assigned by her gynaecology ward manager to work with her preceptor on the same shifts in the first month after rotation. However, at the beginning of relationship, Heidi experienced some internal tensions when her preceptor asked some questions not directly related to clinical practice and criticised her harshly and scolded her. The following interview excerpt reveals that Heidi felt quite angry initially, especially since she had already worked as an independent night in-charge at the paediatric unit. Nevertheless, Heidi self-mentored and made personal adjustments within a short period of time by putting aside emotional baggage from the paediatrics and embracing her role as a new staff member to learn openly in the gynaecology unit. By shifting to stay non-defensive in the face of her preceptor' criticism or scolding, and thinking positively about the criticism and scolding, Heidi later found herself benefiting from her preceptor's comprehensive teaching and perceived that she was being treated like a daughter. They gradually developed a close and friendly relationship. Heidi seemed to retell her story of mentoring in

accepting the scolding as both something she should take out of respect for her preceptor's expertise and as a rite of passage of NGRNs.

> On the first day at the gynaecology unit, she [Heidi's preceptor] asked different questions that I didn't know how to answer. 'How many hospitals are there under the HA [Hospital Authority]?' 'How many clusters are there?' 'What is the generic name of Flagyl [An antibiotic]?'… 'What? How can you have worked in paediatrics for such a long time and not know about them?'… 'You are so stupid!' Honestly speaking, I had just picked up everything in paediatrics. I wondered what was going on in gynaecology. I felt quite discouraged and angry with her initially. However, after an hour or two, I realised that I had to 'tune' and treat myself as a brand new nurse in gynaecology and learn modestly. It's ok to be scolded by her, as an expert with many years of experience. She may feel more balanced psychologically when she is teaching me more knowledge. It's even more horrible when they see you making mistakes and don't give you a reminder. Some new graduates of 2011 ventilated their unhappiness with me after being scolded by the ward manager. I said, 'It's normal to feel unhappy after being scolded. Every fresh graduate has the same experience, it's inevitable as a rite of passage [Chinese: 必經階段]. You can ventilate with friends and relax after work. I won't think [of the unhappiness] after work.' (Heidi, second interview)

With her personal adjustment, an arrangement of duties allowed Heidi to work with her preceptor, and her preceptor's motivation to teach and support her, finally gave her the kind of preceptoring experience she had been expecting since registration. In her first week in the gynaecology unit, Heidi once again had a supernumerary status and was not assigned any patients but was given protected time and opportunity to learn from her preceptor, whom she perceived to be a 'knowledgeable and expert' midwife. The preceptoring was not limited to general ward routines, but covered management of different diseases and even revision of the anatomy to teach her how different surgeries were performed, allowing Heidi to gain a better understanding of important pre- and post-operative care. In the second week, Heidi began to get a team of patients, while her preceptor oversaw her, performing a dual role as she was also the nurse of another team of patients in the context of nursing shortage. This was different from the initial plan of Heidi's preceptoring, which was for her to learn by working with her preceptor on the same team. Even so, the sacred plotlines of inadequate human resources did not seem to have resulted in Heidi being pushed to work beyond her practice readiness as she had been in paediatics. She felt adequately supported by her preceptor in the gynaecological ward. After the first month, though Heidi and her preceptor seldom worked together on the same shift, her preceptor

continued to support her learning during the end-of-shift handover. Even though she ended up using more time for handover, her preceptor highlighted the important points that needed to be observed, according to Heidi's experience in taking care of patients with different conditions, despite more time were used for handover. Heidi appreciated the teaching and support from her preceptor and reciprocally she strived to perform at her best, concerned that any reports about her dissatisfactory performance would damage her preceptor's reputation. It was important to note that her preceptor's willingness to teach her systematically and comprehensively seemed to give Heidi a great deal of certainty when she was taking care of her gynaecology patients. This was in stark contrast to her past experience and sense of uncertainty and bewilderment in the paediatric unit.

Heidi learnt not merely from her preceptor, but also from other senior colleagues via opportunistic mentoring. They welcomed her questions and allowed her to work slowly, provided that patient safety was not jeopardized. Heidi found herself in a positive learning environment that emphasized patient safety and allowed her space to learn and grow gradually. Under the teaching and support of the seniors, particularly her preceptor, Heidi perceived that she picked up knowledge faster in the new environment, and felt more calm and confident even when something unexpected happened. Heidi relived and retold her story of mentoring, which is useful and worthy of being implemented in supporting NGRNs. Without these experiences of preceptoring and opportunistic mentoring in the gynaecology unit, Heidi might continue to perceive mentoring as meaningless and useless. Even though she would one day become more experienced, she might never have had the motivation to mentor, but merely expected NGRNs to self-mentor.

Heidi also shared her retold stories and coping mechanism of thinking positively about criticism and scolding as a learning experience or even a rite of passage when her younger generation ventilated to her. Heidi's positive thinking or coping mechanism was similar to the perception of scolding as 'putting money in your pocket' (Chinese: 袋錢落你袋) [that is, having good intentions in taking the initiative to teach you something], which seems to be the ingrained way of thinking among some of my preceptor, stakeholder, and even NGRN participants. Yet the conclusion demonstrated earlier showed that the effectiveness of scolding as a way to

mentor NGRNs for good work is rather complex and depends on the nature of mistakes, established relationship, intention, tone of voice, and provided opportunistic mentoring. The primary outcome for NGRNs often remained quite negative. Thus, if NGRNs use a coping mechanism to think positively about any scolding and, overall, accept the use of scolding as a rite of passage, it might mean that they are tolerating the intolerable during their transition. Also such behaviour is worrisome because it might implicitly encourage their use of scolding one day when the NGRNs become the mentor, as this alarming result has been reported, of how mentors tended to repeat their past negative experience on their younger generation (Deppoliti, 2008).

Heidi shared another retold story of mentoring with her younger generations based on her past experience. In the past, she perceived herself to be not good enough, worried about making mistakes, and kept putting herself under a great deal of pressure. She felt unhappy and stressed and even perceived herself to be a burden to her senior nurses. It was not until months after registration during the staff development review (SDR) by the nursing sister that Heidi was told that the other senior nurses had positive comments about her performance and appreciated her work. Heidi realised she was worrying too much and that her perceptions might be different from the reality. She became more open-minded and welcomed different learning opportunities. In fact, such a formal review can be viewed as opportunistic mentoring for NGRNs to build their confidence and reaffirm their nurse stories and stories to live by. While a formal review might be structured and could be scheduled before the end of probation and also annually, it was revealed that NGRNs who lacked confidence in transition need ongoing feedback from seniors, even informal feedback, to build their confidence. This agrees with the literature which reports that new graduates need constructive feedback, both positive and negative, to evaluate their competence, build their confidence, guide their practice, and alleviate their anxiety in transition (Chernomas et al., 2010; Duchscher, 2009; Kramer et al., 2013).

Though Heidi had retold her story of mentoring NGRNs for good work, her experienced mentoring by others seemed to emphasize task completion that mainly involve physical care or meeting tangible goals. Upon self-reflection of her upcoming personal and professional experience, Heidi seemed to have self-mentored

to re-discover the ‘human side’ of nursing and relive and retold her stories of mentoring NGRNs for good work in meeting the holistic needs of patients and their families or the intangible goals.

11.5 Reliving and retelling the stories of empathy

Shortly after rotating to the gynaecology unit, Heidi also relived and retold her stories of mentoring NGRNs for good work with her self-mentoring to see the new meaning of empathy under the shaping of a personal miseducative experience. Heidi returned to the paediatrics to support a former colleague whose family member had passed away within 24 hours after admission. Heidi understood the pain from her past personal experience, because her father had been sick and unfortunately passed away while she was still transitioning into her role as an NGRN. She felt grateful for the support and care provided by her paediatric ward manager and nursing colleagues and now wanted to support her former colleague, who faced the same personal life challenge in losing her loved one. However, a senior paediatric nurse said, ‘Heidi, you are more fortunate than others since you had more time to work on your feelings before your father passed away. She [the paediatric colleague] is different and more miserable, as her family member died unexpectedly.’ Heidi was deeply affected by this comparison and the judgmental comment. This led her to self-reflect or self-mentor, transforming the comparison of different painful experiences into an educative experience. Heidi saw new meanings of empathy, moving from a superficial and theoretical understanding of staying non-judgmental (the definition cultivated in nursing school), to an experiential understanding as she realised the possible detrimental impact. The educative experience was a painful one. Tears welled up in her eyes as she recounted the situation that caused her such deep introspection and as she reminisced about her beloved father. Heidi self-mentored in learning about empathy from this personal experience, which contributed to her personal practical knowledge (Connelly & Clandinin, 1988), ethical knowing (Carper, 1978) and learning the ethics of care (Benner, 1991), all of which further shaped her nurse story.

Though the following story was Heidi’s first experience in caring for one of her dying patients, she seemed to be well prepared due to her self-mentoring. She drew

from her personal practical knowledge of advocating for holistic patient/family-centred bereavement care. Heidi empathized with her patient and the family, and demonstrated good work in nursing by showing her care and concerns to the family while breaking the bad news on the phone. She also spoke up to ensure that the family had adequate time and space for bereavement instead of conforming to the hospital story lived by the experienced health care assistants (HCA), who treated the last office as merely a task to be completed efficiently. She valued leaving the family their bereavement space, rather than consoling them with some comparison or judgmental statement. She took care of the dead body with great care, not only out of respect for her patient, but out of concern for the feelings of the family when they saw their loved one at the mortuary. Meanwhile, the sense of discomfort and stress commonly reported by new graduates caring for the dead and dying did not come up in her story (Casey et al., 2004; O'Shea Kelly, 2007; Qiao et al., 2011; Yeh & Yu, 2009). By sharing this story in my narrative inquiry, Heidi also intended to inspire readers, particularly NGRNs who had not experienced any mentoring about the intangible aspect of nursing, about the importance of empathy for better bereavement care and good work in nursing. Her retelling story is as follows.

> My patient, a 99-year-old lady, just passed away from an end-staged cancer. When I broke the bad news on the telephone, I reminded her relatives to take care of themselves while they rushed from Macau to the hospital. Some healthcare assistants urged me to hurry and perform the last office. Although I was new and did not know them and they are more senior than me [in terms of age and tenure], I stopped them. There were other empty beds for new admissions. I insisted on waiting for the relatives to arrive from Macau and allowed them to stay with the deceased for a little longer. We shouldn't hurry to finish the procedure and reach the handover. It is unnecessary for the family to feel regret. I also realised that we shouldn't say things like 'It's good that Po-po [Chinese: 婆婆 refers to old woman] doesn't have to suffer anymore', which we imagine has a consoling effect. All they need at that moment might be to cry or grieve, while the attempt at consolation might be perceived as comments by an unwanted outsider [Chinese: 講風涼說話]. The family left the unit peacefully four hours later. Because I had felt discomfort about the bruises over my father's limbs at mortuary, I was cautious in performing the last office of my patient to ensure all the ties were not too tight and the patient was tidy and placed in her most comfortable and serene position. I hoped that the relatives would feel comfort when they saw their loved one at mortuary. My father taught me a lot, both about work and about life. (Heidi, second interview).

The above was an educative experience for Heidi. She self-mentored to speak up for her patients and their families. Looking back, it was fortunate that Heidi was not shaped negatively by an earlier potentially miseducative experience of speaking up. She shared the experience in an email titled 'A Little Story'. In summary, there was a boy who shared a room with a girl, who was also undergoing special treatment. The parents of the boy were highly concerned about any sounds that would disturb the sleep of their child. Despite communicating and negotiating with the boy's parents, the parents insisted on taking away any toys that made sounds and muting the television while the girl was playing or watching television. They even complained that the girl cried most of the time. Heidi and her colleagues were extremely angry, since auditory stimulation was important to the girl's development and they perceived that her frequent crying was normal since her parents were not by her side. Heidi experienced a feeling of loathing when interacting with the boy's parents. She expressed her feelings of anger, unfairness, and even self-doubt at the end of her email. She was in a state of tension to sustain her stories to live by or good work in nursing by 'treating all alike without discrimination' (Chinese: 一視同仁), but her care of and communication with the boy and his parents slowly fell to the most basic level. As she continued to self-mentor through reflection, she shared the following.

> … *The experience of a little story has led me to reflect on the meaning of good work in nursing, which should mean treating all alike without discrimination. However, as I witness the uneven distribution of social resources and how the [problematic] system has caused society to become distorted, and as I encounter such repulsive parents, I really find it difficult to face them with a peaceful state of mind [Chinese: 未能做到平常心去面對]. [After all the communication and negotiation with the boy's parents who insisted to treat the girl with so much unfairness only as they want the best for their own child at the expense of another.] I did find myself resorting to providing only basic nursing care when I attended to their child's needs. I seldom chatted with the boy's family after that or try to understand their needs. While I understand that every parent wants the best for their children, I don't think it is fair that they should be so selfish. However… I wonder, when we live in a society, should we be more considerate of the others as well. Perhaps, I may understand [their perspective] one day when I become a parent. However, I only see selfish parents now who gain benefits for their own boy at the expense of the growth and development of another girl. Whenever I see the parents [of the boy], I detest them. Am I violating the values of my profession?* (Translated email from Heidi on 6 December 2011)

I further explored Heidi's self-doubt in our second interview and revealed a second layer of the story. The two involved patients were children of non-eligible mainland parents and Heidi intended to provide equal care management to patients and relatives irrespective of their background. Heidi and her colleagues also intended to but could not speak up for the girl in opposition to the boys' parents because their ward manager was unsupportive and worried about the parents' complaints. The ward manager even blamed the staff for 'playing' with the girl and 'disturbing' the boy, and did not allow for further negotiation. Understanding the situation from the personal and social narrative space, Heidi's sense of loathing and shaken stories to live by seem to have reflected her lived tension from the issues of ethics. This refers to the pressure from parents of one patient, her concern to safeguard the rights of another and the story told by ward manager under the shaping of the sacred story of the hospital complaint system that disempowered Heidi and her colleagues from being patient advocates or pursuing good work. This was miseducative to their learning to speak up and advocate for the rights of their patients. In addition, Heidi's emotional reaction would have hindered any further relationship building with the boy's parents as emotional engagement is needed to facilitate the establishment of a close and therapeutic nurse-patient relationship (Allan & Barber, 2005). The change could have led to further misunderstanding. In view of the conflicting stories, Heidi and her colleagues could only advocate for the girl by unmuting the television or returning her toys secretly, so as not to trigger any direct confrontation and complaints. They seem to self-mentor, peer-mentor, and support each other, in transforming the miseducative experience into educative one to sustain their stories to live by through protecting the rights of their patients who lacked the voice of her parents. This storied experience revealed the importance of an open dialogue in transforming miseducative experiences into educative ones. The open dialogue within the health care team, including nurses, ward managers, patients and their families, could have enhanced mutual understanding, trust, perspective taking, and even cultural appreciation for better collaboration. The open dialogue between frontline nurses and ward managers in sharing their emotions and reflections might relieve some of the tensions, alleviate some of the emotional work and minimize chances of exhaustion and intention to leave (Huynh, Alderson & Thompson, 2008; Miller, 2011). Most importantly, it is hoped that new possibilities could be identified through this open dialogue for nurses to live a consistent stories of good work in the

midst of other competing and conflicting stories. Nursing literature also reports that inadequate support from management when handling complaints can contribute to reduce nurse satisfaction and decreased intention to stay (Choi, Cheung & Pang, 2013).

In our third interview, Heidi shared that the previous six months had been uneventful and that she had nothing much to share. She was a bit stressed before the final closing interview with the concern that she would be unable to answer my research questions. I reassured her and explained once again my intention to learn from her experience and perspectives. After the interview, I wrote the following field notes reflecting on my state of mind, growth, and happiness in embracing uncertainty.

> *… Each interview is always filled with the unexpected and surprises… Originally Heidi said that she merely worked as a runner and didn't have much to share. Glad that I was not feeling down or discouraged too easily and too early, but stayed open to listen actively and explore with curiosity. That triggered Heidi in recalling important stories that she had forgotten…* (Field notes, 3 October 2012)

11.6 The surname was remembered and the story of spiritual care was retold

One important story Heidi had forgotten was about self-mentoring to provide better spiritual care, an important aspect of good work in nursing. The self-mentoring was triggered by taking care of patients with miscarriages, as a mentoring event, in which Heidi was being influenced in important way after she engaged in self-reflection (Angelini, 1995; Darling, 1985a). She recalled the story during our unstructured interview or dialogue when I was asking a follow-up question about her view of the importance of nursing, which she had shared in the first interview. In contrast with the more physical care emphasized by the medical profession, Heidi sees nursing as more holistic in providing round-the-clock monitoring and care, including physical, psychological, social, and spiritual care. This led me to ask a question about spiritual care. Heidi recounted the following educative experiences. When she was new to the gynaecology unit and worked as a runner, she did not know how to take care of patients who had had miscarriages and had avoided interacting with the first patient she encountered. The next time Heidi noticed her own patient lying listlessly on the bed, eyes red after a suction evacuation, and empathized with her patient's needs to express her negative emotions. She seemed to be self-mentored by realising the

salient point of the situation and making the moral decision to be present with her patient, showing her concern, giving a pat on her shoulder and listening actively, despite all her other busy work. Having finally received a sense of comfort and support, her patient could cry and express her psychological stress and spiritual pain. The patient showed her appreciation for Heidi's care upon discharge by giving her a pat on her shoulder and addressing her with her surname. The experience was educative and as she retold it she realised its importance, seeing as well that spiritual care might not be as difficult as she previously perceived. The patient's appreciation gave Heidi the confidence to sustain her spiritual care in the future. When Heidi was practicing independently after her transition and had entered the stage of integration (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013; Öhlén & Segesten, 1998; Tradewell, 1996; Trice & Morand, 1989), working without the direct supervision of her senior nurses, patient appreciation becomes an important indicator in guiding her nurse story and sustaining her stories to live by. Though other senior nurses did not provide any opportunistic mentoring to Heidi about how to support women after miscarriages, they seemed to cultivate space for her to self-mentor. Heidi's retold story of spiritual care seemed to be shaped by their stories also, for they valued spiritual care and supported each other by taking care of other events when the unit was busy and chaotic. Heidi's retold story of spiritual care might also have been shaped by her narrative history, as she valued the pat on the shoulder and support given by her paediatric ward manager and colleagues when she was grieving the loss of her beloved father. Following is her story.

> I didn't know what spiritual care was in the past. To be honest, I didn't know how to handle a mother who was crying after a miscarriage when I first encountered her as a runner. I walked away. When I was the team leader myself, I saw my patient lying on the bed, listless, both her eyes red after suction evacuation. I wondered why she had to suppress her tears and pain. I went to her bedside and drew the curtains and asked, 'How are you? How is the pain and bleeding?' I started chatting with her and asked, 'Are you feeling unhappy?' I allowed her to express her emotion as she wanted. I don't know about counseling. I could only say, 'Cry if you feel unhappy.' I asked whether her husband has been informed of the bad news yet. She said she didn't want her mother-in-law to know. I understand the possible cultural meaning of her mentioning her mother-in-law. I naturally reached out my arm and patted her on her shoulder and said, 'It has been tough for you to suppress your emotion. There is nobody else here. If you want, feel free to cry and express your emotion.' She burst into tears. I realised that a small action could help her release her pent-up feelings. It is this patient who

> returned a pat on my shoulder upon discharge and said ‘thank you’ to me by calling me by my surname. I felt very happy and fulfilled. This built up my confidence and helped me to see the vulnerability in others, helped me handle future similar situations. Since then, I have tried to be with the patients who may benefit from my chatting with them and passing them tissues and patting them on their shoulders even though it might be busy in the unit. I do it no matter what role I assumed for the day, whether a team leader or a runner. I think this is another part of my learning and development in the gynaecology unit. Also, I appreciate my ward culture. My nursing colleagues understand the needs of these patients with miscarriages and emphasize spiritual care. Even when the ward is busy, they will not mind if I spend some time with the patients and we cover and support each other. Therefore, I think my success in supporting the patient who showed appreciation about my care was not merely my personal effort, but the effort of the entire team. (Heidi, third interview)

In the story above, Heidi’s colleagues understood the need to give particular attention to patients with miscarriages and have emotional attunement with them despite their lack of time. This positive environment allowed and implicitly supported Heidi to continue to self-mentor for the intangible aspect of good work in nursing, the important spiritual care.

11.7 Realising her work quality from patient appreciation

Heidi’s past positive experience with patient appreciation again influenced her in an important way, as it allowed her to reflect more on her quality care practice. She learnt to understand patient care as more than a task to be completed. The continual influence from patients is vividly described in her story as she empathized with her patients as human beings who experienced pain. For example, during wound dressing, she always attended to them gently. Accordingly, she took much longer for the procedure when compared with her senior nurses. She said:

> I followed the same approach that I used in the paediatrics when I take care of my [gynaecologic] patients. I mean attending them gently and softly. I found my seniors finish five to six wound dressings quickly, while I have to use much more time. I began to ask myself why I was working so slow and not contributing much, while my seniors could finish their work so fast. It was not until a time a patient told me she appreciated me while I was dressing her wound. She said, ‘I think you are very gentle when washing [my wound].’ I wondered if she was praising me to make me felt happy. She continued, ‘The other patients feel the same.’ The patient appreciation triggered me to wonder if my care and practice made a difference in the speed of my wound dressing.

> I open all the dressing materials very quickly. However, once I attend my patient, especially those with wounds, I won't be hasty since they are painful. Also, I soak blood clots when I attempt to remove them, if possible. It was not until the patient expressed her appreciation to me that I realised I was working slower but with quality, and I have succeeded in attending to my patient with a caring heart. I guess this is a turning point. I stopped comparing myself to the others and continued in doing what I think is right in providing quality care (Heidi, third interview).

The experience was educative because Heidi no longer doubted her competence when her performance was different from her seniors. She retold a different story of mentoring for good work in realising the importance to sustain her stories to live by, rather than merely following the practices of her seniors. Based on this retold story, Heidi continued to self-mentor and sustain her reaffirmed stories to live by. In her second SDR after registration, Heidi shared the story just described above with the nursing officer who was assigned by the ward manager to evaluate her performance.

> I am happy and satisfied that I shared this experience with the nursing officer who evaluated my performance in the SDR. She reassured me that the acts of some seniors may not be right, but nobody will scold them since they are seniors. She reminded me not to follow them, but to continue doing what I believe is right and not go against my conscience. (Heidi, third interview)

The nursing officer agreed with Heidi's retold stories and further reaffirmed her stories to live by. She also advised her not to be blindly shaped by her senior nurses, who may not be always right. On the one hand, the nursing officer's reassurance can be viewed as an instance of opportunistic mentoring for good work. On the other hand, their dialogue could also be viewed as a 'good work community' for sharing and learning from each others' self-mentoring and supporting each other to sustain good work through searching for new possibilities in the midst of the competing and conflicting stories lived and told by other co-workers in the health care landscape.

11.8 Leaving in the midst

These were Heidi's four relived and retold stories of mentoring for good work that she shared with me during the narrative inquiry. After enjoying dinner at a Thai restaurant, Heidi continued telling me her stories in the gynaecology unit. She has further developed herself by getting a top up bachelor degree, as well as a diploma in midwifery. I am grateful that our participant-researcher relationship has evolved into

a friendship and that Heidi shared my transition from being single to married in my personal life. I also look forward to sharing her joy as she transitions to being a midwife in September 2015.

CHAPTER TWELVE

DEBBY'S STORY - AN NGRN IN THE ACUTE MEDICAL UNIT

12.1 Introduction

As I walked around the hospital canteen searching for a quiet corner seat for the interview, I was both excited and nervous. Debby was the 18th NGRN participant that I was going to meet in the first round of interviews. I was excited to meet another new friend and listen to her stories. I wondered whether there would be any surprises or new revelations or whether my data was going to be saturated. Debby was referred by a department operation manager (DOM) (not from her medical department) whom I met when I was gaining access to her hospital. She was also an administrator of the hospital supportive programme and had frequent contact with NGRNs from different departments. Meanwhile, I did have some reservations about recruiting NGRN participants through the higher officials of the hospital supportive programme, since I worried that their participation might be shaped by implicit pressure from the authorities. Recalling my first telephone conversation with Debby, I was cautious and addressed her situation in a frank way, mentioning that she may have felt pressure to participate because of the invitation from the DOM. I emphasized that her participation was confidential and on a voluntary basis, and reinforced the fact that she could withdraw at any point of the study if she needed to. I had a relaxed telephone conversation with her and hoped to give her time and freedom for further consideration, without expecting her to make her decision on the spot. Nonetheless, Debby had no second thoughts and agreed to participate. Our first interview was scheduled one month after our telephone contact because she was heavily occupied with her top-up degree programme. She had then been working as an RN for about one year and three months. The way we were going to develop the participant-researcher relationship and proceed with our narrative inquiry remained a concern. This was because Debby, as a NGRN participant recommended by a higher official of the hospital supportive programme, might perceive implicit expectation to provide only positive comments and no negative ones. This thought loomed in my mind, while muffled somewhat by the noise of the televisions and chatter from other diners at the hospital canteen. I walked towards the hospital cafe, another place suggested by Debby, to see whether it would be quiet enough for our interview. The choice of the hospital canteen seemed to verify Debby's comfort level regarding our interview, but most of all, it might have just been more convenient to her. At that moment I received a telephone call from Debby, apologizing for being late due to a delayed release from her in-service training. She also told me that she could not stay too long as she had to return home immediately after the interview to prepare dinner for her father, who had had a sudden onset of lower back pain. Although I suggested rescheduling the interview, because I did not want to create an extra burden on her when her father was not feeling well, Debby preferred to continue. Therefore, our first interview was conducted in a rather rushed manner. This is how the stories of Debby and me begin to intersect. I hoped that Debby would

enjoy the research process and find meaning throughout it. (My field notes, 2 December 2011)

This chapter is about Debby, an NGRN in the acute female medical unit. This was a brand-new environment for her, as she had no previous practical or working experience at this hospital before graduation. She chose this hospital mainly because of its proximity to her home. Debby had worked as a Temporary Undergraduate Nursing Student (TUNS) at the special care baby unit (SCBU) at another hospital for two years during her three-year hospital-based nursing programme. However, despite its familiarity she chose to leave it to have a brand-new start at another hospital, because she was interested in adult nursing rather than paediatrics. This chapter is an interpretive account of Debby's storied experiences, written in a way intended to give a deeper understanding of the meanings of mentoring for transition and good work in nursing. Her stories of experiences told in our three interviews were co-constructed and re-constructed with her according to the metaphor she provided below, which she used to capture her first two years of clinical experience.

> <u>The metaphor of a baby learning to walk and getting lost repeatedly</u>
> I think it's similar to a baby learning to walk. When I was still a [nursing] student, I didn't know how to walk. After experiencing different setbacks, I gradually learnt to walk with a steadier gait. There was still a long way ahead of me. I don't want to get lost. I always get lost when I feel discouraged at work. I get lost when I am extremely busy at work and I don't have a chance to think and I just work based on instinct and reflex. I felt lost and then found, lost and found repeatedly. (Debby, third interview)

What does Debby mean about getting lost? Does her description of work as 'based on instinct and reflex' and without 'a chance to think' mean she is being merely task-oriented? The metaphor of getting lost repeatedly seems to indicate that Debby's transitional experience did not happen in a linear or straightforward fashion, progressing from one point to another. 'Getting lost' seems to paint a landscape filled with mist that hinders clear vision and makes it easy to lose one's direction and walk astray. What happened to Debby when she was learning to walk, but getting lost repeatedly? Did she receive any support from the others when she got lost? How could I arrange Debby's narrative to capture the repeated sense of getting lost without creating confusion for the readers? As I struggled with reconstructing her experiences, I kept referring to the transcripts Debby and I had co-constructed. While she shared her experiences, she had not told a messy story, but attempted to make

sense of her experience. She distinguished unhappy experiences from happy ones. The way she presented her stories have reflected her perceived trust in me as our researcher-participant relationship and co-participation developed. Given the established trust, she was more readily to share with me her secret stories when we came to a later stage of our relationship development in the safe space we had co-created. Therefore, I chose to follow Debby's way of arranging the stories when I wrote this narrative account. Her experiences of being lost and found, and her telling and retelling of those unhappy stories are presented later in the chapter, after all the happy stories she told me at the beginning.

12.2 Learning began one month before registration and unexpectedly the role of being a full-ledged team leader

Debby's job application for an RN position was successful and she was employed as a pre-RN TUNS (see Chapter 6) at her current medical unit for about one month while waiting for her practicing certificate. Debby had a supernumerary status, was counted as an extra staff member, and was assigned to work with a senior RN whenever their duties matched up. This RN was later her preceptor after professional registration. Her preceptor taught her about the unit routines and practices, and how to be an RN and a team leader. Though Debby could hardly recall any concrete experiences related to her preceptor in the first two months she worked as a pre-RN TUNS and an NGRN, the following story reveals the sense of safety, security, and certainty she felt with the presence and support of her preceptor, which was all the more remarkable given that she was also adjusting to a new unit and hospital.

> Without a mentor: A squid swimming without direction
> As a fresh graduate, whenever I worked with my mentor [she used the term interchangeably with preceptor without being aware of the conceptual difference in colloquial use], I felt safe. She led me as we followed the doctor rounds and told me what had to be done. If some relatives asked me questions, she helped me to answer them. This allowed me to observe her approach in tackling the questions from relatives. My mentor helped me a lot. Without a mentor, I might have swum like a squid without direction. (Debby, second interview)

The image of the non-directional movement of a squid is not a metaphor that we commonly used for our conceptual construction, but it can be a marginal metaphorical concept (Lakoff & Johnson, 2003). It helped me to better understand

the situation Debby imagined she would be in if she did not have a preceptor: lacking guidance and direction, like walking in the mist. This seems to align with her other metaphor of repeatedly getting lost.

Despite the support from her preceptor coupled with her years of experience working as a ward runner and getting all routine work done when she was still a nursing student or a TUNS in the SCBU of another hospital, Debby perceived the same kind of routine work to be more challenging after graduation. She used 'more advanced' to describe the knowledge required to work as a pre-RN TUNS or RN. A task-oriented approach and a narrow perspective, focusing on a single system of the patient, became unacceptable, and Debby learnt to think from a broader and holistic perspective when performing familiar routine work. The following story reveals the complexity of nursing in an actual situation, where NGRNs might not have the competence and practice readiness to work and think like an RN (Etheridge, 2007) and at a time - immediately after graduation - when further support and learning are needed.

> Ryle's tube feeding is not simply a Ryle's tube feeding
> In the past, when we were taught about Ryle's tube feeding [in nursing school], we only focused on milk tolerance and considered the amount of gastric aspirate needed to further adjust the amount of milk to be given to the patient. When you really became an RN, the required knowledge becomes more advanced. You also have to consider the respiratory status of the patient, who is not fit for digestion if she is desaturating. If the aspirate is some coffee-ground fluid [indicating gastrointestinal bleeding, in which case the Ryle's tube feeding has to be withheld] the doctor has to be informed immediately. You learnt to relate one thing to many other aspects. (Debby, first interview)

Two weeks after registration, while Debby continued to work in supernumerary status as a ward runner, her preceptor or other senior nurses serving as the team leader assigned four of their patients to Debby to help her learning to be a team leader. In contrast to other units that expected immediate practice readiness from NGRNs and assigned them to work independently as team leaders immediately after registration, Debby perceived her unit was good about giving her a month for her transition and adaptation. However, without any forewarning and shortly after being given the four patient assignments, Debby unexpectedly found herself assigned with

a full team of patients the very first day after the first month was up. I was also surprised to hear it.

> The unexpected day of becoming the full-fledged team leader
> The first day I was assigned my own team [of patients] was unexpected. [*Bernice: Not because someone was calling in sick or there were inadequate staff?*] No. After the morning breakfast break and with only three to four hours left before the end of the [eight-hour] shift, while the doctor round was beginning, a senior nurse [not Debby's preceptor] said it was almost time. She handed over her [10] patients to me suddenly. The handover was so fast that I didn't know what she was talking about. I didn't have enough time to read through the kardex by myself [to familiarize myself with my assigned patients and their conditions and catch up with the information I missed in the fast handover], since I had to rush through finishing the prescribed treatment [and other routines]. Although the patients were not critically ill, I remembered the day was a mess. The kardex were messy. I was a mess also. I didn't know what I was doing. I did whatever I saw that had to be done. The handover that I delivered was a mess. That morning shift was extremely stressful. If there was nobody overseeing my performance, I must have missed something. That's also the first day I administered oral medication [in this medical unit]. I was so nervous and terrified. The other [nurses] were giving their medication so fast, while I was so slow. I took out one instead of two tablets of senokot [as prescribed] and was reminded by the senior nurse 'Two tablets!' [*Bernice: Are you satisfied with your performance?*] It's not about satisfaction, as I didn't know what I was doing. Nevertheless, I was assigned to work as a team leader after that [despite this messy performance]. (Debby, first interview)

The above story paints a rather messy or chaotic day when Debby began her story of being a team leader. It stands in stark contrast to her previous well-managed learning experience taking care of four patients. Although both of the learning opportunities took place under the supervision of a nurse, the second was different from her previous one in three ways. First, the number of assigned patients was more than double, increasing from four to ten. Second, Debby had to administer oral medication to her own patients as a full-fledged team leader. This is a routine normally performed by the team leader and so Debby did not have any prior experience with it despite her one month of TUNS experience and one month of transitional experience as an RN in the same unit. Third, the learning experience took place in the middle of the shift, which came as a surprise to Debby. The other learning experiences took place at the beginning of the shift, a time that may offer more certainty and flexibility for handling challenges. Some questions came to mind: who were the people deciding? Was it the senior nurse involved in the story or a group of senior nurses,

including Debby's preceptor and the ward manager? How was the time for such a learning opportunity decided? What is the meaning of 'it is almost time'? Did it refer to the time that Debby was ready to work independently as a team leader? Or was it the time to test Debby's competence after the previous two months of learning as a TUNS and an NGRN? Assuming the latter one was the case, despite Debby's dissatisfaction with her performance, it seems that she passed the test since she became a team leader after all. More than a year since that chaotic day, Debby still could not figure out the reason(s) behind such an arbitrarily timed arrangement.

In Debby's sharing, she had a rather disorganised workflow without good planning and prioritisation, as well as ineffective communication with her colleagues. This affected her in both receiving and delivering the handover. Her emotional responses also revealed her sense that she was unready and incompetent. On the one hand, her unsatisfactory performance could have been largely due to the unexpected learning opportunity and her consequent fear and stress. On the other hand, it also revealed that two months of learning as a TUNS and an NGRN were not adequate to equip Debby with the necessary competence. Furthermore, Debby articulated feeling no satisfaction from the above experience. I am concerned about whether the experience was an educative one, helping her to realise her mentoring needs and areas of needed improvement, or whether it was miseducative in negatively affecting her perceived progress, confidence, efficacy, and self-image and hindering her further professional and personal development. This sense of dissatisfaction with her disorganised performance could have been a key incident contributing to her metaphor of learning to walk and getting lost repeatedly. One important element that is common to the experiences of other NGRN participants was the confusion that resulted the day they received their first team assignment. The NGRNs did not expect it and were unprepared and unready. Is there a possibility of minimizing such uncertainty when mentoring NGRNs in transition? Or has such a schedule been perceived as a good way to equip NGRNs with the necessary adaptability? Although living with uncertainty is inevitable in the complex and dynamic health care landscape, the above situation could have been better managed by giving prior notice, to reduce uncertainty and minimize unnecessary anxiety and feelings of being overwhelmed. In Debby's situation, it would have been safer to have the close supervision of a senior nurse, to prevent potential medical incidents. However, it is questionable whether

patient safety can ever be assured when NGRN participants are assigned to work in an understaffed situation with minimal supervision.

12.3 Every senior nurse is a mentor

Since Debby did not have a completely matched schedule with her preceptor even in the first two months, who supported her when she got lost? In the absence of her preceptor, Debby sought advice or opportunistic mentoring (see Chapter 8) from other senior colleagues working in the same shift who were willing to answer her questions. 'Everyone in the unit is experienced and a mentor. If my mentor was not at work, I asked the other nursing colleagues.' As mentioned earlier, colloquially the terms 'preceptor' and 'mentor' were used interchangeably in the local health care landscape, because practitioners were not aware of the conceptual differences identified in the literature (Stewart & Krueger, 1996; Yoder, 1990; Yonge, Billay, Myrick & Luhanga, 2007). However, Debby seemed to have a different concept of 'mentoring/preceptoring' when compared to other NGRN participants in the previous chapters. They generally had a narrower perspective of 'mentoring/preceptoring' and perceived that it was absent or inadequate in their transitional experience, since they rarely worked with their assigned preceptor. Their narrower concept may be shaped by the hospital story told and stated in the hospital supportive programme about the formally assigned one-to-one relationship that a preceptor is supposed to be (HA, 2006). In contrast, Debby seemed to have different and broader concept of 'preceptoring/mentoring', in which the relationship was not confined to a particular person. It is unclear whether Debby's concept was shaped by her narrative history as an NGRN trained at the hospital throughout her three years of nursing education and her concurrent years of experience employed as TUNS. Her story was consistent with that of my ward manager participants in the focus group interviews, as well as the ward managers in stories told by my NGRN participants, all of whom were graduated from hospital-based programme: 'Every senior can be a mentor [preceptor]'. Is the nursing education the only reason that Debby's concept of 'mentoring/preceptoring' was so different from the other NGRNs'? Does her different story of 'mentoring/preceptoring' merely emphasize teaching to get work done or was Debby able to establish close relationships with her senior colleagues? The story below reveals that Debby was supported and cared for by her colleagues as

an NGRN and a team member. Their support was important to Debby and was not merely work-related but holistic, both professionally and personally.

> My senior nursing colleagues were the most important people in my transition. They taught me how to work effectively as a nurse. They tolerated my mistakes. I didn't hear any gossip about me at least. When my team was so busy that I couldn't finish my work, they took the initiative to help. When they noticed that I was sick, when I had severe dysmenorrhea, they put on the protective gowns and helped me to perform the napkin round for my patients [this is a routine care normally performed by the team leader for her own patients] 'It's ok! Let me do it! Do you have to skip the meal time to leave earlier to rest?' my colleagues suggested. [*Bernice: This is really touching!*]. When I was unhappy, they consoled me. There was a time when I felt unhappy because of personal matters. I cried uncontrollably during the handover. Although this colleague didn't know what was happening, she sent me a message, 'Debby, take care', during her night duty. I greatly appreciated it as it is not a must for colleagues to be so caring. (Debby, third interview)

Although the patients in the unit were formally divided among the four team leaders, the division of labour and the boundary of each cubicle seems more fluid or 'permeable' in Debby's medical unit, which was consistently busy and chaotic. Debby revealed that the nurses complemented each other and actualized excellent team work and good solidarity. Initially I perceived 'nursing colleagues' to refer to the frontline junior and senior nurses, which would include ENs and RNs. I was glad to learn that 'nursing colleagues' also included the nursing officers, who are supposed to assume more management, leadership, and administrative roles. 'Our nursing officers are good and supportive. They helped with any kind of bedside nursing care, ranging from administering medication and handling new admissions to even performing the napkin round.' This further reveals that even the hierarchical structure, ranks, and their corresponding roles and responsibility were less rigid in Debby's unit.

Whenever Debby made any mistakes, her senior nurses would take a non-blaming approach and were supportive of her, which also seemed to shape her different concept of 'mentoring/preceptoring'. This was revealed when she described how they 'tolerated my mistakes' and how she 'didn't hear any gossip about me'. This was further supported by a near miss, an incident that did not but had the potential to do harm to patients. The near miss took place when Debby had been registered for only two months and occurred during visiting hours when patients' families and/or

domestic helpers were assisting and feeding the more dependent patients their meals and medications. Domestic helper A, knowing that her grandmother had a problem swallowing asked Debby to crush the oral tablets. She then went to the washroom. Debby did not realise that two of her patients each had their domestic helper with them. Because of the fleeting encounter, Debby did not get a close look and possibly made some assumptions. She then gave the crushed medication to domestic helper B. When domestic helper A returned and asked the other nurses about the cup of crushed medication, that was when the near miss was identified. Fortunately the cup of crushed medication had not been given to the wrong patient yet. This storied experience reveals two underlying plotlines. The first is that, the common would have been for the other nurses to blame and scold Debby, who was responsible for the near miss. As an insider myself and having observed and heard what other NGRN participants have shared, that was what I expected, and I was glad to learn that Debby's seniors responded differently and showed that they understood that Debby had not made the mistake intentionally. They provided opportunistic mentoring by supporting Debby to learn from the mistake or near miss and reminding her to be more careful in the future. This support enabled Debby to engage in more reflective learning about the kinds of assumptions she made. Debby realised that the medication incident could occur despite her adherence to the standard medication administration procedure (three checks and five rights) for giving the right medication to the right patients. The experience was educative in increasing her awareness of the potential risks or traps of medication incidents in the complex health care landscape, in which medication is not necessarily always given to patients by nurses directly, but with the assistance of other layperson carers such as domestic helpers and family members. Debby became more aware of the need to ensure that medication be given to the right patient when re-administering it after further processing such as crushing.

The second plotline of this story was revealed only after discussion with my chief supervisor, Angela, when she questioned the practices I had taken for granted as an insider. She asked why the domestic helpers were allowed to deliver medications to patients, since this seems to be at odds with the theoretical understanding of the process of medication administration. What does it mean in practice? It seems that Debby, her senior nurses, and I all found this practice acceptable, but it was regarded

as unacceptable when we were all being taught as nursing students to ensure that patients received their medications from us. This narrative inquiry seems to reveal a theory-practice gap that might have been taken for granted, and NGRNs seem to be mentored for this modified practice. It is important to understand why asking domestic helpers or families for assistance had become acceptable practice. It is also important to know what the possible narrative histories behind it are. Is it merely because the nurses are busy and the help is convenient? Or is it because practitioners perceive these carers, though laypersons, are more familiar with the patients? Family members know their relatives' usual medications, eating habits, and preferences, in contrast to the nurses, who are taking care of multiple patients in the unit, where patient turnover was high and length of stay was brief. Given such a background, do nurses allow themselves to be assisted based on the trust they have in relatives' knowledge of the patient? While caregivers' involvement in patient care has been documented in the literature such as family- and caregiver-centred care (Cameron, 2013; Gillick, 2013; MacKean, Thurston & Scott, 2005) or relationship-centred care (Nolan, Davies, Brown, Keady & Nolan, 2004), it is certain timely to re-examine the issue of overlap in nurses' decision-making process and the involvement of caregivers in patient care. Or is it even possible to identify areas for carer education? For instance, if the patient has a newly diagnosed swallowing difficulty, it is possible to take the opportunity for layperson carers to be taught to use thickener to minimize patients choking after discharge. Also, it is important to ask whether current oral medication procedures are adequate to address the complexity of the health care situations, with all their many areas of potential error. These risks can be easily overlooked and taken for granted by nurses as part of their everyday practice. These procedures should be reexamined not only to ascertain patient safety but for their significance for good work, such as improving the performance and education of layperson care givers.

Returning to the earlier mention of collegial support without blame and gossip the following counter story further reveals how important such support is. When Debby compared the different approaches to NGRNs' mistakes in her own female and the opposite male medical unit, she found that the attitudes of the colleagues toward mistakes had a considerable impact on the staff involved, both in relieving their stress and helping them learn from the experience.

> When I made mistakes, I tended to over-exaggerate them. There was a time I expressed my frustration with a senior nursing sister that I had made a careless mistake. She said, 'It is not a mistake if it can be rectified'. She helped me to feel relief. In fact, you have to know how to prevent committing the same mistake again. When new graduates made mistakes in the opposite male unit, the gossip about the mistakes would spread to our female unit. Many of the new graduates over there wanted to resign. That would not happen in our unit. (Debby, third interview)

Debby's nursing colleagues had a supportive and non-blaming attitude towards those who made mistakes, accepting the fact that to err is human (Corrigan, Donaldson & Kohn, 2000) and judge the seriousness of mistakes based on their impact on patient safety. This attitude helped Debby cope with the stress resulting from making mistakes and transformed the experience to an educative one by focusing on finding ways to prevent similar mistakes in the future. Conversely, the use of blaming and gossiping in the opposite unit seemed unconstructive in ensuring patient safety, as opportunistic mentoring was ineffective or even not provided to NGRNs. Hence, the experience was likely to be miseducative. Similar mistakes might be repeated, and those who made the mistakes would experience higher stress levels and stronger intentions to leave after being scolded or realising others were gossiping about them. Debby expressed her frustration over her careless mistakes to a nursing sister. This reveals the trust in their collegial relationship. It may have even been a 'mentoring/preceptoring' relationship. There also seemed to be a commitment to retain staff in her unit, perhaps by providing this supportive understanding. Debby's act of seeking reassurance or opportunistic mentoring from the nursing sister seemed to reveal that her different concept of 'mentoring/preceptoring' was not limited to seeking information for task completion, but also involved some advisory, counseling, and psychosocial components. Hence, her different concept of 'mentoring/preceptoring' can be viewed as an evolved concept of mentoring NGRNs for good work. This evolved concept of mentoring NGRNs for good work, was not confined to a particular person, but depended on the upcoming events, people involved and their supportiveness in the situations, and the established trust and relationships with the NGRNs.

'Gossip' was mentioned twice by Debby in the sentences, 'I didn't hear any gossip about me' and 'the gossip about the mistakes would spread to our female unit'.

Gossiping is a kind of indirect communication, mainly about some negative aspects of a person, with a third party in a less public, more secret place. Although gossip was not an effective way of communication or a form of opportunistic mentoring for patient safety, it seemed to be an important informal way for Debby to better understand how her performance and efficacy were perceived by the others. Her stories to live by and self-confidence might also have been shaped by her desire to avoid negative gossip.

As I continued to listen to the stories Debby told, I kept thinking about her metaphor and her repeated sense of getting lost. Except for the one unexpected day she was made a team leader and felt lost and confused, the stories she had told so far were, overall, positive. Where were the stories of getting lost? The stories seemed to be too linear and uneventful, with only one narrative thread. Where were the other narrative threads? Almost at the end of our first interview, when I was exploring Debby's vision of her future, she finally mentioned something in passing about her sense of feeling lost during her first-year experience in the unit. Her sense of being lost seemed to be related to her exhaustion and frustration dealing with her busy and imbalanced work-life that prevented her from finding meaning at work, despite the supportiveness and teamwork in her unit.

> [I am] Looking forward… to having better health [she frequently felt sick and suffered from low back pain]. Looking forward to having better sleep [she always had nightmares before work]. Also, looking forward to less grumbling. [*Bernice: Do you grumble persistently or there is a recent increase?*] A few months ago, I felt depressed, exhausted, and dispirited for the entire month and didn't want to go to work. I am alright now. [*Bernice: How did you get through the month?*] I did some knitting. I found friends to chat with. I had enroled in a piano class and I am going to start my first class there this month. I found myself through learning something new. I felt like I had lost myself in the first year because my life involved only work and I felt too exhausted to find friends and became isolated. It's over now. When all these had passed, it's like a breath of fresh air. (Debby, first interview)

Debby mentioned how her colleagues had supported her when she could not finish her work. But how busy was it in her medical unit? She briefly mentioned grumbling less, but who and what did she want to grumble about and why? Was she grumbling about some conflicting stories to live by the others? Her stories seemed to align with those lived by her nursing colleagues, so who else in the professional knowledge

landscape that had lived conflicting stories? Patients? Relatives? Doctors? Administrators? Wait! Before talking about the conflicting stories, I needed to find out what her nurse's stories are. What is her story to live by?

12.4 A shift in a busy and chaotic medical unit

While I was reading and analyzing the stories lived and told by Debby, a series of images emerged in my mind that I captured and reconstructed in the field note below, as though I were a non-participant observing the busyness and chaos of her medical unit.

*At the end of the morning and the beginning of the afternoon shift, all the nurses were gathered at the nursing station waiting for the daily staff handover. In the meanwhile, some nurses were checking the cubicles they were responsible for on the duty list, which had just been assigned and written by the morning shift in-charge nurse. When the ward manager started the handover by making an announcement about the new fall prevention form [*the third modified form in two years*], some nurses wrinkled their foreheads, some exchanged comments with their colleagues nearby, others grumbled about the need to adapt to the new form with its new layout and contents. When the staff handover given by the ward manager ended, except for the morning and afternoon shift in-charge, who remained at the nursing station for their handover, the eight other nurses walked towards their assigned four cubicles for patient handover. The unit was full with no empty beds, and the 38 patients were divided among the four incoming team leaders. A few patients were connected to breathing machines, while others had continuous cardiac monitoring. Suddenly, someone yelled, 'CARDIAC ARREST! E-TROLLEY! E-TROLLEY!' [*Emergency trolley for resuscitation*] A nurse rushed to push the E-trolley forward. The two shift in-charge nurses heard this and started calling the doctor and the patient's relatives. The nurse at the cubicle had lain the unconscious patient supine. She checked the carotid pulse of the patient and started cardiac compression. Other nurses went in the cubicle to help by pulling the curtains, giving oxygen, connecting the patient to the cardiac monitor, and preparing medication and equipment for intubation. Someone rushed to the store room to get the ventilator. The doctors arrived a few minutes later and were about to begin intubation. Nurses of the other cubicles started moving out to continue their handover and saw a new patient on a stretcher being pushed through the unit main entrance by the supporting staff. As the unit was full and the patients who planned to discharge today were still waiting for their discharge documents, the shift in-charge asked the HCAs to open a camp bed for this new patient in the corridor. A nursing officer also walked through the main entrance with a pile of papers. She intended to conduct an audit after the staff handover and noticed that the unit was busy and chaotic with the resuscitation, new admission, and handover all happening simultaneously. She approached the shift in-charge nurse to better understand the situation and planned to return for the scheduled audit after finishing audits of other units. Meanwhile, the pulse of the unconscious patient resumed and she had already been put on a mechanical ventilator. The afternoon shift cubicle nurse was in a hurry to finish all the required resuscitation records, the*

medication sheet, and the documentation. The morning shift cubicle nurse and other nurses were tidying up the patient and equipment, and moving the over-bed tables in the cubicle to prepare a path for a portable chest X-ray. When the chest X-ray was taken, the nurses at this cubicle continued their unfinished handover. Other nurses were in a hurry to catch up with the delayed routines that included vital sign monitoring, napkin round, administration of intravenous medication, and admitting the new patient. The fax machine alarm went off, notifying the unit that another new patient was going to be admitted shortly. Two of the relatives of the intubated patient arrived and more were coming. The team leader put aside her routine work and approached the anxious relatives.

The short description above is an account of what happened in less than two hours' time. Such an episode is not uncommon in the medical unit. This description gives a clear picture of the busyness and complexity of the female acute medical unit where Debby worked. The patient admission rates, as well as the patient turnover rates, are high. While it is mandatory for nurses in the State of Victoria in Australia and in California in the United States to take care of no more than six patients (International Council of Nurses, 2009), the patient-to-nurse ratios elsewhere are high with each team leader typically responsible for 8 to 11 beds. However, in a shift, some patients can be discharged or transferred to other units or hospitals, and the empty bed soon be occupied by another newly admitted patient. Therefore, the team leaders always have to take care of more than 8 or 11 patients per shift on 'normal days'. It is not uncommon for the unit to be full with patients still waiting to be hospitalized. Camp beds have to be added and the patient load of each nurse will be increased. Besides the non-stop new admissions, the medical unit is filled with uncertainty and unpredictability. Some patients are critically ill while others deteriorate unexpectedly. Resuscitation is always taking place, and it is not uncommon for more than one resuscitation to be happening at a time. Likewise, emergency situations can always happen during staff meal time when human resources are reduced. Despite the dynamic and chaotic workplace situation, the medical unit still has to follow the hospital mission of quality assurance. There are numerous tasks involving paperwork and documentation, as well as auditing and accreditation, which occupy a large amount of time that Debby thought could be better spent with her patients to communicate with them and better understand their needs. It was also not uncommon for Debby to sacrifice her meal time or work overtime to get all her assigned work done.

12.5 Self-mentoring to resolve the moral dilemma in pursuing good work

In such a busy and demanding health care context, has good work been compromised? 'Can you recall any happy experience or one that left a lasting impression on you?' was an open-ended question I asked Debby. I found that asking such a question is an effective approach to elicit stories of good work, rather than the more direct approach of asking 'Can you recall any story of good work in nursing?' Good work in nursing seemed to be too idealistic or high-minded to many NGRN, preceptor, and stakeholder participants who thought of it as unrealistic in the actual health care landscape. They tended to connect good work immediately to the hospital story of quality assurance through audit and accreditation, a story that they disagreed with. I understand that pursuing good work is challenging in the complex health care landscape, but I am not certain that good work is really too idealistic or unrealistic because as the happy experiences they themselves shared with me often reveal a consistent story of good nursing according to the profession, patients, and relatives. I also wonder whether the seeming embarrassment or discomfort among these local Chinese nurses, when asked about their stories of good work, was shaped by Daoism and the cultural values that encourage modesty and humility (Chang, Simon & Dong, 2012). The following two stories not only reveal Debby's stories of good work, but also the way in which she seemed to self-mentor (see Chapter 8) to resolve a moral dilemma and maintained her principles in the busy unit.

> Finding a cheap private CT scan
> Happy experience… My patient needed a CT [computer tomography] scan for numbness in her fingers. However, the waiting time was a year at the public hospital. Though the shift was busy, I managed to find one with an acceptable price for her after calling different private hospitals. I gained some personal satisfaction in helping her to save $2000-3000. (Debby, first interview)

> Negotiating ways to have better diabetic control
> There was another time an old lady came in who had poor drug compliance. She was frequently admitted for hyperglycemia and required an insulin drip to normalize her high blood glucose. After some discussion with her, she agreed to allow the community nurse to visit her at home to ensure better drug compliance. Many extra things have to be done when filling out the referral form, as well as completing the pages of nursing discharge summary [not required for usual patient discharge]. However, the patient later refused the service because of concern of the cost of the service. She promised to have better drug compliance after discharge. Whether or not the patient followed my advice, I tried my best. I believe she could feel my concern and

> my intention to help. [*Bernice: What motivates you to help when you are so busy?*] I do have an internal struggle, as I couldn't even finish my work and was tired. Ultimately, it is a matter of whether you can live with your own conscience [Chinese: 最終你過唔過到你自己]. She really needs your help. Both of them felt happy with my help, which gave me a sense of satisfaction. (Debby, first interview)

Debby articulated her internal struggles about meeting the expectations in the competing stories of nurses told by the unit/hospital and the patients. On the one hand, she needed to get all the routine work, doctor's prescriptions, and documentation done before the end of the busy shift. On the other hand, she also sometimes needed to do 'something' that not official or not a responsibility that was explicitly stated, usually patient needs she recognised by communicating with her patients and because of her personal practical knowledge (Connelly & Clandinin, 1988). Debby was caught in a moral dilemma when she chose to perform an altruistic act while also needing to meet the expectations in the competing stories despite her busyness and fatigue. She resolved the moral dilemma internally by self-mentoring and asking herself 'whether [she] could live with [her] own conscience'. This perceived feeling of right and wrong, or common-sense morality (Hanssen & Alpers, 2010), rather than any ethical principles, seemed to play an important part in her decision making process. This also revealed her professional identity or nurse stories to live by (Connelly & Clandinin, 1999), which she used through the self-mentoring process to make decisions that were defensible to herself without moral distress. The personal satisfaction she derived from these resolution experiences were educative in guiding her future practices or nurse stories and further self-mentoring for good work. I also invited Debby to share specifically about her perception of good work, which further revealed how her stories to live by were shaped by the busy landscape.

> Good work in nursing. I am practical and realistic [Chinese: 實事求事] and do things that I perceive are important and assist anything related to health. However, I only have one pair of hands. Though pouring a cup of water can be regarded as a kind of nursing care, I have to admit frankly that I am busy now and could only help later. It depends on the importance. I think good work is possible, when there are adequate human resources. (Debby, first interview)

Debby gave a different meaning to the stories of good work as she lived through her experience in a context of heavy patient load and inadequate human resources. Instead of living stories shaped by the sacred theory/practice story of good work as

holistic and individualized patient care, which is the ideal cultivated in nursing school, Debby emphasized ‘practical and realistic’, ‘depends on the importance’ and ‘assist anything related to health’. She also illustrated this with a counter story of good nursing told by patients. Her use of ‘a kind of nursing care’ to describe pouring a cup of water seemed to reveal her awareness of the act’s potential importance to the patient, in terms of not merely meeting physical needs but also possibly her psychological need to feel cared for. However, this action became trivial and against the backdrop of a busy and understaffed health care situation. Debby seems to have self-mentored in giving priority to more urgent and important patient needs, mostly physical ones, while other aspects had a lower priority. Debby also communicated with her patients frankly, telling them that she could attend to their needs only after finishing other more urgent and important work. She did not give them any false hope. Nevertheless, her emphasis on human resources for good work to occur seems to imply her idea of good work was meeting patients’ needs immediately. Meanwhile, their holistic needs often were invisible and, because they were not part of the hospital’s documentation, were not recognised. Instead, her efforts to ensure patient safety in the chaos were expected to be basic, and ‘safety’ often referred to the physical and to injuries. This seems to echo the stories of good work told by other NGRNs, preceptor, and stakeholder participants in the focus group interviews, who perceived good work as something of an ideal in a busy ward. This brought to mind the question raised by some researchers, suggesting the need for a modernized mandate, since the traditional one of providing high-quality, patient-centred, holistic care seems to be overambitious and unrealistic, and seems to have become a source of dissatisfaction and low morale for nurses (Maben, Latter & Clark, 2007). This possibility might give frontline nurses hope that the concept of good work will change in a more fit-for-purpose mandate that does not expect them to actualize good work alone, but rather through ensuring quality and ethical care in collaboration with supportive HCAs and lay caretakers as a team.

12.6 Self-mentoring to relive and retell a story of good death

Debby recounted another important and satisfying story, one that reveals that she self-mentored to gain a broader perspective of ‘a good death’. In doing so, she relived her stories of good work. Her patient had passed away a few hours after

resuscitation and she initially experienced a sense of guilt because the resuscitation seemed to have brought additional suffering to the patient. It was only after the weeping family expressed their appreciation for their effort in caring for and resuscitating the patient and through her reflection or self-mentoring that she had an awakening. She relived her stories of a good death, which was no longer confined to the patient and her health, but was now broadened to include benefit that the resuscitation had provided in allowing space for better family and bereavement care.

> My patient developed cardiac arrest. After a short period of resuscitation, the patient had regained her pulse and was put on a mechanical ventilator. Her family arrived at the hospital shortly. However, the patient passed away a few hours later. At that moment, I felt guilty because I thought the resuscitation seemed to have extended her suffering. It was not until her weeping family said 'Thank You' to all of us that I felt differently. I realised the significance of the resuscitation to my patient and her family, as it provided time for her family to be present and pray for her at her bedside stay. Even though it was just a few hours, it could be of benefit to them. Although in the end the patient passed away, I believe the patient was happy [to pass through the final stage of life with her family]. That was an extremely busy shift, but the resuscitation, because it extended her life for those few hours more, was worthwhile and meaningful. (Debby, second interview)

When Debby was invited to share her experiences with the incoming NGRNs one year after her at the orientation session of the hospital supportive programme, she chose the story above. She hoped to inspire them with the meaningfulness of nursing and the daily reward derived through active engagement rather than just putting in the time and going through the motions without reflecting on their meaning. I appreciated the space that was created for former NGRNs to share their valuable experiences with the younger generations of nurses. However, the sharing session was structured in a rather unidirectional manner, in which the audience, the NGRNs of 2011, was not given an opportunity to raise questions. Nor were they encouraged to have further interactions and exchanges. Otherwise, another layer of mentoring - peer mentoring between recent NGRNs - could possibly happen, which might be more constructive for them as they began their own stories of good work. This might further strengthen Debby's story of being a 'successful' mentor for good work in that episode.

Though getting appreciation from the family made the experience more satisfying and educative, it seems that the conflicting stories of good work told by some

relatives and the one told by hospital administrators contributed to Debby's sense of being lost in her nursing practice.

12.7 The conflicting stories of good work told by relatives and hospitals

Relatives were recognised as one of the most challenging aspects to adapt to in Debby's transition, while the other three aspects were shift work pattern, different hospital practices, and work stress. When I explored whether Debby's stories of nursing had changed after her first year of practice, she said she had found that nursing was not a profession respected by some patients' relatives.

> Distrustful relationship with some relatives
> In the past, I thought nursing was a respected profession. However, the concept of nursing in our society might have been different now. That's why I felt downhearted sometimes. For example, the relatives bought two new packs of diapers for their elderly relative but when only a few diapers were left two days later, they suspected we had used the diapers for other patients, not knowing the frequent changes of diapers were required for this patient! In another instance, the cardiac monitor showed '0' on the screen because the sensor was poorly connected or even disconnected due to the patient's movement. The relatives immediately thought the disconnection was our fault and criticised us for not monitoring the patient closely [without allowing any explanation]. These kinds of happenings have led nurses to feel very frustrated. If they did not trust us, would it be better not to come to the hospital. But these are words that can't be said. (Debby, first interview)

The above story not only reveals the limited understanding of the relatives of the patient's condition and preferences, but most importantly reveals the problem of mistrust between nurses and relatives which led Debby to feel 'downhearted' and 'frustrated'. Similar stories were told by other NGRN, preceptor and stakeholder participants about taking care of patients and families who did not trust the health care professionals. I had a similar experience as an insider which helped me to understand her experienced feelings and need for trust, understanding and appreciation when taking care of a number of patients in the fast and busy clinical environment. The result was equally revealing even after I tried to distance myself from Debby and my nursing experience, and adopt the perspective of a patient's relative: it was still apparent that relatives need to be tolerant of nurses, understanding that they are acting out of their concerns and with the intention of protecting the family members. For layperson care givers with limited medical

knowledge and clinical exposure and their great concern of the patients, their relatives, they might have quickly judged the nurses for their poor monitoring of patients from simply reading off the patient's status on the screen that appeared to be 'dead' in this case. However, they might not have understood that nurses often assess patients' conditions as a whole by including their general appearance, whether they are chatting happily with the families, turning on their sides, or gasping for air and becoming unconscious. Hence nurses are not merely depended on the equipment, which might have poor connection or malfunction. [Bernice's thought at this writing: I wonder at this juncture, are we missing a chance for an opportunistic mentoring when nurse-patient relative's misunderstanding perhaps could be clarified and the trusting relationship be re-established]. Nevertheless, it would not be easy as the relatives' mistrust could possibly be shaped by previous negative experiences with the health care system or even a negative image created by the mass media (Gillett, 2012). It seemed paradoxical but perhaps simply with no other choice that the relatives would allow their family members to be taken care of by nurses whom they did not trust. One way to compensate perhaps is to monitor the nurses' care performance of their patient relatives. However, these stories of the relatives' behaviour, as well as Debby's feeling of being downhearted and frustrated, had to be suppressed in front of the patients and relatives, which required some emotional work. The stories could not be openly discussed, but only told and shared in secret and safe places, for instance, with trusted colleagues at the nursing station, in storerooms, in the hospital corridors, in the pantry and canteen, or with someone outside the workplace like me, an insider who can understand the situation, or after building a trusting relationship in other safe places where she could not be overheard by patients. Meanwhile, there is an official place at the hospital, the patient relation office (PRO), for patients and relatives to tell their stories of good work by nurses. It's possible that the majority of the stories told at the PRO are complaints about the 'bad work' happening at the hospital, but a minority of them is stories of appreciation for 'good work'. Some of the complaints are reasonable and valid, while others likely are unreasonable and irrational. Some are even made with the intention of abusing the complaint system to obtain additional benefits. It is normal for each hospital to establish a PRO to listen to stories told by patients and relatives and possibly identify areas for further improvement. Nevertheless, it is understandable that the hospital administrators and managers want to minimize complaints and negative stories about

the hospital told by patients, relatives, the mass media, and the general public. This was also how Debby described her hospital below.

> A conflict involving bed assignments & lack of institutional support
> The relatives didn't understand this was an acute hospital and camp beds [though less comfortable] have to be added when the admission rate is high. They insisted on having a hospital bed, and could not understand that a hospital bed with bed rails had to be reserved for a 90-year old senior [with higher fall risk]. Why should a 60-year old lady who is self-ambulatory compete for a hospital bed with an elderly 90-year old? I tried to explain but they refused to listen and made unreasonable complaints. I felt I was being treated unfairly as the relatives seemed to have overlooked all the other things we have done for the patients and focused solely on their request for the hospital bed that was refused. Is the hospital bed more important than the health of the patient? Other than giving them the hospital bed, what can we do? [Otherwise the relatives will complain at the PRO.] Meanwhile, the higher officials would not support us, but merely thought that the complaint resulted from poor arrangement by the nurses. Did they ever think about the importance of reserving hospital beds for critically ill patients who need close observation or even resuscitation? It is futile to discuss this with the higher officials because they will simply ask us to empathize with the unhappy relatives who have a hospitalized family member. However, is it necessary [for the relatives] to exert their bad temper on the nurses? Many nurses become dispirited.
>
> Did the higher officials ever respect or feel concerned about the stress that we were under? There was a time the admission rates were so high [that other better places had already been occupied] and the extra camp beds had to be placed on either side of the corridor right behind the main entrance. You can easily imagine how busy and overwhelmed we were. A higher official visited our unit. He merely apologized to the patients sleeping on the camp beds. He didn't say anything to us but left after completing a short patrol. I wonder whether they have ever considered and cared about the nurses. Although we are paid, we shouldn't be expected to work like this. They seem to have taken things for granted. If this was a leisurely working environment, it would be ok that they are not considerate. But when people are inconsiderate in such a busy workplace, what is the point of working so hard? (Debby, first interview)
>
> Disrespectful relationship with some relatives
> The patients and relatives complain of anything that they perceive as their right. What about the rights of nurses? We were being scolded loudly in the corridor, but we have no place to complain. There was a time an old lady had acute retention of urine and required insertion of a urinary catheter. She attempted to pull out the catheter [which could traumatize her urethra]. Therefore, we restrained her upper limbs immediately, before we had a chance to inform the relatives, who arrived right at that moment. Though I tried to explain, they kept scolding me for applying the limb restraints, as well as inserting the urinary catheter. I suggested that he [one of the relatives] talk with the doctor, but he refused and disturbed me for an hour so that I

> couldn't do my own work. I really wanted to blow up. I don't feel I am being respected. Some people respect us, but there is more disrespect than respect. I felt discouraged after working as a nurse for only one year. (Debby, first interview)

I gained a better understanding of Debby's grumbling and her sense of feeling lost and dispirited from the above conflicting stories of good work told by the nurses, the hospital, the patients, and the relatives against a backdrop of inadequate understanding, support, and appreciation from higher officials in the complex health care landscape. As a nurse taking care of multiple patients with only limited resources, Debby had to assign patients to hospital beds or camp beds according to their needs and conditions based on her personal practical knowledge. This aligned with her story of good work mentioned earlier, in which she prioritised according to importance and urgency based on hospital protocols, guidelines and her professional judgment. In contrast, the relatives lived and told a conflicting story from a layperson's perspective. They focused on one patient only and on the moment that they observed during the visiting hours, and ignored the rest of the patients. Some relatives seem to understand the hospital story of minimizing the number of complaints, and they abuse their rights and use the complaint system in the hope of getting what they want, such as a request for a hospital bed. Meanwhile, the higher officials seem to demonstrate no understanding of the nurses' situation and merely ask the nurses to empathize with patients and relatives, or even criticise or blame the nurses even though the patient complaints were unreasonable. Nurses pursuing good work seem to receive little appreciation and recognition from patients, relatives, and higher officials for their efforts and endeavours. All this contributed to Debby's feeling powerless, as articulated through her question of 'what can we do?', as well as feeling downhearted, frustrated, stressed, discouraged and dispirited, and receiving inadequate consideration and care from the higher officials. These negative feelings, together with the relationship with some disrespectful relatives who shout, scold and complain can result in exhaustion and burnout, and even shaken professional identities among nurses. This was revealed in Debby's questions about 'the rights of nurses'. When nurses are fulfilling their duties and obligations, are they and their rights being respected and protected? This hospital story of complaints seems to have disempowered NGRNs from doing good work according to their personal practical knowledge and professional judgment.

Furthermore, Debby and her colleagues had to cover up and suppress these negative emotions, avoiding direct confrontation with patients and relatives and their complaints, and could ventilate only in the secret places. Since nurses use feelings to make moral decisions or self-mentor for good work, as discussed earlier, what would happen when they are asked simply to empathize or to suppress their feelings, without any forms of support? An open and safe space for dialogue between NGRNs and higher authorities is needed, not simply so that feelings can be ventilated, but hopefully to identify constructive ways to address competing or even conflicting stories. For instance, the hospital might have to protect the rights of health care professionals and advocate for them against uncivilised behaviour. Lately, sporadic reports have appeared in newspapers about health care professionals taking legislative action against patients and relatives who displayed uncivilised behaviours against health care workers. This is an important educative experience for the general public to remind them of their responsibilities as well as their rights. This could be a way to show support to frontline staff and would be more consistent with the story of the hospital supportive programme.

As another area where conditions could be improved, could the hospital authority (HA) take a more proactive role in facilitating a better understanding between the general public and health care professionals? The mass media's information about the health care system seems to be overwhelmingly bad stories about hospitals and their medical errors. Could the HA collaborate better with the mass media to ameliorate the mistrust between the general public and the health care profession? Good stories about hospitals that appreciate the endeavours of health care workers and project a positive image could be shared through the mass media with the hope of diluting some of the general public's negative narrative history. Common misunderstandings, for instance, the conflicts common in NGRNs' stories, could be clarified. It might also be time to increase the transparency of the health care system instead of merely telling cover stories. I recognise a rather successful example that took place in the public hospitals in Hong Kong during the winter surge and the outbreak of H7N9 bird flu during Chinese Lunar New Year in 2014. The attendance rates at the accident and emergency departments (AEDs) were sky-high, as were hospital admission rates. The waiting time was long. Patients and relatives in the

waiting hall could not imagine how busy and chaotic it was inside the AEDs and other units. They merely complained at the frontlines about the hours of waiting, despite the fact that their semi-urgent or even non-urgent medical problems should be managed at general clinics instead of the AEDs. The HA made a public announcement through the mass media about the overcrowded situation at the public health care sector and the sky-high admission rates and appealed to the citizens, advising them to visit private clinics or general clinics instead of the AEDs for non-urgent medical problems. After this, the situation drastically improved. This reveals that the HA can be more transparent and improve their communication with the general public.

12.8 Self-mentoring to regain the empathy of reasonable relatives

Debby and her trusted nursing colleagues had been ventilating, grumbling and sharing other negative feelings and their stories about relatives in secret places. In the midst of ongoing conflicts with some relatives, and shaped by her colleagues' stories of relatives and the hospital story of minimizing patient complaints, Debby seemed to have a diminishing empathy for relatives. It was not until two years after registration, before our final interview, when Debby was reading the previous interview transcript, that she retold a different story about relatives. It was at a time when her medical unit was fortunate to be more peaceful and less busy. Debby seemed to have regained her empathy by reflecting on her experiences and self-mentoring.

> After reading the transcript and reviewing what I have told you in the past, I realised that I could be more positive. I am thinking differently now. I did not have high expectations for myself in the first two years. But since I am more senior now, I have to be responsible to my patients, as well as myself. I have higher expectations of myself. [*Bernice: What things would you do differently?]* For instance, I would have more communication with my patients. In the past, I became easily irritated since the patients and relatives seemed never to understand even after repeated explanations. However, when I look back now, I understand their reasons when I put myself in their position. I would grumble less when I am thinking from their perspective. [*Bernice: What led you to have the increased understanding or empathy?*] Indeed, I understood the relatives when I was still a nursing student, a TUNS. I was influenced by the culture after registration. After I have heard so many people say… 'That's ridiculous!' 'The laymen wouldn't understand.' 'Sigh. It's time wasting to talk with them.' Gradually, I [also began to] think it's

> wasting time to talk with the relatives and would feel irritated. It is easy to be influenced. Ignore the extreme ones [unreasonable relatives]. Some relatives may keep bothering you when you are busy; however, it is acceptable since they are asking questions out of their concerns for the old lady. [*Bernice: I am interested to know why you have had such an awakening suddenly?*] A few days ago, the doctor was negotiating with the daughter of a 90-year old lady about DNR [do not resuscitate order]. The daughter was not married and had been staying at home to take care of her mother. I could observe her love for her mother. She thinks resuscitation should continue no matter what, as there might be hope for recovery. My colleagues became very irritated with the endless explanations. Although I disagree with the daughter's decision [of continuing resuscitation even with no hope of recovery], I empathize that the layperson may not understand [the suffering that futile resuscitation causes for the patient]. I think this needs time and patience to communicate. (Debby, third interview)

Before the above self-mentoring to regain empathy toward relatives, Debby seemed to be unaware of the powerful shaping that her nursing colleagues' stories of relatives had had on her since registration. In fact, this is understandable, as these nurses were important to Debby in transition. Debby recognised them as her supporters, mentors, and role models. Also, Debby and her colleagues would continue to explain matters patiently to the relatives despite the relatives' failure to understand, even though they had limited empathy and assumed that the relatives would not understand. Hence, Debby gradually became irritated and impatient quite easily, especially in the busy landscape with inadequate support from higher authorities. Her diminishing empathy might also have been shaped by her negative experiences of conflicts with relatives that resulted in her feeling lost and more easily shaped by others' stories about relatives.

Thinking in the personal-social interaction dimension, it is important to understand how and what had triggered Debby to retell her stories about the relatives from her initial diminishing empathy and the shaping effect of her nursing colleagues. It might have related to her having space to reflect and time to be self-mentored. Reading the transcripts of our previous interview at a time when her female medical unit was fortunately more peaceful and less busy seemed to have created an opportunity to 'pause' and critically reflect on her practice and self-mentor for good work. At the beginning of this chapter I mentioned her need for this self-mentoring space to think and reflect while describing the metaphor she chose for her nursing experience. However, when the admission rate and patient-to-nurse ratios were high, Debby was

shaped to work robotically by reflex or became task-oriented. She had neither time nor energy to communicate with her patients, nor do further study on some new knowledge that she discovered in her clinical experience. She was sometimes so exhausted that she chose to put whatever feeling of the day aside after work. Reflecting on her practice or writing in her diary about her work would only take place when she made a mistake or when something happy had happened. This limited the self-mentoring space she had for reflection, which might have contributed to the feeling that she had lost direction and meaning at work, as well as her lack of awareness of the shaping of her colleagues' stories of relatives on her diminishing empathy. This may be the reason why Debby repeatedly mentioned the need to improve the patient-to-nurse ratio, since a lower ratio would not only improve the possibility for living her stories of good work in practice, but also allow her to self-mentor in sustaining her shaken stories to live by and prevent exhaustion, hence minimizing her intention to leave.

12.9 Self-mentoring to retell 'positive' stories of hospital and stories of unit

Besides regaining her empathy, Debby also retold her stories of hospital and stories of unit after reading the transcripts of the previous interviews. Because of her reflection or self-mentoring, Debby said in our third interview that she could think more positively. However, I found the two retold stories could be taken in a negative or unhealthy way when thinking about mentoring NGRNs for good work.

> <u>Better to believe instead of doubting the conflicting stories of hospital</u>
> I used to find many of the protocols and procedures at work troublesome. Sometimes, you also think that you should adapt to the culture while working there, although I haven't adapted yet. It is better to believe in the rationale behind them rather than doubting them. [*Bernice: Do you mean conforming to those you disagree with or doubt?*] When a new policy or documentation form is developed, it is irreversible. You can't leave the form unfilled. The only thing I can do is to tell myself the form is useful, even though it may be useful in just four out of ten aspects. Accepting it is better than grumbling about its uselessness, which would make me even more unhappy. (Debby, third interview)

> <u>Better to ignore or accept the conflicting unit stories</u>
> [In the past], I would think something had to be changed, for example, the placement of apparatus so that it could facilitate our smooth [operations] at work. Some medications have to be administered using the infusion pump [for an accurate infusion rate]. These medications are usually urgently needed

> [with limited time for preparation]. However, the infusion sets were stored in the treatment room which was quite a distance from the medication room where the intravenous medication cart was stored. In fact, some infusion sets can be stored in the medication cart for urgent use. The junior nurses agreed with me and thought that the changes would be more convenient. However, the seniors are used to the old ways and perceived the current arrangement to be unproblematic, and they returned the infusion sets to their original position. They perceived making changes to be impossible and only causing problems. They claimed that our ward manager prefers tidiness, though it is unreasonable to favour the ward manager rather than us who are working on the frontlines. I tried for the past two years [but was unsuccessful]. I do not have much motivation and would ignore the problem now. As a lower-ranking RN, I have no power to make changes. It is better to accept things as they are. It is no big deal and isn't worth the conflict with my colleagues. (Debby, third interview)

Though Debby was aware of the problems of the hospital/unit stories, they were so powerful that Debby, as an NGRN in the lower echelon of the hospital hierarchy, could not resist them or suggest changes, but the result was that her practices or nurse stories were affected. She retold her stories of hospital and chose to believe the hospital stories and accept that the administrators had their own rationales and perspectives for making all those new changes in the policies, protocols, and documentation forms. She seemed to be making sense of the situation. Otherwise, unhappiness or cognitive dissonance would have resulted. In her unit, Debby had also been trying to initiate changes for the past two years, but was unsuccessful. She found that her senior nursing colleagues, who used to be her mentors, were resistant to change and intended to maintain the status quo and continue in doing things they have always done. This echoed with the experiences of NGRNs in Scotland who perceived their senior nurses as having entrenched views about care and demonstrated resistance to even minor changes for the benefit of patients (Horsburgh & Ross, 2013). Debby did not want to be labeled as someone who caused troubles and made changes at the expense of the established harmonious collegial relationship, which was important in the busy and demanding unit. As a result, Debby also retold her unit stories and chose to accept or ignore the conflicting unit stories.

Debby seemed to have coped with her strong sense of powerlessness to resist the hospital/unit stories and feelings of unhappiness by thinking more 'positive[ly]' in striving to balance of her feelings by reducing the unhappiness. However, her retold stories seem to have a negative or unhealthy layer. That is why I have used quotation

marks to convey my uncertainty of applying the term ‘positive’. Debby seems to have been disempowered for good work in nursing by the powerful hospital/unit stories. She saw no meaning to raising questions and no possibility to suggest improvements. Her professional narratives have had to give way to the hospital and unit plotlines, since the new forms and usual unit practice seemed to become static or ‘irreversible’ after implementation. In order to live with the conflicting hospital/unit stories, Debby shifted from doubting, questioning, and making suggestions to becoming accepting and ignoring the issues, or as I would put it, falling silent. Debby seems to have self-mentored to fall silent and suppress her voice for better quality care. What kind of mentoring is this? Are we mentoring NGRNs to simply follow instructions, norms, and practices, and discouraging them from thinking critically about the meanings of their work, much less alternatives for improving care quality? It is problematic if voices of Debby and other NGRNs were not being heard and gradually fell silent. This could shape their nurse stories and stories to live by and result in them losing sight of who they are and what they know. It is problematic when everyone thinks that they have to conform to the hospital/unit stories in order to preserve good collegial relationships. While good collegial relationships may facilitate the mentoring process, the lack of room to grow and learn beyond what may be different from the administrative plotlines will hinder NGRNs’ possible improvement for better and safer care. How can we improve mentoring for good work in nursing?

12.10 Retelling her story of audit

Debby continued to retell her final story of the hospital, which was about the use of audit for quality assurance. In the first and second interview, Debby recognised the audits as something that she has difficulty adapting to during the transition period. Although Debby agrees that auditing has a surveillance function, she had previously disagreed with their frequency and timing. Auditing can be conducted for various reasons in the clinical workplace, such as documentation, administration of oral medication, prevention of fall to name just a few. Debby found the auditing was conducted too frequently, thus creating an extra workload for the frontline staff. She also recognised the time chosen for auditing seemed to have disregarded the situational aspects of the unit. Although the scheduled audit might be postponed

during a resuscitation and would be conducted later in the same shift, Debby identified that by dropping all the routines to attending the urgent need of resuscitation would have caused a backlog of work, and the continuous audit would in and of itself another added stress on the already chaotic shift. At the time of our final interview, the frequency of the audits had not been decreased at her hospital. Nevertheless, Debby seemed to have self-mentored in retelling her stories about audits, though its meanings was no longer confined to the interest of her patients, but how others' storied audit that could be about her and her unit. The following retold story also revealed her growth in performing the procedure of Ryle's tube feeding, which was mentioned at the beginning of the chapter. She has since had space for reflection, which gave rise to other concerns.

> I was audited on giving Ryle's tube feeding two weeks ago, and abdominal tapping today. I do not worry about giving Ryle's tube feeding. It is a procedure that I perform every day, while some other procedures are less frequently performed. I am happy to be audited now because I do learn from preparing for the audit as it requires me to review points that I might have overlooked in my daily practice. The experience in giving an oral presentation of the procedure for the audit is also a kind of learning which can build up my confidence. If you asked me what I worry most about auditing, it's not only about whether I can answer the questions correctly, but importantly about how my performance may affect the reputation of my unit. That's why I spent so much effort to ensure that I don't miss any points when I gave my answers. (Debby, third interview)

Similar to her previous stories of self-mentoring, Debby's feeling of happiness and satisfaction seem to have played an important role in her retelling of her stories of hospital. Debby has shifted to see the positive meanings of auditing in strengthening her knowledge required for her good performance. Furthermore, her concern about affecting her unit reputation seems to have revealed Debby's growing sense of belonging to the unit. This expanding identity is reflected from one of her interviews when she would talk endlessly about the ongoing supportiveness of her senior nursing colleagues but her concerns about gossiping of the units. In her retelling, Debby no longer seem to have perceived herself as an individual nurse in the unit, but rather a view of the unit as part of herself. Her satisfaction derived from her self-mentoring combined with the peer mentoring has further accentuated the importance of NGRN's development of her sense of belonging to the unit and the collegiality for

survival. A sense of belonging, in turn, would likely improve nurse retention and possibly result in better quality care as good work.

12.11 Leaving in the midst and pending an opportunity for reliving

Debby experienced various conflicting stories in her first two years of clinical practice that had caused her to go astray and get lost. She was supported by her nursing colleagues in the busy and dynamic unit to get her work done, while she mostly self-mentored to find herself and regain her empathy. To use Debby's metaphor, the baby continued to grow and learnt to walk with a steadier gait, and even supported her younger generation. Debby volunteered as a peer mentor to support eight NGRNs two years junior than her, all of whom worked in the medical department of her hospital. She met them once at the hospital orientation programme and had a short chat, exchanged telephone contacts, and took a group photo. Initially, it was interesting to learn that Debby seemed to have not expected these NGRNs to contact her and perceived a limited meaning to her role as a peer mentor. I was glad that our interview seemed to have stimulated Debby to reflect on her role and gain some insights about how she could take more initiative in energizing the group and making it more supportive. But it is also uncertain how she will pass down many of her retold conflicting stories in the health care landscape, such as her stories of good work about a good death and empathy and her hospital and unit stories of accepting, ignoring and falling silent. The following story also reveals many of her uncertainties, which could be related to her first experience as a peer mentor, or inadequate preparation and institutional support, or both. Once again, it seems the new peer mentors were assumed to have the mentoring competence they needed based on their past experience and were left to self-mentor even while they were taking on a new and important role.

> We have exchanged contacts. I have asked them to find me if they feel unhappy. However, I guess they won't call me even so. I think they know who to find to ventilate with. It depends on the acquaintance. [*Bernice: Then this kind of mentoring seems to exist in name only? [Chinese: 形同虛設] Or can it be viewed as an additional channel for venting?*] In fact, yes. If the gathering is limited, the impact will be limited. It depends on us [peer mentors]. You have reminded me, I haven't created a group in the messaging app that I had promised. It's good to have a group for chatting. However, I guess not many of them would feel comfortable discussing personal issues

> among a large group of people. Except for the two new graduates who work in my medical unit, I seldom meet the others… I think a mentor should represent the spirit of the group. You have inspired me. Let me invite them for a tea gathering! (Debby, third interview)

That's all I have learnt about Debby from our three interviews. After Debby left the cafe where we had our final interview, I stayed at the cafe and reflected on our stories and relationship. Debby was one of the participants referred by a higher official, a DOM. Meanwhile, she was the participant with whom I spent the least amount of time in the interviews. We had our first interview in a rushed manner. In fact, this happened to our second interview as well. Debby was heavily occupied with her studies and, for our second interview at a cafe in her hospital, could only squeeze some time during her lunch hour before her afternoon shift. I was glad to meet Debby in a more leisurely manner for our third interview, at a cafe outside the hospital. Not only did we have more time, but the time spent better. After knowing each other for about one year, I was glad that Debby's increasing commitment to the study and our participant-researcher relationship evolved into friendship, so that we were comfortable sharing about both our professional and personal lives. When Debby shared her feelings as a participant, I was relieved to understand better why Debby had never replied to my emails, and I was happy to read her words of appreciation, which motivated me throughout the rather frustrating inquiry process.

> [*Bernice: How did you feel about participating in my study?*] It is good to have someone to talk with, like helping me to review my feelings of being lost and found again, as well as my experience over the past two years. Also, I have made one more friend. You are really good. You have sent me so many emails, while I have replied to none. [*Bernice: You have replied to my text messages.*] I am someone who is too lazy to type and seldom switch on my computer. If you give me a call, I can chat with you for an hour. I also learnt something from you. I realise that passion and sincerity can impress others. You have sent emails at different times giving me an impression that you are not seeking me [only] when you need help. You have put a lot of effort into sending emails, typing the transcripts, interviewing, and revising. You treated each of your many candidates seriously. You are willing to accommodate the others. [*Bernice: That's what I should do.*] You always fit my schedule. I know I always come late and you wait for me patiently. I can feel your sincerity. That's why when you ask me for an interview, I think I have the responsibility to do the job well. I wouldn't have prepared if someone else interviewed me. Although I have briefly written something on a small paper, I have really thought about them. [*Bernice: I know. I can feel it.*] I am happy that I can help you. (Debby, third interview)

By the time I finished writing this narrative chapter, Debby had already graduated from her top-up degree and gotten her master's in cardiology. Her request for a clinical rotation to work in the cardiac unit, where her interest lies, had also been approved. She was looking forward to applying the knowledge she gained at university to practice, as well as to professional development in a workplace with a lower patient-to-nurse ratio. She also hoped that, with time, she will not get lost so easily.

PART FOUR

CHAPTER THIRTEEN

NARRATIVE THREADS AND DISCUSSION

13.1 Introduction

Throughout the inquiry process, I kept thinking narratively of the stories of the experiences of my NGRN, preceptor, and stakeholder participants and the research puzzle about the meanings of mentoring NGRNs not only for the transition, but also to sustain good work in nursing. I felt sad when listening to the painful stories of NGRNs, which were miseducative for good work, that seemed to perpetuate my past experiences at the neuroscience unit with a three-year time lag. I also empathized with their assigned preceptors and with many of the senior nurses for their experience of disempowerment in mentoring NGRNs for good work through living the different sacred stories about the complex health care landscapes. There were times when some of the participants questioned the meaning of this research study, as preceptoring was absent from their experience and doing good work seemed too ideal and unrealistic. I confess that I felt frustrated, wondering what I was inquiring and whether I was searching for nothing. Through my iterative reflections and discussions with my chief supervisor, I regained the confidence to see the meaning and significance of this narrative inquiry. It has the potential to offer deeper and broader awareness of the mentoring experience of practitioners in the health care landscape, both educative and miseducative for good work, as many participants were able to relive and retell stories of their experiences. It also questions assumptions that we might have taken for granted and opens new possibilities for mentoring NGRNs for good work in nursing.

Initially, six narrative threads were identified, namely the preceptorship programme; self-mentoring, opportunistic mentoring, and peer mentoring; confusing the term practice readiness; the use of scolding, blaming, and gossiping; sacred hospital and unit story; and knotmentoring and not-mentoring. These threads, both micro and macro ones, were not mutually exclusive but had interrelationships and dissonances.

Nevertheless, the six narrative threads did not seem to be the best way to represent the complex meaning of mentoring for good work, especially many of the interrelationships, overlaps, and ambiguities, but resulted in multiple repetitions. It seemed better to represent the complexities in using fewer narrative threads.

In this chapter, four narrative threads were discerned, namely: 1) Contrasting stories of the preceptorship programme, 2) Knotmentoring for good work with the self, opportunistic and peer mentoring, 3) Understanding Not-mentoring through assumptions about practice readiness and scolding, and 4) Disempowerment through sacred hospital or unit stories. The complexity is shown when illustrating each of the four narrative threads and contrasting with what was stated in the hospital document with stories of the experiences in practice.

13.2 Contrasting stories of the preceptorship programme

Each hospital has its story of the preceptorship programme for their newly employed NGRNs in transition, as revealed from stories of the experiences of NGRNs and a document analysis of the guidelines of the Hospital Authority (HA). Four common key components include: (I) preceptorship with a unit-based nurse as a preceptor, (II) cluster/hospital orientation, (III) three-hours of simulation training, and (IV) clinical rotation (HA, 2010a). However, the NGRNs' stories of their experiences indicate that their everyday experiences were inconsistent with this hospital story, in which three other kinds of informal mentoring relationships could be identified in the participants' stories, which are discussed in the next narrative thread. The NGRNs' stories of their preceptorship programmes were not included in the previous six narrative chapters over concern that their identities would inadvertently be revealed due to some unique characteristics of individual programmes. They are discussed collectively in this section by using a randomized code (ranging from NGRN 01 to NGRN 1000) without specifying the hospitals' respective specialties, in order to explore inconsistencies at the operational level or in everyday practice.

13.2.1 Preceptorship

The document analysis revealed the hospital story of preceptorship, which is defined as ‘an individualized teaching/learning arrangement in which each new graduate is assigned to a particular preceptor so that s/he can experience a role model and receive guidance from a resource person who is immediately available in the clinical setting’ (HA, 2006, p.1). The period of preceptorship varies across different clinical areas and hospitals and ranges from eight weeks to months. However, the stories of preceptorship told by NGRN, preceptor, and stakeholder participants revealed inconsistencies with this hospital story, some gaps between theory and practice, and two underlying plotlines using in-vivo codes: (i) ‘preceptorship is abstruse, vague, and insubstantial!’, (ii) ‘Being a preceptor is stressful and the preceptor might be blamed!’.

13.2.1.1 Preceptorship is abstruse, vague, and insubstantial!’

Though each NGRN participant was assigned a particular preceptor in their respective unit, more than half of all NGRN participants seldom or even rarely had the opportunity to work with their preceptors on the same shift, even in the first month after professional registration when they needed a great deal of support and guidance. Under the shaping of the hospital story, NGRNs had expected their preceptors to be immediately available to them in the clinical setting and to be their role model (HA, 2006), though they were disappointed to find inconsistencies. For instance, Edwin, who received limited support from his preceptor, especially when being pushed to work beyond his practice readiness, described his preceptorship using the Chinese phrases for ‘abstruse, vague, and insubstantial’ (Chinese: 虛無縹緲) and ‘in name only’ (Chinese: 有名無實). Heidi also perceived preceptorship as ‘meaningless and useless’, as she rarely work with her preceptor who was rotated to another unit after Heidi’s first two weeks there and she was not assigned a new one. Meanwhile, she learnt and adapted based on her self-mentoring in realising her knowledge deficits and asking questions of any senior nurses, but feeling bewildered as she may not be able to pose the right questions to the right seniors in getting the right answer to solve her present situation. Hence her learning may not be easily occurred and to be used for a similar future situation. Preceptorship also appeared to be a paper exercise for the other NGRN participants, who described their

preceptorship as ‘rhetoric’ (Chinese: 名義上), ‘did not have much connection with it’, and ‘could not feel its existence’ (Chinese: 無存在感). Their stories of preceptorship of the hospital are simply a paper exercise, which involves assigning someone to sign the record book. Without a matched duty as designed, it was hard to think of how NGRNs could benefit from the preceptorship.

> Rhetorically, I was assigned a mentor [used colloquially and interchangeably with preceptor]. But we didn’t have much of a connection. My ward manager didn’t assign me to work with my mentor on the same shift. (Day Centre, Timothy, 1st Interview)

> I could not feel its [the preceptorship] existence. My mentor [preceptor] was always having long nights [only night duties instead of the usual alternating of morning, afternoon, and night shifts] (ORTH, Isabel, 1st Interview)

> Sometimes, I want to find my mentor [preceptor] to chat or even to sign the preceptorship record book. However, we don’t have the opportunity to work together. I can only put the record book inside her locker for her to sign. (MED, Lucy, 1st Interview)

NGRNs yearned to work closely with their assigned preceptors besides of their learning needs for specific knowledge and skills, moving the theoretical notion of preceptoring to mentoring even though they are not aware of the differences. It seemed difficult to do without a matched duty, especially at the initial period of transition. In fact, a matched duty was not only expected by the NGRNs, but also by some preceptors. The following excerpt revealed how a preceptor’s expectations of preceptoring were shaped by his past experiences as an NGRN.

> In the past, I followed my mentor [preceptor] for three months. We had established good rapport. I approached her when I had any problems or uncertainties even after work. After years, even though I have been promoted, I still call her my mentor. However, you couldn’t work with your mentee [preceptee] and establish a close relationship now. (GERO, Preceptor 5, FG 3)

Duty arrangements seem to have disempowered NGRNs from benefiting from the preceptoring relationship, which was normally arranged by the ward managers (WMs). The sacred story of a nursing shortage seems to have provided a rationale for the failure to ensure a matched duty between NGRNs and their preceptors, and for the impossibility of experiencing at the operational level the hospital story of preceptorship. Different from the hospital story, the following WM could only

arrange for a modified or watered-down version of preceptoring, by arranging for a senior nurse to work with the NGRNs, although this nurse was not their own preceptor.

> In my ward, I assign a preceptor to each new graduate. However, it is impossible to arrange for them to work on the same shift. Although the teaching may not be consistent, I could only arrange for an extra [nurse] to work on each shift, a senior nurse [not confined to the preceptor] to work with and teach the new graduate in the first month. This is a toilsome arrangement, which depends on the human resources of the ward. (MED, WM 7, FG 2)

The complexity of preceptorship has been revealed, and the situation differs from the story of preceptorship told by the hospital. Preceptorship, in fact, depends on the WM and on the situation in the ward. The above WM was aware that the teaching of different senior nurses might vary. However, her story of preceptoring seemed to emphasize teaching for staff orientation or adopted the functionalist perspective. Also, she seemed to have assumed that every senior nurse had the competence and motivation to support NGRNs, although this might not necessarily be the case. In contrast, most of the NGRN participants yearned for a relationship not merely for task or role orientation, but also provision of psychosocial support. Some NGRN participants were lucky to have a matched duty with their preceptors, such as Agnes in the SCBU and Heidi in the gynaecology unit, even if only for a short period of time. It seems that the quality of how the limited time for preceptoring is used matters more than the quantity of time. This in some ways echoed with the argument of quality versus quantity of time used for patient communication (Chan, Jones & Wong, 2013). With the established trust and relationship, the dyad could continue in supporting each other in sustaining their stories of good work, like the preceptor of Agnes who not only advocated for her but also role modeled for Agnes in her speaking up for the patient with the thermovent being connected to the humidifier by the unit influential figure, Miss A. For some other NGRN participants, though they may not experience the kind of mentoring that they yearn for, they relived and retold their stories of mentoring by the end of their first two years of practice and our one year narrative inquiry. They developed increased awareness of the importance of communication for relationship building and understanding the mentoring needs of NGRNs, such as Edwin, despite his traffic signal metaphor. Ning shaped by her peers developed increased motivation and initiative to support her younger

generation and regained her hope to develop friendly relationship with her future mentees. Debby was also stimulated by our conversation in the inquiry process to reflect on her role as a peer mentor and gained some insights about how she could take more initiative in building relationship and energizing the group to be a supportive one.

13.2.1.2 'Being a preceptor is stressful and one might be blamed!'

Even as a preceptorship might not benefit NGRNs as expected in the hospital story, preceptorships could become an additional source of stress to preceptors or other senior nurses if there were not enough of them to supervise NGRNs in an already busy and overwhelming environment. In a health care landscape with nursing shortages, it was not uncommon for seniors to assume dual responsibilities, as both preceptors of NGRNs and ward runner, team leader, or shift in-charge. With an imbalance between junior and senior nurses, seniors might have to oversee up to four NGRNs, as reported by a preceptor participant, who had graduated in the same year as I, and hence had only three years of clinical experience. Many of them expressed fatigue or even exhaustion in being assigned to engage with the non-stop cycle of preceptoring that occurred when nurses were newly employed and rotated in from other units, as well as from the high turnover of nursing students on their clinical practicum. Similarly, Agnes's preceptor had her patient assignment at the NICU while preceptoring Agnes and her three peers, during which her limited learning was revealed one month later when she took care of a patient independently.

Being blamed for the mistakes made by NGRNs was another reason why preceptors were feeling stressed. Preceptors were expected to teach/coach NGRN's to develop their knowledge and skills. Yet the lack of a matched duty between them and their NGRNs made it difficult for them to provide immediate guidance and act as role models as stated in the hospital document on preceptorship (HA, 2006). For instance, Nancy's preceptor was scolded when Nancy performed in an unsatisfactory manner during the drug administration assessment, or Ning's shift in-charge was scolded when Ning forgot to arrange transport for her patient. All of the other preceptor participants also commented on their stress during the focus group sessions. Most NGRNs participants who focused on their stress in our initial interview seemed, in our subsequent interviews, to be able to tell their stories by taking the perspective of

their senior. They understood that their senior felt that it was stressful to work with and oversee juniors to prevent them from making mistakes that might do harm to the patients. The following interview excerpt illustrated the demands on and the stress felt by preceptors and senior nurses with dual responsibilities. The vicious cycle of blaming or scolding is further explored in another narrative thread.

> The mentor [preceptor] is recognised by other colleagues as merely a person from whom the NGRN is to seek help, or who is to be **blamed** when the NGRN makes mistakes. **'What is she doing? How did you teach her?'** Working as a mentor has become burden to me, especially when I am not working as a shift in-charge, but as a team leader. As the in-charge, I can temporarily put off all administrative work to oversee the new graduates in taking care of patients. However, if I am a team leader, I am taking care of more than a dozen patients, and overseeing hers, so I am taking care of about thirty patients. It might be better if she were my own mentee [preceptee], in which case it would be my responsibility to look after her. However, we also have to oversee other new graduates when their preceptors have a day off, which is quite frightening and stressful. 'Oh my God! I have to oversee her [the other's preceptee] today!' Everyone wants to shirk the responsibility of mentoring [when NGRNs are not their preceptee]. The new graduate is miserable about being perceived as a burden by others, especially when they are being pushed to be a team leader after one to two months. This is a vicious cycle under the 'accountability system' [Chinese: 責任制]. Some have reported sick themselves [in view of their dual responsibilities] or have even asked new graduates to report sick by saying 'I don't want to see you, don't come back tomorrow!' I understand the reason behind this, as we are simply under too much stress [to be a preceptor]. (GERO, Preceptor 5, FG 3)

The NGRNs described their preceptorship amidst a complex health care landscape as 'abstruse, vague, and insubstantial', and one that provided limited space for learning and sustaining good work. However, the scenario was equally stressful for their preceptors. Their lived stories of mentoring are very much at odds with the grand narrative of the hospital documents.

Another aspect of the story of the mentoring experience is the emphasis on the contents of the mentoring. It seems that only the physical or tangible side of patient safety was emphasized, especially those aspects that require documentation, such as falls, injuries, and the effects of medication. The intangible side, which is just important to patients, such as communication, bereavement care, or the psychosocial needs of the patients, was often overlooked. This intangible side, which is an important aspect of good work, often depended on the NGRNs' self-mentoring or on

the opportunistic mentoring of others when the need for mentoring was noticed by chance.

13.2.2 Cluster/Hospital orientation

Basically, all cluster/hospital orientations were conducted in the form of lecture-, classroom- and workshop-based learning. There were variations across different hospitals/clusters in terms of the components, contents, duration, ways of conducting the orientations, and attitudes of the administrators and organisers. Some programmes also incorporated discussion sessions between the NGRNs and the organisers and administrators. In some programmes other nurses outside of the NGRNs' workplaces were assigned to provide additional support; in which case, such nurses might be assigned to visit NGRNs at their workplaces. No in-depth qualitative study on these orientation programmes could be identified. Two programme evaluations of two hospitals using a quantitative approach could be identified, although these were in the format of conference proceedings. As limited information was provided about the studies it was difficult to evaluate the validity and reliability of the findings. The findings that have been limited to programme outcomes have been overwhelmingly positive. These include the satisfaction and one-year retention rate of NGRNs (Chan, Choi & Leung, 2012; Tsang, Chan, Lau, Wong, So & Chan, 2015) and the brief feedback of supervisors (Chan et al., 2012). In contrast, it was not uncommon for the NGRN, preceptor, and stakeholder participants of this narrative inquiry to comment on the orientation programmes of their hospital as being borderline or even not very useful and helpful, giving different reasons that will be discussed below. Their comments were possibly shaped by the story of support told by hospital at their orientation sessions, which led them to form certain expectations of the support that they would receive, as well as by the stories told by others of their orientation, such as those told by other NGRNs, their senior nurses, and WMs.

13.2.2.1 Lecture-, classroom-, and workshop-based learning

Based on the document analysis, I determined that each hospital or cluster has its own long list of topics to be covered in the orientation, similar to my past experience of being oriented to both soft and hard skills. Some of the soft skills include the hospital's vision and philosophy, professional ethics, clinical communication, and

stress management. Hard skills include patient documentation, the administration of medications, blood transfusions, basic life support (BLS), the hospital computer system, infection control, occupational safety and health, and workplace violence. Although the list of topics seems to be comprehensive and well-structured, many of the NGRN participants commented that these structured learning experiences were not very helpful and useful to their transition and pursuit of good work. There seemed to be two underlying plotlines. First, it seems that the orientation did not meet the mentoring needs of the NGRNs. This mismatch has been briefly reported in another study, conducted in Taiwan (Feng & Tsai, 2012), while this narrative inquiry attempted to provide more details about how the orientation was a mismatch with the NGRNs' need for complex knowledge in practice. From the stories of their experiences in the narrative chapters, it can be concluded that their daily clinical practices were more complex and unpredictable than they might perhaps have expected, with the knowledge gained from these experiences not necessarily transferable to other situations where the context was different. Much of their work and decision making was not straightforward, but required a holistic understanding of the entire clinical situation. For instance, delivering a well-integrated handover, speaking up to report problems to the more senior doctor to advocate for their patients, managing emergency situations, and being the night in-charge nurse. It is perhaps the case that in the orientation too much emphasis was placed on standards, protocols, and procedures applicable only in stable and controllable situations, but not in the often unstable and unpredictable yet common clinical situations where it is easy to make mistakes. It is also perhaps the case that the common mistakes made by NGRNs were not evaluated to identify the root cause of the mistakes and the mentoring needs of the NGRNs. The first excerpt below revealed the NGRNs' yearning for the kind of knowledge or mentoring that is needed in practice, rather than the theoretical knowledge that can be gain by reading or self-mentoring. Also, as the second excerpt indicates, it is open to question whether the common mistakes made by NGRNs were evaluated to identify the root cause of the mistakes and any mentoring needs not only of one NGRN, but possibly of all other NGRNs.

> The orientation programme sucks… For instance, it is a prerequisite to complete the E-learning [online learning] prior to taking the course on workplace violence. However, the full-day course just repeated the same teaching material as in the E-learning. What was the point of attending? In

> contrast, the basic life support course was useful, as we were sure to get practical experience. (NGRN 35)
>
> The orientation programme is truly a vain effort [Chinese: 唬氣] or even a failure. I don't think it can help the new graduates [one year junior to the NGRN 70] in any sense, as after a year they continue to make the same mistake of administering the wrong intravenous infusion. (NGRN 70)

The NGRNs' stories of their orientation programmes echoed those told by some preceptor participants in the focus group interviews, as shown below. The use of terms such as 'gimmick' and 'token exercise' revealed conflicting stories of the orientation programmes told by the hospital administrators and some nurses formally assigned as preceptors of NGRNs. Their descriptions of 'not helpful… even worse and just time wasting', and 'limited and routine' gave some clues that the complexities of nursing could not be addressed by the orientation programmes.

> **Preceptor 5 (GERO)**: The hospital's supportive programme, honestly, is just a gimmick [Chinese: 綽頭]. It is just about copying some overseas orientation programmes to reduce the attrition rates based on statistics. Although a new graduate has an assigned mentor, they seldom work together. This makes it difficult to establish the kind of close relationship that I had enjoyed with my mentor.
> **Preceptor 4 (MED)**: I agree with Preceptor 5 on the hospital's supportive programme. The ward already had an inadequate number of staff, while the new graduates kept going to attend classes. Could they absorb the large amounts of information? It just appeared that the hospital had provided some training to them. It is also supposed that the new graduates could then take up their new role more quickly. As a nurse who has worked at the medical unit for many years, I don't think the classes would be helpful and believe that they are just a waste of time (FG 3)
> **Preceptor 10 (SURG)**: The classes are only token exercises [Chinese: 象徵式]. I couldn't see any improvements in the new graduates after they had attended the classes. It just depends on the attributes of the new graduates…
> **Preceptor 8 (MED)**: The support provided at the institutional level is very limited and routine… It can't help much. (FG 4)

In contrast, the orientation programmes seemed to have shaped the expectations of some preceptor and stakeholder participants about the knowledge of the NGRNs or their ability to take the initiative to ask questions. It is reasonable to evaluate the effectiveness of an orientation programme based on the performance of the NGRNs. However, underlying these expectations were assumptions that the orientation programmes were effective at equipping NGRNs with the complex knowledge needed in practice. Concerned about the nature of the theoretical contents and the

sheer volume covered in the few days of the orientation, many preceptor and stakeholder participants questioned the NGRNs' capacity to absorb the information and integrate the learning into practice. One found that some NGRNs failed to return demonstrate procedures that were covered in the orientation, such as checking the validity of the glucometer (SURG, APN 6, FG 2).

The second plotline is about the time for conducting the orientation programme to benefit the NGRNs in their stressful transition.

> The orientation programme sucks, as it was provided two months after registration. [Sigh!] What's the point of teaching? (NGRN 35)

This is an interesting issue, yet I believe there are some narrative histories behind such an arrangement. It is possible that the intention behind the arrangement was to meet the need of all NGRNs for orientation. These NGRNs have different appointment dates, as the date for issuing the licence to practice varies across institutions. It is also possible that some new graduates might delay their employment until a later time, when they return from a vacation or graduation trip. From a logistical perspective, it is reasonable for the institution to organise a mass orientation programme for all NGRNs. However, it might be time to reflect on the core meaning of conducting the orientation and its potential significance to NGRNs in transition and, ultimately, to patient safety, especially when NGRNs are often pushed to assume full responsibilities soon after registration due to a shortage of nurses.

Although the orientation programme is compulsory for all NGRNs, the hospital's orientation story might conflict with the realities faced by some WMs, especially when their unit suffers from a staff shortage. A medical WM participant articulated the difficulties she faced in managing the human resources of her unit, as the unit had too many NGRNs and had to provide monetary compensation for them to attend the orientation programme on their day off. An NGRN participant had the opportunity to attend the orientation programme herself; however, she shared what she heard about the experiences of other NGRNs in her hospital. The information is a secondary source, nevertheless the stories of others were meaningful enough to this NGRN participant for her to share them during our unstructured interview on concerns about

the time for conducting the orientation programme. It also allows us to look at the hospital story of orientation from a different perspective. Ironically, the orientation programme intended to support NGRNs through a stressful transition, seemed to have itself become an additional layer of stress.

> It [the orientation programme] is compulsory [for all NGRNs]. However, many of them were not officially released by their WMs to attend, except for the first day of orientation. [*Bernice: Because of inadequate human resources?*] Yes. Or I heard that some NGRNs were assigned to their team of patients, yet were being asked by their WMs to attend the [half-day] orientation. The patients were temporarily being cared for by other nurses. These NGRNs had to follow up on their patients' care after the orientation, and the situation was chaotic and awkward for them to manage. (NGRN 25)

The shortage of nurses could have been a way of preventing NGRNs from receiving some support from the hospital by attending the orientation programme. One might ask why some WMs did not allow their NGRNs to attend the orientation programme. Was it because they thought that the orientation could not adequately equip NGRNs with the complex knowledge that they need, or that the NGRNs were competent and ready to practice? It seems possible that they might have perceived the NGRNs to be incompetent, but who could be supported by other senior nurses. However, whether this necessary opportunistic mentoring to ensure patient safety can occur in the midst of a staff shortage is questionable.

In terms of time, it is important to note the continuous changes and improvements along the narrative inquiry, as some hospitals organised intensive orientation programmes of almost one week before assigning NGRNs to individual units. The stories of their experiences revealed that the orientation programmes seemed to be held up as a panacea (Mills, 2009). Nevertheless, this narrative inquiry unveiled the assumptions of this orientation that might have been taken for granted. It is important to ask what, how, and when the orientation programme should be conducted to truly meet the mentoring needs of NGRNs and to benefit NGRNs in their transition and in sustaining their good work in a complex health care landscape.

13.2.2.2 Free discussion session, and ward visit

Dissatisfaction with the communication between NGRNs and organisers seemed to be another reason for the complaints by many NGRN participants that the orientation

programmes are not useful or helpful. In the hospital story, various components such as free discussions between NGRNs and organisers/senior nurses, and ward visits by senior nurses outside the workplace seemed to be intended to provide psychosocial support to NGRNs.

Discussion sessions

By including a discussion session, a space seemed to be created for NGRNs to discuss with the organisers and their peers the concerns and difficulties that they encountered at workplace. However, the effectiveness of such a session would depend on how the discussions were conducted to encourage mutual communication. Some NGRNs had been voicing their concerns about some sacred stories that disempowered them from doing good work, such as the hospital complaints system and excessive paperwork. Ironically, their voices were not heard with an open mind to encourage further discussions to find constructive ways to address the issues. Instead of providing psychosocial support, such discussions conveyed negative meanings of lack of supportiveness, lack of care, and close-mindedness. It even had a silencing effect, as the NGRN participant below hesitated to express similar concerns after witnessing her peers being refuted or ignored.

> Many of the new graduates voiced their concerns, such as about the hospital complaints system and excessive duplication in paperwork. They felt that it was unfair that more attention has to be given to patients simply because they had made complaints. However, their [the higher officials'] responses revealed that they were not listening. We were comparing apples and oranges [Chinese: 你有你講，佢有佢聽]. [*Bernice: What were your expectations?*] To be listened to, to receive feedback, and to see follow-up actions. Not to be refuted immediately. [NGRN 48]

In contrast, two NGRN participants from another hospital appreciated such opportunities for discussion. They felt safe to express their opinions and felt that they were being heard with empathy by high officials of the hospital hierarchy. Some of their suggestions, such as on how to improve future programmes, were taken into consideration and appropriate changes were made to subsequent programmes. These two different stories of the discussion session highlighted the importance of consistency in telling a story of support and offering support, rather than treating such a discussion as a task to be completed.

Support and ward visit from a senior nurse who was not working in the same place

Some stakeholder participants in this study mentioned that the ward visits by senior nurses outside the NGRNs' workplace seemed to be positive and supportive. Such visits were also used in some programmes examined in other studies to help NGRNs solve problems and reflect critically (Ronsten, Andersson & Gustafsson, 2005; Scott & Smith, 2008). However, the excerpt below reveals that the ward visits do not address the complexity of mentoring in a busy and public workplace. Temporally, there was a lack of time for in-depth communication. Spatially, the workplace was not considered a safe and private one for NGRNs to express their concerns authentically, given the presence of the WM, senior nurses, and many other people. Socially, it was questionable whether enough trust had been established between the NGRN and the visiting senior nurse for the latter to offer the necessary psychological support, given the hurried and frantic nature of the visit and the frequent use of closed questions. The rushed ward visit described below seemed simply to be intended to fulfill the task of visiting and asking questions.

> Although the senior nurses [from outside the workplace] came to visit us in our unit, we were heavily engaged with our team of patients, which didn't allow us to speak out but only to chitchat. '**Busy? Ok, ok… No problems? Adapting well? Your mentor is good? Your WM is good? I'll see you next time.**' Also, how could I express myself [authentically] to the senior nurse when my WM and nursing officers were just behind us? It is meaningless to have different programmes that claim to provide support and turn out to do no such thing or that remain at a superficial level. I prefer meeting after work in a private place to share our feelings, like we are doing now in exploring my feelings [during the in-depth interview] (NGRN 70).

Also, not only the NGRNs, but also the senior nurses assigned to make such ward visits need to establish a relationship of trust with the NGRNs who are involved, so as to be able to understand their needs before providing appropriate emotional support. A stakeholder participant shared her experiences of visiting NGRNs who were not working in her unit and with whom she had built only a limited relationship, and stories about the difficulties that she had encountered in supporting the NGRNs involved. Thinking along the dimension of personal-social interaction when both NGRNs and senior supporters brought their doubts, this kind of support seemed to be too artificial to move beyond the level of superficiality without the facilitation of others.

> Although senior nurses were asked to volunteer to support the children [new graduates], some were assigned by their WMs. As we worked in different wards and they already have their own mentor in their ward, we were not expected to teach skills or knowledge, but asked mainly to show our care and concern. However, I think this is quite difficult and much depends on whether the juniors treat you as friend and are willing to share their thoughts with you. They might be scared of your seniority and rank and won't tell you their true feelings. They can't tell you 'The staff who scolded me is bad!' I wonder about the effectiveness of this kind of programme. (NEURO, APN 10, FG 2)

13.2.3 Three hours of simulation training

Three hours of scenario-based stimulation training was provided to the NGRNs, although at different times in their first year of clinical practice. According to the hospital document, its objectives are to consolidate the clinical skills of the NGRNs, particularly in the aspects of patient assessments and the management of medical emergencies (HA, 2015b). It is important to note that the NGRN participants who showed strong appreciation of its usefulness belonged to medical units where they learnt about how to make decisions in emergency situations. In contrast, although participants in the other specialties, especially paediatrics, commented that the stimulation training was interesting, they found that their learning had limited applicability or transferability to their daily practice. This might be closely related to nature of the five scenarios, which focused on adult nursing in situations commonly encountered in acute medical units, such as asthma attacks or desaturations. On the one hand, the positive comments, although limited, seemed to confirm the effectiveness of simulation in orienting the NGRNs to their professional role, building up their competence and confidence, and providing them with a safe and supportive environment for learning (Ackermann, Kenny & Walker, 2007; McNiesh, 2007; Olejniczak, Olejniczak & Schmidt, 2010; Walder & Olson, 2007). On the other hand, this narrative inquiry might have revealed the more complex mentoring needs of NGRNs, especially when the use of simulation training is gaining popularity at the HA (2015b). NGRNs yearned for not only general knowledge or a standardized simulation, but also for further facilitation in transferring the knowledge that they had gained in the training sessions to their daily practice or even for scenarios specific to their specialties. Further research is needed on the effectiveness of simulation training for facilitating or mentoring NGRNs for good work or specifically for acquiring some of the knowledge that the participants identified as being troublesome (Perkins, 2006). Perkins defined troublesome knowledge as

'knowledge that appears counterintuitive, alien (emanating from another culture or discourse), or incoherent (discrete aspects are unproblematic but there is no organizing principle)' (Meyer & Land, 2006, p. 9). Troublesome knowledge is related to threshold concepts (Perkins, 2006). Meyer and Land (2006) view a threshold concept as 'a portal to a new and previously inaccessible way of thinking about something. It represents a transformed way of understanding, or interpreting, or viewing something without which the learner cannot progress' (p. xv). For instance, NGRNs may not have a problem with carrying out and handing over or stating each doctor's prescription. However, all NGRN, preceptor, and stakeholder participants agreed that they might not grasp the organizing principles linking each intervention and investigation with the patient's diagnosis, progress, and medical history. They might also not understand the holistic situation of each patient in a team of patients well enough to deliver a well-integrated handover. In some ways, this is consistent with Kneebone's (2009) argument of the need for simulations to reflect rather than to simplify the chaotic health care landscape, with its many uncertainties and unpredictabilities. It is also important for the organisers of these programmes, the experts, to work with the novices to identify their mentoring needs – needs that they are often unaware of or find difficulty articulating (Eva, Cunnington, Reiter, Keane & Norman, 2004; Kneebone, 2009). This collaboration is important to ensure that a simulation addresses their needs and, ultimately, to ensure patient safety and good work amidst a nursing shortage and concerns that NGRNs are often being 'pushed' to take on leadership roles beyond their practice readiness, which could jeopardize patient safety and undermine the NGRNs' confidence. More 'advanced' simulation training on the responsibilities of a shift in-charge or on how to take care of the more critically ill and unstable patients might also be needed to meet the shifting needs of a complex health care landscape.

13.2.4 Clinical rotations

As part of the mentoring programmes, NGRNs are expected to rotate twice within the two years of their transition. Based on the document analysis, the aim of these rotations, expected to commence at around 12 months post-registration, is to broaden the NGRNs' clinical experience to ensure sufficient time for them to initially establish themselves (HA, 2006). This benefit of clinical rotations has the quality of a sacred story, and has not been questioned. However, two underlying plotlines that

seem to be taken for granted could be uncovered through the fairly consistent stories of their experiences told by the NGRN, preceptor, and stakeholder participants.

13.2.4.1 Clinical rotations become a source of stress and exhaustion

Among the seventeen NGRNs who remained in the study two years after their professional registration, six had experienced a clinical rotation, while the rest often had their rotation in their third or even fourth year of practice. The lateness of the rotations had much to do with the severe shortage of nurses and the poor mix of skills, referring to qualifications, experience, and competencies (Spilsbury & Meyer, 2001). Among all six NGRN participants who had experienced a clinical rotation in their first two years of clinical practice, only Heidi had the 'luck' to be supported by her preceptor, who even relived her stories of mentoring for good work. In contrast, the other five were assigned to assume full-fledged responsibilities as team leaders in the first few days after their rotation with inadequate support. They had been self-mentoring, and seemed to assume that the personal practical knowledge (Connelly & Clandinin, 1988) that they had gained was transferable to the new unit or was adequate for NGRNs to use in identifying their knowledge deficits in seeking further opportunistic mentoring. Without systematic mentoring or teaching, their stressful experiences would be very similar to those of Nancy, who perceived herself to be a burden to other nurses, and their confidence would be affected. Two NGRNs left the HA after 1.5 and 3 years of practice due to dissatisfaction with their units. Most alarmingly, patient safety is likely to be jeopardized with the many assumptions made and confusion over the term 'practice readiness'.

In the dimension of personal-social interactions, not only NGRNs, but many preceptors and stakeholder participants, as mentioned earlier, articulated a great sense of fatigue, low morale, and even exhaustion with the non-stop cycle of 'mentoring' nurses who had newly graduated or who had been rotated from other units. Without much improvement in the matter of the shortage of senior nurses in each unit and adequate managerial support, the clinical rotation seems to have become an added source of stress or even exhaustion to both NGRNs and preceptors in an already overwhelming health care landscape. Once again, 'preceptoring' remained task-oriented but also ineffective.

> The clinical rotation has its pros and cons. New graduates might receive more clinical exposure, and hence be more vigilant of problems, as orthopaedic patients could also have medical or gynaecological problems. However, it is also difficult for us to teach, as they seldom work with their mentor [preceptor] – one week at most. I could only tell her what she had to do when taking care of patients with a fractured hip. They had to pick up managing cases in the specialty on their own. This is stressful and difficult for them. (ORTH, Preceptor 6, FG 4)

> The notion of clinical rotations is good if human resources are adequate. When the shortage of nurses is affecting the normal operations of a unit, it is questionable whether going on rotation does good or harm. New graduates had just adapted and were then rotated. They also felt scared. (SURG, APN 4, FG 1)

> Clinical rotations seem to be a good pathway for graduates to gain different experiences. However, they are highly discouraging for their assigned mentors or senior nurses, as the new graduates who have finally adapted after several months, then leave the unit and move on to their next rotation. I feel exhausted that I have to mentor another new graduate again and again. It is a strong blow to the morale of the mentors. (GERO, Preceptor 5, FG 3)

The overload and exhaustion felt by senior nurses as a result of the perpetual cycle of clinical rotations and the lack of support that NGRNs receive from their assigned preceptor have also been reported in the literature (Ballem & MacIntosh, 2014; Clark & Holmes, 2007). However, without addressing the problems arising from a severe shortage of nurses, it is doubtful whether the 'benefits' of clinical rotations can outweigh the potential risks of doing harm to patients and causing both NGRNs and senior nurses to form the intention to leave. This may be another reason why some preceptor participants have labelled the entire preceptorship programme a 'gimmick', implying that they doubt its value and effectiveness in the local health care landscape.

13.2.4.2 Clinical rotations related to the recruitment and retention of nurses

The second plotline is about the relationship between clinical rotations and the specialty's recruitment and retention of NGRNs. Three NGRN participants, including Agnes and Nancy, struggled to leave their temporary undergraduate nursing student (TUNS) units upon registration, but were unsuccessful. Meanwhile, another three NGRN participants purposely applied to work at another hospital so as to leave their TUNS units, all under the paediatrics specialty. Apart from realising that they had limited interest in further developing a career in the paediatrics specialty, many of them were very concerned about the difficulty and stress of the

clinical rotation, which was highly likely to be in adult nursing. In a similar vein, some preceptor participants from acute medical units echoed these NGRNs. They encountered NGRNs who had been rotated from a unit of a contrasting nature, such as the accident and emergency or outpatient and rehabilitation departments, who were like 'a blank slate (Chinese: 白紙)' after one year of practice and were unfamiliar with many nursing procedures and operations of the unit that they regarded as 'basic'. They were aware that such a clinical rotation was highly stressful to these NGRNs and even affected their confidence. A nursing shortage could be used as sacred story to leave the voices of NGRNs unheard. However, a lack of capacity or/and ability to support and to care about the NGRNs seemed to be the message that was being conveyed, which was in conflict with the hospital story of a preceptorship that emphasized support for better retention. On one hand, it is doubtful whether the voices and concerns of NGRNs can be taken into consideration when assigning these NGRNs to various specialties. On the other hand, adequate time for the transition and better mentoring should be emphasized in clinical rotations to retain TUNS and recruit NGRNs to specialties that are less 'popular'. This narrative inquiry might uncover our taken-for-granted assumption of clinical rotations, which might also be related to the fact that the paediatric departments of the HA consistently had the highest turnover rate of all specialties from 2006 to 2011 (e.g., in 2011 turnover rate in paediatrics was 9.6% (highest) versus surgery 4.4% (lowest), and overall turnover rate of registered nurses 5.8%) (HA, 2011c).

13.3 Knotmentoring for good work

Returning to my research puzzle, what are the meanings of mentoring NGRNs not only for the transition, but also for sustaining good work, especially when the above hospital story of preceptoring often does not happen as documented, but is highly dependent on context? Three other types of mentoring, namely self-mentoring, opportunistic mentoring, and peer-mentoring, seemed to contribute to many of the educative experiences captured in the narrative chapters. These three types of mentoring were often interrelated, and did not occur in isolation. Furthermore, thinking narratively of the stories of the NGRNs experiences, it is apparent that they were often complex, involving different people and events occurring at different times and places, with different patients and evolving clinical situations. Although I

have been scrutinizing an in-vivo code to capture the complexity of these experiences, I have not been able to find a suitable word for them. Thus, I have coined a new term to capture this complexity of mentoring – knotmentoring. The term was created by making reference to the concept of knotworking, developed within the theory of cultural-historical activities, which describes collaborative work as situations that involve constantly changing combinations of individuals distributed over time and space (Engeström, 2008). This concept of knotmentoring is explicated below and then illustrated with an example.

Knotmentoring is defined as mentoring that involves continually changing combinations of individuals distributed over time and space under the shaping of their narrative histories. It is non-linear, unstable, unpredictable, partially improvised, loosely formed, and transient in nature. It is closely related to the complex health care landscape, where different people work together to take care of multiple patients and their relatives at different times and in different places in a hospital. The use of knotmentoring also intended to capture the complexity of NGRNs' experience of mentoring for good work in the social, temporal, and place dimensions. Thinking narratively in the dimension of personal-social interactions, NGRNs could learn from different people, ranging from their own preceptor (preceptoring), other senior nurses, WMs, and doctors (opportunistic mentoring), to other NGRNs (peer mentoring) and also to themselves (self-mentoring). In fact, not only were the NGRN participants being shaped by their experiences, but possibly others as well. Thinking narratively in the temporal dimension, the actions taken by each involved a person, hence their interactions and mentoring experiences were shaped by that individual's narrative history, which was like a thread (e.g., a unique educational background, personal and professional experiences, personal practical knowledge, and stories to live by). The learning in each of these mentoring experiences becomes a past experience, adding to an individual's narrative history and personal practical knowledge. Hence, the existing thread shapes the future ones, when they interact with others at different places and times. When different people come together, they bring with them their threads of narrative histories when tying the knot of mentoring. This is why the term 'knotmentoring' is used here. Nevertheless, the newly tied knot of mentoring is not a stable or fast knot. It is soon untied and later retied with the different threads of different people at different times and places in future experiences. Thinking

narratively in the dimension of place, when there were conflicting stories in the complex health care landscape, such a knot of mentoring that contributes to the educative experiences of NGRNs and other people who are involved may not take place at an out-of-team place, but only in an in-team place.

The story of Ning's experiences is used to illustrate the above concept of knotmentoring. Take her story of speaking up to withhold a doctor's prescription that a Ryle's tube be inserted. Her personal practical knowledge led her to self-mentor in considering the risks and benefits of making the moral decision to speak up for her patient's safety, not merely physical, but holistic. The experience would not be educative if her voice had not been heard by her nursing and medical colleagues, which can be regarded as an example of peer and opportunistic mentoring. The three parties hence tied a knot of mentoring in the experience, which was soon untied after the issue was settled. Nevertheless, the learning in knotmentoring contributed to Ning's thread of narrative histories, hence to her personal practical knowledge or specifically to the ethical knowing of Carper's (1978) four patterns of knowing (empirical, esthetic, moral, and personal knowing). This also strengthened Ning's stories to live by in acting for the benefit of patients, which further shaped a future experience of speaking up for another two patients with intractable wounds, to allow them to use stomahesive powder. Once again, Ning had to self-mentor based on her personal practical knowledge in thinking of the alternatives, rather than merely following the 'usual practice' of the unit, which was to dress the wounds. She was supported by some senior nurses and other NGRNs in the unit, embodying the success of opportunistic mentoring and peer mentoring. However, her mentor, an influential figure in her unit, neither supported nor created space for discussion. The knot of mentoring for good work or acting for the benefit of patients could only be tied in a safe and relatively private in-team place when interacting with supportive colleagues, not a public out-of-team place. Although Ning and her peers had to live a secret story and tell a cover story in public, the knotmentoring seemed to have stimulated them to self-mentor or reflect on their stories to live by and nurse stories. This further shaped them to take another moral action to speak up collectively in suggesting the use of stomahesive to the WM, who promised to conduct a pilot study. Unfortunately, the WM changed his mind without scientifically and thoroughly examining the effectiveness of the alternative approach, but simply 'banning' its use

based on the comments of some unsupportive senior nurses. The experience was miseducative, as there were conflicting stories in the health care landscape that were not resolved, and being in the lower echelon of the hospital hierarchy NGRNs were often disempowered by different sacred stories. In fact, knotmentoring is a pun that could also mean 'not-mentoring' when the knot that is formed is not educative but miseducative to the people involved in sustaining their good work. 'Not-mentoring' is further discussed in the next section.

The concept of knotmentoring for good work is consistent with the concept of good work reported in the literature, which is that good work is likely to be achieved when the stories of the practitioner, influential people in the field, the customers and society, and the values and beliefs of professions are in alignment (Barendsen et al., 2011; Gardner et al., 2001). The new term of knotmentoring seems to have contributed to the need for a new understanding to catch up with an expansion in the types of mentoring and their relationships currently in practice (Crow, 2012), especially in a health care landscape of increasing complexity, as identified in Chapter 4. Knotmentoring broadens the perspective of mentoring to capture the instability, unpredictability, fluidity, temporality, and partial improvisation that characterizes the relationship in the complex health care landscape. Hence, knotmentoring is no longer limited to the stable dyad perspective of a one-to-one mentor-mentee relationship or to a triad perspective, by including the organization on top of the dyad relationship (Jakubik, 2008). Such a relationship is often disturbed by shift work, the changing condition of multiple patients and their relatives, and the problem of a shortage of nurses. The goal of knotmentoring is to sustain good work by reflecting on different stories of educative and miseducative experiences, reassuring those whose confidence has been shaken or searching for new possibilities in the midst of a miseducative experience. Therefore, the goal in knotmentoring is not merely to maintain the status quo in an organization and to ensure organizational efficiency and equilibrium, which seems to have move beyond the functionalist perspective of mentoring identified in the literature (Crow, 2012). The need for knotmentoring is a part of nursing practice rather than a strategy by the organization to retain nurses (Carroll, 2004; Mills, Francis & Bonner, 2008b). In contrast with the functionalist perspective that views the mentor as possessing the power of an expert while the mentee is the passive recipient of knowledge (Crow, 2012), knotmentoring

does not assume the existence of a power relationship. The reciprocal nature of mentoring for good work is not overlooked in knotmentoring, but acknowledges an individual's personal practical knowledge. In knotmentoring, practitioners are encouraged to take an active role in sustaining, searching for, re-searching, and exchanging stories of good work in a complex health care landscape. Authentic dialogue or good work community might facilitate the search for possibilities that will satisfy different stakeholders, possibly with different stories of good work under the shaping of their narrative histories. Instead of focusing on either patients or NGRNs, both the care providers and the recipients are taken into consideration in knotmentoring.

Also, knotmentoring is not confined to the stage of transition, but can take place in the stressful stage of integration when the professional identity of an NGRN is still being formed and influenced by other conflicting and competing stories (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013). Here, a gap exists in the literature. Many of the NGRNs seemed to have retold their stories of good work to gain a broader and deeper understanding about caring after their stage of transition (the first few months after registration). For instance, Nancy, Ning, Edwin, Heidi, and Debby developed an experiential understanding of the importance of empathy and communication in providing holistic patient and family care in the stage of integration after the first 6 to 12 months of practice. Researchers believe that the development of this more complete professional identity, in caring with both competence and compassion, is shaped by the growing emphasis on competence in a complex health care landscape (Day, Field, Campbell & Reutter, 2005; MacIntosh, 2003; Price, 2009). Such an identity includes familiarity with practice standards and protocols and with the expectations of other people in the work environment. It is further explored in the plotline on disempowerment by the sacred hospital/unit story in the narrative thread of 'not-mentoring'.

13.4 Understanding Not-mentoring through assumptions about practice readiness and scolding

When the knot of mentoring that is formed is miseducative to the people involved in sustaining their good work, it is referred to as 'not-mentoring' instead of as

'knotmentoring'. 'Not-mentoring' could jeopardize patient safety, affect the confidence of NGRNs, and even shake their stories to live by, leading to an increase in the intention to leave (Law & Chan, 2005), contradicting the hospital story of nurse retention (HA, 2011c). The reasons behind 'not-mentoring' have often been shown to relate to others' conflicting stories in a complex health care landscape, leading to incoherence or misalignment. Two interrelated plotlines could be identified from the stories of the participants. They are: 1) Confusion over the term 'practice unreadiness', and 2) The use of scolding, blaming, and/or gossiping.

13.4.1 Confusion over the term 'practice unreadiness'

The practice unreadiness of NGRNs to work independently, especially in taking care of the more critically-ill patients and even in serving as the night in-charge nurse, was revealed in previous narrative chapters. Some of them had voiced their lack of readiness directly to their WMs; however, a nursing shortage was often used to rationalize such arrangements and the NGRNs were asked to seek help from others if necessary. Nevertheless, it seemed illogical that while the WMs were aware of the NGRNs' pleas, they still assigned them responsibilities that the NGRNs did not feel ready to undertake, which might have jeopardized the safety of patients. Why did the WMs perceive practice readiness on the part of the NGRNs? Was this related to their belief that it was normal for the NGRNs to feel uncomfortable at first, but that learning by doing was the key to learning in practice, especially given their assumption that support was 'available' and that the NGRNs' were able to ask for help when needed? Grappling with these conflicting plotlines between the two extremes of practice unreadiness and readiness, I identified a new state and a new term – practice semi-readiness – after reflecting on the stories told by different stakeholders and discussions with my chief supervisor. Perhaps the difference here refers to NGRNs' sense of unreadiness to take on those responsibilities of an RN and while the seniors expected that their knowledge deficits could be attended to by drawing on available support and asking questions whenever they did not know (practice semi-readiness). This assumption has inadvertently enabled the WMs to feel comfortable in assigning patients to NGRNs despite their expressed sense of unreadiness. Nonetheless, the obvious conflicting plotlines again created tensions for the NGRNs, as they lived with the storylines of the often invisible preceptors, the stressed preceptors and other senior nurses, and their ability to ask for help when

they were in fact not aware of their knowledge deficits and of what, when, and who to ask so as not to jeopardize patient safety.

In the following paragraphs, the three different states are briefly defined in terms of my research focus – mentoring. Stories of experiences are then provided to illustrate how confusion over the term practice unreadiness might lead to 'not-mentoring', diminishing opportunities for others to provide mentoring to NGRNs, which could jeopardize patient safety.

13.4.1.1 Practice readiness versus unreadiness and the missing semi-readiness?

Practice readiness is a state when a nurse is ready to practice independently (by carrying out the assigned roles and responsibilities) and needs no mentoring by others. Practice unreadiness is the antonym of practice readiness. It refers to a state in which a nurse is not ready to practice independently because of an inability to recognise deficits in his/her knowledge and skills through self-mentoring based on personal practical knowledge, and also to respond to cues from the clinical situations by making the appropriate clarifications or seeking opportunistic mentoring. Without adequate supervision, a nurse could unintentionally jeopardize a patient's safety. Practice semi-readiness is located along the continuum of readiness when referring to any state between the two extremes of practice unreadiness and practice readiness. Practice semi-readiness refers to states in which a nurse is only semi-ready to practice independently because he/she has some knowledge deficits and requires opportunistic mentoring or other support, yet is able to recognise his/her knowledge deficits and respond to cues from the clinical situations in making the appropriate clarifications and seeking opportunistic mentoring. This might actually be the most common state in which many nurses in clinical practice are positioned, especially at a time when the health care landscape is constantly being challenged by various emerging diseases and unpredictable situations.

When the NGRN participants were assigned increasingly heavy responsibilities, from ward runner to team leader and even night in-charge nurse, many of them expressed a strong sense of frustration and confusion. They were concerned about making mistakes that might harm the patients, and looked forward to mentoring. This revealed that they were aware of their state of practice unreadiness. This sense on the

part of NGRNs of being pushed too soon and of being unprepared under an inadequate orientation has also been reported in the literature (Deppoliti, 2008). However, this narrative inquiry revealed that the WMs of NGRNs and other senior nurses often seemed to confuse the NGRNs' practice unreadiness with practice semi-readiness. This led the WMs and senior nurses to cut down on NGRNs' experienced support, teaching and supervision, hence leading to 'not-mentoring'. This confusion is further illustrated below with stories of the experiences of NGRNs who were assigned to take care of critically-ill patients and to assume the duties of the night in-charge. Their stories are then triangulated with stories of the experiences of other stakeholders, hence revealing that the confusion might have been shaped by other interrelated plotlines, the taken-for-granted assumptions about the experiences and additional 'training' of former TUNS, ineffective communication, different educational backgrounds, and a nursing shortage.

The stories of Edwin and Ning are used as examples. Both were assigned to take care of the more unstable and critically-ill patients, who had been situated in the central cubicles near the nursing station. Both were aware of their state of practice unreadiness. Although Edwin (surgery unit) and Ning (neuroscience unit) were given about one and nine months respectively to take care of the more stable patients, their stories revealed that the length of time that they were provided was inadequate. Despite the increasing complexity and instability of their patients' conditions, Edwin and Ning were not provided with additional mentoring, as the seniors assumed that the knowledge and skills that Edwin and Ning had acquired in the unit working with stable patients was directly transferable to dealing with more complex situations and advanced responsibilities. Both had been self-mentoring and were worried about being unable to realise their knowledge deficit. For instance, Ning exclaimed that 'The most scary aspect is not realising what you don't know', and thus failing to seek out opportunities for mentoring by asking the right questions of the right person to get the right answer, which might have put patients at risk. She had recounted her 'lucky' story of seeking opportunistic mentoring by chance when she asked her senior nurse about something else. Otherwise, her patient might have suffered, as she did not realise the deficit in her knowledge and had mixed up an arterial line with a peripheral line. Ning and Edwin were also aware of the potential risk of doing harm to patients, especially if early signs of deterioration were overlooked due to their

knowledge deficits. The confusion between practice unreadiness and semi-readiness was revealed when their WM asked them to ask for help if necessary.

This seemed to be a rhetorical request, as being greatly concerned that their mistakes might harm their patients, the NGRNs would seldom hesitate to seek help in making an immediate decision if they realised their knowledge deficits. Both seemed to be disempowered by the unit's sacred story of a nursing shortage, which seemed to have added to the confusion. Edwin's story was further shaped by others taking for granted that his two years of TUNS experience in the same unit had equipped him with the practice readiness to serve as an RN and a central cubicle team leader, although he had no experience at all in working those RN routines. When compared with other NGRNs without former TUNS experience in the same unit, Edwin seemed to be a better choice to take on the above responsibilities. Although his WM wrongly perceived that Edwin was in a state of practice semi-readiness and had promised to ask other colleagues to support him, ineffective communication was revealed. This, in turn, led some nursing colleagues to wrongly perceive that Edwin had reached a state of practice readiness when he was assigned by their WM to be in charge of the central cubicle. This confusion led Edwin to experience great tension and stress, to the point where he even formed the intention to leave his workplace. In the literature, 'Don't you know that?' was also the reported response of seniors to questions raised by NGRNs. The response was analysed from the perspective of whether NGRNs were welcomed by their senior nurses (Kelly & Ahern, 2009). In this study, the question 'Don't you know that?' revealed a different perspective – the confusion between practice unreadiness and semi-readiness.

Ning also told a counter story to the above confusion, which was clarified when Ning and her peers voiced their practice unreadiness to serve as a central cubicle team leader. After this negotiation, a senior nurse with supernumerary status provided three or four times the number of 'additional' mentoring opportunities. Unfortunately, this is a counter story that only echoed that of another NGRN participant, Lucy. In the stories of other NGRNs, senior nurses and WMs were often shown to be unaware of the NGRNs' state of practice unreadiness, confusing it with practice semi-readiness.

When the NGRNs' practice unreadiness was confused with semi-readiness, they were assigned to be the night in-charge alone, like Nancy, or with more junior NGRNs such as the other participants, Heidi and Wing. 'Not-mentoring' became even more severe when immediate support or opportunistic mentoring was not available. Only more distant support was to be had by seeking help from senior nurses in other units or calling the night nurses or doctors. Both were courses of action based on their self-mentoring. It is also important to highlight the fact that many acute situations in the health care landscape might not provide space for NGRNs to refer to protocols or guidelines, while the necessary information is often not easily retrieved at work. Therefore, unless the knowledge deficits were obvious, such as on how to manage complex emergencies such as resuscitations or how to deal with babies born before arrival (BBA), NGRNs tended to make the necessary decisions, such as about bed assignments or informing the patients of marginal abnormalities based on their personal practical knowledge with many uncertainties. Opportunistic mentoring might take place after mistakes are discovered by a senior and patient safety is jeopardized. For months, Wing changed all of her night duties with other people to avoid being a night in-charge in the gynaecology unit and doing any harm to her patients due to her practice unreadiness and other people's lack of awareness of the confusion.

Such confusion and the resulting 'not-mentoring' did not seem to be merely related to the problem of a nursing shortage, but to also to have been shaped by the assumptions arising from the former TUNS experience and the night in-charge 'training'. Such 'training', which ranged from two to five nights only, was revealed to be inadequate for equipping NGRNs to take on more complex roles and responsibilities and to deal with troublesome knowledge (Meyer & Land, 2006; Perkins, 2006), such as reporting marginal abnormalities, making decisions about bed assignments for new admissions, and managing emergency situations. For instance, Nancy's mind went blank when she encountered the complex emergency situation of admitting a baby born before arrival, despite having read and reread the guidelines and protocol and having been taught by different senior nurses. Without experiential learning and observing, she did not know how to prioritise the many things that needed to be done. In fact, Heidi and Wing began to self-mentor in the 'training', as contrary to their expectations and possibly those of the WMs, their

seniors did not provide any systematic teaching or opportunistic mentoring. Once again, it is questionable whether effective communication took place between these senior nurses and the WMs about their expected role in working with NGRNs on the 'training' nights, and whether the senior nurses had the willingness, motivation, and teaching pedagogy to take on this task of mentoring. Also, many senior nurses seemed unable to understand and be aware of the knowledge deficits of NGRNs that were shaped by the NGRNs' past years of personal and professional experiences and their different educational backgrounds.

The stories that the NGRNs told of senior nurses were consistent with the stories told by the preceptor and stakeholder participants in all four focus group interviews. They frequently complained about NGRNs who did not ask questions when they did not know something (Chinese: 佢唔明佢又唔問喎). They also advised NGRNs that 'If you don't know, ask'. That was also the advice of senior nurses, managers, and educators in a nation-wide study conducted in the United States (Kramer et al., 2013). Their complaints and advice revealed an underlying assumption that NGRNs were aware of their knowledge deficits but did not seek help. However, this assumption was not valid, as the NGRNs' self-mentoring could be ineffective and they often became aware of their knowledge deficits only after the mistakes were made and noticed by their seniors. They were in the state of practice unreadiness. Senior nurses seemed to confuse the NGRNs' practice unreadiness with practice semi-readiness. Although I had initiated discussions about the NGRNs' practice unreadiness in two stakeholder focus group interviews, their responses and the dynamics were quite interesting. They often shifted to immediately discussing their perceptions of the reasons behind the NGRNs' failure to recognise their knowledge deficits. However, it seemed that not only do we have to understand the reason why NGRNs fail to recognise their knowledge deficits, but also how to facilitate NGRNs to move from the state of practice unreadiness to semi-readiness. Some asserted that NGRNs need to be extraordinarily alert and be good observers and listeners to realise their knowledge deficits. Hence, the NGRNs continued to be expected and encouraged to self-mentor, not only within their team, but outside of it, by exploring their knowledge deficits before others could provide opportunistic mentoring. The WM below urged NGRNs to seize the opportunity to learn by observation, which might also reveal her awareness that NGRNs without prior experience might be assigned to

more advanced responsibilities, but be expected to transfer their knowledge gained from past observations and learning and ask questions if needed. Ironically, their discussions did not seem to be constructive in the sense of seeing new possibilities for facilitating NGRNs to move from a state of practice unreadiness to semi-readiness via knotmentoring rather than self-mentoring. Such confusion was revealed to contribute to 'not-mentoring' in allowing NGRNs to take care of patients while being unaware of knowledge deficits that might jeopardize patient safety, or to the provision of opportunistic mentoring only after mistakes were made and harm possibly done.

> **Bernice**: Many of you have mentioned the problem of new graduates who didn't ask questions when they didn't know something. It is interesting that my new graduate participants pointed out [that the reason for not asking was because] they did not realise what they didn't know.
> **WM 9 (AED)**: Is that the problem of the basic [nursing] training?
> **APN 10 (NEURO)**: They didn't have the experience, so they didn't know. However, they assumed that they knew.
> **WM 7 (MED)**: That's why I teach them to keep their eyes and ears wide open [to be extraordinately alert]. To have eyes in the back of their head (Chinese:眼要望四方，耳要聽八方). *[**APN 6 (SURG)**: They couldn't hear.] [**APN 8 (SURG)** laughed loudly.]* This is what they have to learn, in fact, from the many things happening around them. *[**APN 8**: Learn from others.]* If they hear some sounds [outside of their team], they should be aware and think about what is happening and whether they have had such an experience before. If they don't know, then they should immediately report to the in-charge nurse their intention to observe. Otherwise, others would not know what you don't know. (FG 2)

In a similar vein, another paradox was revealed in a preceptor focus group interview, where the following comment was made.

> They [NGRNs] are not missing something intentionally, but merely because they don't know that something has to be done. We remind them when we realise what is missing. They really need time to adapt as an NGRN. Even if I rotate to a new workplace, I may also need several months to adapt… As the in-charge nurse, I can't oversee each and every person at the same time. They continue working on their routines. If they are not reporting any problems to me, I wouldn't know and couldn't help. They have a nursing licence and should be responsible. I don't worry, as they learn from mistakes. (MED, Preceptor 3, FG 3)

In this excerpt, the preceptor, on the one hand, seemed to understand that NGRNs had knowledge deficits and made mistakes unintentionally. On the other hand, she

stated that she could only teach and support NGRNs when they ask questions. Once again, confusion between practice unreadiness and semi-readiness was revealed and many mentoring opportunities were missed. Although the preceptor did not seem to be worried and perceived NGRNs as being responsible for their own mistakes, it is alarming to me that patient safety could be jeopardized. Perhaps, ultimately, NGRNs with a licence to practice are thought to be accountable for their actions. Then again, there were also plotlines of the utmost importance concerning patient safety and the blaming of preceptors for the wrongdoings of the NGRNs, which muddled the clarity of the term practice readiness, even with the introduction of practice semi-readiness.

The above paradoxes also revealed the significance of narrative inquiry involving interviewing different stakeholders to gain a more in-depth understanding of the different perceptions of practice unreadiness and uncovering taken-for-granted assumptions. Thinking about the possible reasons behind the different perceptions and confusion led me to think of the two aforementioned related concepts – troublesome knowledge and threshold concept. Could the confusion between practice unreadiness and semi-readiness be related to the irreversible characteristic of the troublesome knowledge or threshold concept (Meyer & Land, 2006; Perkins, 2006)? Expert practitioners have reported that they found it difficult to look back across thresholds that they had overcome years ago to understand from their own transformed perspective, the perplexities experienced by the untransformed student perspective (Meyer & Land, 2006). Thus, this study further unveils the need to gain an in-depth understanding about troublesome knowledge from the perspective of knotmentoring or ‘not-mentoring’.

The NGRNs’ practice readiness seemed to echo Kragelund’s (2011) concept of collective not-conscious disjuncture, which might offer a theoretical way of understanding the confusion between practice unreadiness and semi-readiness. Disjuncture is defined as a social situation in which there is disharmony between a person’s experience and the situated context, where there is potential for learning (Jarvis, 1987). The concept of collective not-conscious disjuncture was further developed from Jarvis’ (1987, 2005) concept of disjuncture in a qualitative study examining the learning of Danish nursing students from their interactions with psychiatric patients and their mentors. Collective not-conscious disjuncture refers to

a potential learning situation that both the student and mentor are unaware of and wrongly perceive as a routine situation. The author also highlights the importance of transforming the collective not-conscious disjuncture to collective conscious disjuncture before teaching and learning can occur between nursing students and their mentors. This is in some way similar to my findings, as 'not-mentoring' instead of knotmentoring would take place without clearing up the confusion over the term practice unreadiness and awareness of knowledge deficits of NGRNs. But how? Awareness of knowledge deficits of NGRNs would not be an individual effort. Storytelling and dialogue seemed to help senior nurses to reflect on their past experiences, especially when they were learning some troublesome knowledge, to empathize with the stress that NGRNs feel in the transition, to be aware of their own knowledge deficits and the situational support that is needed. This awareness on the part of the senior nurses is important if they are to co-create a space / a good work community for mentoring the NGRNs or each other in sustaining good work in nursing and not leaving them to self-mentor, which might put patient safety at risk. With such awareness, they could assist NGRNs to move from the state of practice unreadiness to a state of practice semi-readiness through opportunistic mentoring. The following interview excerpt revealed the importance of such reflection and awareness. Instead of merely complaining that NGRNs have no 'common sense', senior nurses might realise that there might actually be an area that has been taken for granted and in which further knotmentoring is needed.

> [The performance of NGRNs] depends on the person's common sense. Something really common that you couldn't imagine [a mistake] could happen. For instance, it is common sense to make a follow-up appointment for patient upon discharge. The doctor had already typed the indication on the printed discharge summary [but merely written 'home' on the kardex without indicating the need for a follow-up]. Sometimes the in-charge or senior nurse is too busy to counter-check the work done by a new graduate. It was noticed that the patient had been discharged without a follow-up appointment and medication. We asked the kid [NGRN] why. She said that the kardex only had 'home' written on it. [**APN 8**: She wouldn't ask questions.] She won't ask questions. We find it hard to understand. Sometimes, I wonder whether these kinds of mistakes also happened to me when I was a new graduate. (NEURO, APN 10, FG 2)

In a similar vein, Agnes seems to have adopted the perspective of her seniors two years post-registration, who were disappointed with the lack of support from NGRNs during an emergency situation. However, by reflecting on her past experiences, she

seemed to have a higher awareness of the NGRNs' experience when wondering what had led the NGRNs to perform unsatisfactorily. The above findings reveal the importance of preparation and of providing ongoing support to senior nurses by creating space for storytelling, dialogue, and reflections to uncover taken-for-granted assumptions. Further research might be needed to explore how such reflective space or a good work community could be created for nurses at different levels to facilitate knotmentoring for sustaining good work in a complex health care landscape.

13.4.2 Use of scolding, blaming, and/or gossiping

Scolding, blaming, gossiping, and even targeting can be easily found in the stories told by the NGRN, preceptor, and stakeholder participants of their experiences. These disruptive behaviours can be explored from the perspectives of the dominant literature on the workplace incivility and violence experienced by NGRNs at the lower echelon of the hospital hierarchy (Duchscher & Myrick, 2008; Horsburgh & Ross, 2013; Hutton, 2006; McKenna, Smith, Poole & Coverdale, 2003; Roberts, DeMarco & Griffin, 2009). They are not the focus in understanding this narrative thread, but they bear some relationship to the mentoring of NGRNs to minimize mistakes in the future. Interesting to note that scolding and other disruptive behaviours are stories that conflict with those about supportiveness told by the hospital; hence, scolding or other disruptive behaviour would absolutely not be encouraged in the hospital stories. Thinking narratively, the continued use of scolding must have its narrative histories, which are explored in this section along with the reported negative perceptions and consequences. Nevertheless, the contextual conditions for these disruptive behaviours to be effective are illustrated and questions are raised to determine whether more a positive and appreciative approach could be adopted.

13.4.2.1 Scolding as an acceptable and effective way of mentoring

The document analysis shows that the HA advocates a non-punitive and non-blame response to errors, and values learning and continuous improvement (HA, 2010b; HA, 2011b). However, scolding or other disruptive behaviours not only exist in the health care landscape, but also tend to be regarded as normal and acceptable by some preceptor and stakeholder participants. For instance, instead of addressing the root cause of Agnes' intention to leave, Agnes's deputy WM, treated the scolding and

targeting of the influential nursing officer (Miss A) as normal, and asked Agnes to simply tolerate it as well. Edwin's WM not only provided no concrete advice about reporting abnormalities, but implicitly encouraged Edwin to learn through trial and error and normalized and accepted the scolding by the doctors. The interview excerpts below revealed that the normalization and acceptance of scolding might have been shaped by the nursing education received by these hospital-trained stakeholders, which differed from that received by the university-trained NGRN participants. Stakeholder participants often criticised NGRNs as being people who pull a long face and cry easily, and have a low tolerance for scolding.

> Our situation was even worse in the past [at the hospital nursing school]. Despite the severity of the scolding, we kept holding back tears, and apologized to the nursing sisters. We cried only in the nursing quarters [after work]. This trained up our emotional intelligence. The new graduates have not experienced much suffering. They burst into tears when you are only longwinded, not even scolding. (Hospital Nurse Educator, APN 1, FG 1)

The following excerpt further revealed that the narrative histories of being scolded by their superiors after registration and even after promotion might have led to a tendency to accept and cope with emotionally taxing work, rather than to resist disruptive behaviours.

> The new graduates are not used to being scolded. In fact, their senior nurses are also being scolded by their seniors. After all the years of working and being scolded, our skin and meat have become tough and hard [a high tolerance of scolding; in Chinese: 俾人鬧到靭皮靭肉]. This depends on their perspective and whether they personalize the scolding. We always become scapegoats. Simply as the shift in-charge, patients scold you not for your mistakes, but for the mistakes made by junior nurses. (SURG, APN 4, FG 1)

Lee et al. (20013) also found that some senior nurses in Taiwan rationalized and viewed mistreatment, including public scoldings and criticisms, as a reasonable part of training for NGRNs. Although NGRNs perceived that they were being unreasonably abused, many of them who had first resisted such mistreatment later rationalized and internalized it (Lee et al., 2013). Nevertheless, it cannot be said that the use of scolding to mentor NGRNs is specific to the Chinese culture, as NGRNs in Australia also perceived that senior nurses seemed to believe that humiliation or 'power games' were the best ways of teaching (Kelly & Ahern, 2009). A cross-cultural study might be needed in the future.

In a similar vein, NGRNs perceived that both generational and educational differences caused senior nurses to find scolding acceptable. These different perceptions of the use of scolding might lead to a new understanding of how intergenerational differences influence the mentoring experience of NGRNs, and fill a gap identified in the literature (Earle, Myrick & Yonge, 2011). Nevertheless, apart from the generational issue, the following excerpt further revealed that some NGRNs perceived that it was acceptable to be scolded when 'doing wrong', but it seemed that NGRNs and their senior nurses possessed different perceptions about what constitutes 'mistakes' that are worth a scolding. These different perceptions might be related to different assumptions about practice readiness. Senior nurses might perceive NGRNs to be in a state of practice semi-readiness, and expect them to ask questions if they do not know something, and thus scold them when they make mistakes because they had not asked questions. In contrast, NGRNs perceived themselves as people who had not done anything wrong but are merely in a state of practice unreadiness, who were not aware of their knowledge deficits and hence did not ask their seniors the questions that they were expected to ask.

> The senior nurses had once been nursing students and new graduates. I can't understand why they don't have empathy for the juniors... We come from a different generation and received a different nurse education. They are similar in age to my mother, who commented 'That's [being scolded is] normal when working in this society!' People of that generation perceive being scolded as acceptable. However, I was not doing anything wrong. I just hadn't had the knowledge yet. (PAED, Virginia, 2nd interview)

NGRNs were being scolded, blamed, gossiped about, or even targeted after doing something 'wrong'. However, it seems that different parties have different interpretations of what is 'wrong' or what constitutes a 'mistake' that is worth a scolding. If there were discrepancies, NGRNs might consider the scolding to be inappropriate and experience a sense of injustice. The inverted commas indicate four kinds of uncertain status. First, what is regarded as 'wrong' or a 'mistake' – whether the action deviated from the principles, standards, and guidelines in doing harm to patients, or simply deviated from the expectations and the 'usual practice' of some influential figures, as in the stories told by Ning and Agnes. Second, as scolding usually takes place prior to any thorough investigation, but is based on face value and assumptions, it is not uncommon for NGRNs and even senior nurses to be wrongly

scolded and accused. For instance, Edwin recounted an incident in which all of his nursing colleagues were being **scolded** by the WM for administering the wrong intravenous fluid, although it was soon discovered that the accusation was wrong. Next, whether NGRNs are solely accountable for the 'mistakes' that were made or whether a systemic approach to dealing with mistakes and collective accountability should be adopted is a matter for debate (Reason, 2000). This issue is closely related to the other narrative threads – namely, to the hospital's 'abstruse, vague, and insubstantial' story of preceptorship, as the NGRNs did not receive the kind of preceptorship that was documented; and confusing the term practice unreadiness with knowledge deficits that it is presumed the NGRNs would notice and address. Because both the NGRNs and senior nurses were unaware of these differences, 'not-mentoring' and 'mistakes' occurred. Lastly, although 'to err is human' (Corrigan, Donaldson & Kohn, 2000), it seems that no space is provided for NGRNs to learn from their mistakes with a gentle reminder, while scolding is commonly used, even for minor mistakes resulting in no harm done to the patients.

Rather than accepting and normalizing the disruptive behaviours, many NGRNs questioned whether the vicious cycle of scolding has to be perpetuated from one generation to another, and asked whether changes can be carried out to improve and eradicate the ingrained culture of scolding. Is the use of these disruptive behaviours being taken for granted, in which case an increased awareness is needed before a paradigmatic shift and cultural changes in how to be a preceptor and/or mentor can occur?

> After being scolded, some other seniors usually reassured us by saying, 'We were even more miserable in the past… ' However, it is not good that their past bad experiences are being repeated on us. Shouldn't they think about ways to improve? (GYNAE, Wing, 1st interview)

Apart from being shaped by the experience of being scolded, some preceptor and stakeholder participants perceived scolding to be an effective way of mentoring, based on their narrative histories as preceptors. The following is an example.

> All of us [nurses] found that a new graduate had the lowest potential for a successful transition among the three. Her mentor [preceptor] did not have any bad intentions, but scolded her when she was dreaming. After being continually scolded, this new graduate won the race and achieved the best

> standard. That's why I think the characters of the staff matter. (ORTH, Preceptor 6, FG 4)

However, the direct causal relationship between use of scolding and the improved performance of NGRNs seemed to be quite weak, with many of the potentially negative consequences, details, and nuances of scolding possibly having been overlooked. This issue is explored in the following sections.

13.4.2.2 Problems of scolding and/or gossiping

Other participants regarded scolding as problematic and felt that it could offer only short-term 'positive' effects. It has negative consequences, including affecting the well-being and identity formation of NGRNs, which might jeopardize patient safety and the quality of care. The problems with scolding are not confined to NGRNs or patient safety; indeed, scolding also takes a toll on collegial relationships, the atmosphere in the ward, and on the organization as a whole.

(I) Scolding is ineffective and not sustainable

Although some preceptor and stakeholder participants regarded scolding as an effective teaching strategy, other participants questioned its effectiveness. Scolding might lead to fear, and immediately trigger behaviour designed to achieve more favourable; however, the effect is temporary. The WM quoted below was aware that scolding would only lead to compliance in public but opposition in private (Chinese: 陽奉陰違). This was the case with Ning, who used stomahesive powder in a private in-team place, while telling a cover story when handing over to an unsupportive senior. The importance of mutual respect and the use of discussions to help NGRNs realise their problems and search for ways to improve was also emphasized by the WM below.

> I initiated a discussion with her [an NGRN whose performance was unsatisfactory] and asked her to evaluate her problems… I did not scold her. Scolding would only lead to compliance in public but opposition in private. It is meaningless and ineffective. (AED, WM 9, FG 2)

In addition, both the NGRNs and preceptor participants recognised that role-modelling is a more effective and sustainable teaching pedagogy, as the following excerpt reveals. This realisation might have been shaped by the Confucian theory of moral cultivation, in which role modelling or model emulation is recognised as an effective way of transmitting values, attitudes, and patterns of thought and behaviour (Pang & Wong, 1998; Yam & Rossiter, 2000).

> I found that mentorship has an important component – role modelling [Chinese: 身教]. I hate those seniors who are not good examples themselves, but who scold others. It is difficult to convince them… Scolding can only obtain an immediate effect, while role modelling is more convincing and the effect is more sustainable and of high quality. (PAED, Virginia, Email on 7 October 2011)

(II) Scolding and gossiping affects the well-being and professional identity of NGRNs

Depending on its frequency and intensity, scolding had a considerable impact on the psychological status, confidence, self-image, and indeed on the well-being and professional identity of the NGRN participants. Crying was one of the most frequently reported psychological responses, and it was not confined to female nurses. Edwin cried during the dreadful week when he was being scolded and wrongly accused. Many of the participants reported that they had suffered from psychosomatic symptoms such as weight loss or insomnia. The stress resulting from scolding could be overwhelming and could have a negative effect on both their professional and personal lives.

> My first half year of practice was filled with memories of being scolded and unhappy experiences… I have asked many new graduates about their transitional experience. Basically, they either always or sometimes cried after work, when taking a bath or in bed, because of all the unjust treatment. I know that some new graduates cried during dinners with their family or boyfriend, when others were very happy. The stress is overwhelming. (GYNAE, Wing, 1st interview)

Virginia was another NGRN who had been scolded frequently, in cases where her seniors seemed to have confused her practice unreadiness with semi-readiness, possibly because of her former TUNS experience in the unit. Knowing that others had been gossiping about her and the bad impression that she had given them, greatly affected her professional identity and confidence.

> One night, the night in-charge nurse asked me to resign as some senior nurses had made negative comments about me: '**Never seen a fresh graduate as bad as me!**' This was really hurtful. My self-affirmation was lost. I cried at home. I had not been involved in any incident. I am motivated to learn. I asked 'Why?' They perceived me as someone who does not follow instructions, but merely argues or talks back [Chinese: 駁咀]. The clerk [who was sitting at the nursing station] heard that the shift in-charge nurses were **gossiping** about me during the handover, saying such things as, '**It's unnecessary to listen to her reports of seizure and cyanosis. She didn't know what a seizure is**.' It's embarrassing. I really want to leave. These people are hateful. (PAED, Virginia, 1st interview)

(III) Patient safety and quality of care

The scolding and other disruptive behaviours are a two-edged sword with regard to patient safety and quality of care. The senior nurses who use these disruptive behaviours might believe that this will enhance the memory and awareness of the NGRNs, thus minimizing future mistakes. However, these disruptive behaviours could also be too overwhelming and stressful for NGRNs, and increase their chances of making mistakes. For instance, Edwin kept making mistakes in that dreadful week, despite diligently checking and rechecking his work, and he observed the same pattern in the younger generation.

> After being scolded, you become nervous and check things many times, yet make more mistakes. If you are flustered, it's easier to make mistakes and then get scolded even more. Since the beginning of the shift, the nursing officer has scolded the new graduate; however, she continues to make mistakes. It is better not to use scolding, but allow the new graduates to work slowly and calmly. (SURG, Edwin, 2nd interview)

To some NGRNs, the working environment did not seem to be constructive in terms of helping them to learn how to do good work, which might have jeopardized patient safety. For instance, Ning's preceptor scolded her when she asked questions after the preceptor had taught her for three days, and refused to provide any further support to help her to consolidate what she had learnt. Virginia was influenced by the culture of scolding in her unit to finish all routine work in haste so as to squeeze time to

rehearse for the handover that she was going to deliver to prevent herself from being scolded. For instance, she practiced what she was going to say, the sequences, and how the prescribed investigation and procedures related to the patient's condition.

> My handover is disorganised. I didn't have the experience of handing over when I worked as a TUNS, and I find handing over to be difficult. I feel very scared and stressed out when I hand over to some seniors [those who scolded]. I will have to spare some time to prepare and rehearse the handover, rather than performing the bedside care slowly. (PAED, Virginia, 1st interview)

(IV) Collegial relationships and ward atmosphere

The negative effects of scolding and other disruptive behaviours are not confined to the dyad, but could potentially activate a chain reaction and affect the atmosphere of the entire ward. Nancy's story that implicated her preceptor and caused her preceptor to be scolded by the nursing officer during the medication assessment, might have caused her preceptor to lose face and to take out her negative emotions on Nancy by gossiping with other colleagues. Fortunately, the chain reaction was stopped among nursing colleagues who believed that Nancy had made the mistake unintentionally; otherwise, knotmentoring might have been affected. Nevertheless, Edwin's ward atmosphere became poor when many of his senior nurses lost their temper over mistakes made by the younger generation, and kept scolding them. This prompted Edwin to keep to himself in his cubicle, as he was afraid that his seniors might redirect their anger to him. The kind of stress that he experienced has also been reported in the literature, even as a witness who was not directly involved in such disruptive behaviour (Lutgen-Sandvik, Tracy & Alberts, 2007).

(V) The root causes of the mistake were not addressed

When mistakes are discovered by some senior nurses or doctors, they tend to scold and blame the 'responsible' nurse based on assumptions and before any investigation has been conducted, while the root cause of the mistakes are often not addressed. For instance, Edwin told many stories about being wrongly accused by his seniors, while the responsible NGRNs did not receive the necessary opportunistic mentoring to prevent future mistakes. A 'personal' instead of 'system' approach was commonly adopted when NGRNs were scolded for any mistakes that they made (Reason, 2000). This might have led to other underlying causes of the mistakes being overlooked, for instance, whether the NGRNs had been taught comprehensively and effectively

before they were pushed to assume heavier responsibilities, or whether there had been confusion over the term practice unreadiness, leading to the absence of the necessary knotmentoring. When the root cause of a problem is not explored, the mistake might simply be perpetuated, jeopardizing patient safety, while NGRNs would not learn from the scolding, but merely experience the many negative consequences of scolding. In contrast to the stories that many of the NGRNs told about their seniors, it is appreciated that a WM participant took a broader perspective of the mistakes that were committed. He seemed to think along the dimension of personal-social interactions and highlighted the importance of reflecting on one's responsibility as a senior nurse to support the younger generations.

> I think the supervisors or seniors are influential... This is not solely the problem of the new graduates. As seniors, we also have to self-evaluate on how we can support and approach them. (AED, WM 9, FG 2)

(VI) Leave intention and financial cost

The scolding and disruptive behaviours led many NGRN participants to form a strong intention to leave. After tolerating the culture of scolding at the paediatrics unit for about 18 months, Virginia lost hope and resigned to work in the private sector. Staff attrition imposes a definite financial cost to an organization, in terms of recruitment and orientation (Halfer & Graf, 2006). The cost of replacing a graduate nurse in Australia with a basic salary of $48,000 is estimated to be $100,000 (Cubit & Ryan, 2011). In fact, the culture of scolding affected not only NGRNs, but also more senior nurses. For instance, Agnes was further negatively affected by the culture of scolding when she witnessed a newly promoted APN resign because of the scolding of more senior nurses, who had provided no space for adaptation during the very stressful transition.

At the same time, the sacred story of a nursing shortage might cause some senior nurses to hesitate to point out the mistakes made by the NGRNs, which may jeopardize patient safety. The interview excerpt below also revealed the limited teaching pedagogy of preceptors, possibly because of a lack of preceptor training and preparation.

> Ineffective handovers might be harmful to patients. Our focus is surely on the patient. It is impossible for me to take care of their feelings... However, things have changed now when nurse retention is being emphasized. Handovers have now become a ritual, as we hesitate to point out their problems. (GERO, Preceptor 5, FG 3)

13.4.2.3 The contextual conditions for scolding to be effective

Despite all of the above negative consequences of scolding, this aspect of the story of mentoring is sustained in the health care landscape, and has also appeared in some of the stories the NGRNs told about mentoring. In this section, two interrelated plotlines on scolding as an effective way of acquiring knowledge in context are illustrated and questions are raised to determine whether more a positive approach can be adopted. Teaching or opportunistic mentoring is the first plotline for scolding to be effective. The complex personal-social interaction dimension of scolding is the second plotline, which is often interrelated with the first one.

(I) Opportunistic mentoring

Effective teaching and learning, or opportunistic mentoring, is essential if scolding is to be an effective way for NGRNs to learn to ensure patient safety. This was revealed in the interview excerpt below. The reasons why mistakes are made also have to be better understood, which translates into the personal-social dimension of scolding. If the NGRNs made mistakes due to knowledge deficits, it is preferable to teach rather than scold. This might be related to the narrative thread of confusion over the term practice unreadiness, as both the NGRNs and their seniors were often aware of the knowledge deficits only after mistakes were made. Otherwise, scolding might be used if NGRNs were found to have made mistakes or not done something because of laziness and irresponsibility.

> Scolding sometimes works. Without scolding, there is no learning. However, the scolding can't be too harsh sometimes. It is important to distinguish whether the new graduate did not do something because she didn't have the knowledge, in which case teaching is very important, or whether she had the knowledge but intentionally didn't do something. (SURG, Edwin, 1st interview)

The following are two counter stories showing that NGRNs were merely left in a state of tension and experienced 'not mentoring' if they were scolded without receiving the necessary opportunistic mentoring, or if important information and expectations were not effectively communicated.

> We have several villains [Chinese: 惡人]. Some scold reasonably when I make mistakes. Some scold anyone unreasonably as if they are angry whatever one does… I was scolded, 'Why are you balancing the intake and output chart? Ask the nursing student to do it. You should do the RN tasks!' A patient vomited. The bed sheets had to be changed. I then thought that this should not be an 'RN task' and asked the health care assistant (HCA) to change the sheets. The senior scolded me again, 'The HCA is very busy. You are staying there and doing nothing. You go and change it.' What are the 'RN tasks'? If she had not been there, I would already have changed the bed sheets and balanced the input and output chart. I don't know what course to take (Chinese: 無所適從). (PAED, Heidi, 1st interview)

> Some senior nursing officers merely scold without teaching the new graduates... A patient was in shock and needed a transfusion of fresh frozen plasma and two pints of packed cells and intravenous fluid in two hours. But he had only one intravenous access. The nursing officer kept scolding the male new graduate for giving the normal saline and packed cells through the same intravenous access without teaching him what to do. Finally, the new graduate was overwhelmed and burst into tears. (MED, Preceptor 4, FG 3)

(II) The complex personal-social interaction dimension of scolding

The dictionary definition of scolding is 'to speak angrily to somebody, especially a child, because they have done something wrong' (Hornby, 1995, p. 514). This definition seems to have two aspects, which were echoed in my participants' stories. First, different people might have different perceptions of whether someone had spoken angrily, depending on the parties that were involved and their interactions throughout the scolding process; hence, this is a rather complex dimension of personal-social interaction. For instance, after being scolded by her referee for not reporting her patient, who may have suffered from a seizure, Heidi learnt without any obvious suffering from the negative consequences of scolding. This might be related to the trust that Heidi and her referee had established before the incident, the referee's tone of voice, the intensity of the scolding, the opportunistic mentoring that was provided, and the subsequent apology from the referee clarifying her good intention to ensure safety of the patient and Heidi. It might also be related to the perceived nature of the mistakes and their potential to harm patient safety, which

might have led Heidi to immediately focus on the patient's interest rather than thinking of herself being scolded as a negative mentoring experience. Second, the above dictionary definition of scold mentions about 'a child', which echoed with the preceptor and stakeholder participants, who had been calling the NGRNs 'kids' or 'children' in the focus group interviews. Nevertheless, it is important for registered health care professionals to think about the dialectic between scolding for learning and being a professional. Senior nurses may view NGRNs as being at the stage of a novice or advanced beginner (Benner, 1984) with limited personal practical knowledge, and contrast the NGRNs to themselves, who are at more advanced stages, from competent to even expert nurse.

The attributes of NGRNs and their coping mechanism were also closely related to the issue of whether NGRNs could benefit from scolding, as revealed in the fairly consistent stories told by different participants. For instance, Edwin used his metaphor of traffic signals to illustrate the different approaches to mentoring that he uses on different NGRNs with different attributes. Scolding would not be used for diffident NGRNs who think with a red light, out of concern for the negative consequences of scolding on their confidence-building and identity formation. Such NGRNs may hesitate to take any actions at all after being scolded. In contrast, a **serious tone, discouragement, or scolding** might be used in context for overconfident NGRNs who think with a green light. His intention was to make them more vigilant about the traps and risks in a complex health care landscape and about their knowledge deficits so that they would seek help when necessary. He also perceived these overconfident NGRNs as being less likely to be affected by the negative consequences of scolding, as they are often aggressive about improving and achieving a better performance. This might imply that it is important for NGRNs to have a coping mechanism or to think positively if scolding is to be an effective teaching strategy. This is consistent with the view of some preceptor, stakeholder, or even NGRN participants, who seemed to cope with the scolding that they received by perceiving that others are 'putting money in your pocket' (Chinese: 袋錢落你袋), instead of focusing on the unhappiness that they felt after being scolded. For instance, after having been newly rotated to the gynaecology unit, Heidi seemed to self-mentor and make a personal adjustment to not become defensive when her preceptor criticised or scolded her, but to think positively and openly. The interview excerpt

below is another example showing the importance of having a coping mechanism for scolding to be effective, underlain with assumptions such as that scolding is acceptable and that personal accountability instead of collective accountability should be adopted.

> I always remind the little kids [NGRNs]. If I have done something wrong or missed something, you have the right to scold me. You can perceive that others are putting money into your pocket… No matter how senior you are, you will make mistakes or miss something. Thus, you have to be open-minded to the scolding. It's okay to be scolded this time, I am sure I will be able to remember in the future. If you forget again, you deserve to be scolded. If you are scolded many times yet keep repeating the same mistake, you should have critical look at yourself. (NEURO, Nursing Officer 3, FG 1)

By the end of the narrative inquiry, some NGRN participants retold their stories of mentoring. They empathized with both the NGRNs and the senior nurses, and emphasized communication, support, and opportunistic mentoring. Nevertheless, scolding had not been eradicated from their stories, but was being used more cautiously and tactically under certain conditions, with concern paid to the tone, intensity, and negative consequences of scolding, and done out of the good intention of increasing the younger generation's awareness of patient safety. However, the following two interview excerpts lead me to wonder why the teaching seemed to be quite unidirectional. Why has space not been created for bi-directional communication to understand why NGRNs make 'mistakes' and to determine their mentoring needs? Their pedagogy seemed to be limited, a circumstance that might have been shaped by their narrative histories as NGRNs and their lack of training and preparation to become preceptors or mentors of their juniors.

> Teaching has to be progressive in the beginning. It's acceptable if the new graduates do not know for the first two times. I would scold her if she did not know for the third time. I do not mean to scold loudly or with a degrading tone. I would emphasize what she has to remember and the rationale. She will only follow your advice when she finds that it is rational. I will be longwinded when reminding her and will explore some strategies to strengthen her memory. (MED, Debby, 3rd interview)

> I found the work done [by some NGRNs] to be unacceptable and I want to scold them sometimes. However, I would put a brake on this. It's not good [to scold people]. The tone of voice has to be soft instead of 'What!? Impossible!'. I would say 'You cannot repeat this next time.' They could sense my anger and would no longer dare to do something unacceptable. (GYNAE, Wing, 3rd interview)

The use of scolding when NGRNs made ‘mistakes’ might be due to an ingrained culture shaped by the narrative histories of senior nurses. Nevertheless, the negative consequences of scolding or ‘not-mentoring’, and the need of NGRNs and senior nurses for appreciation and recognition in a busy health care landscape should not be overlooked. It is suggested that further research using appreciative inquiry (AI) (Cooperrider, 1986), a strength-based approach, be conducted to promote positive transformational changes. AI focuses on affirmation, appreciation, positive dialogue, and co-participation in learning collectively from what works well within an organization or on narrative histories, instead of imposing the thinking of outsiders like sacred stories. AI might also provide the space for nurses who had negative mentoring experiences in the past to transform their miseducative experiences into educative ones. This seems to be more consistent with the hospital’s declared emphasis on supportiveness and the retention of NGRNs.

13.5 Disempowerment by sacred hospital or unit stories

The sacred story (Clandinin & Connelly, 1996) or the sacred hospital or unit story is a pervasive view that is often taken for granted and goes unquestioned. It is assumed to be the only way of doing something, which has caused practitioners to change their practices (Connelly & Clandinin, 1999). A sacred story acts as a macro story or an imposed prescription of other people’s vision of what is right (Clandinin & Connelly, 1996). NGRNs and nurses are unable to resist a sacred hospital story, but live with the tension of what Schwab (1962) called the rhetoric of conclusion or prepackaged acontextual knowledge. The sacred story can easily shape the out-of-team places in the health care landscape when throw down through the conduit (Clandinin & Connelly, 1996). However, many of these sacred stories conflicted with stories that many NGRNs and even preceptor and stakeholder participants told of mentoring and good work, which even led them to live secret stories in the in-team places and tell cover stories in the out-of-team places. For instance, Ning and her colleagues used the stomahesive powder to advocate for their patients with intractable buttock wounds under the sacred unit story told by Ning’s preceptor or by an influential figure in the unit. The term disempowerment was chosen because many participants are not empowered, but have been deprived of the power to pursue their

vision of mentoring and good work (Daiski, 2004; Merriam-Webster, 2015), hence contributing to ‘not-mentoring’.

Five types of sacred stories were revealed in the participants’ stories of their experiences, which are closely related to ‘not-mentoring’ and disempowering knotmentoring or good work in nursing. They include: (i) paperwork and accreditation, (ii) nursing shortages and human resource management, (iii) an interprofessional hierarchy between nurses and doctors, (iv) an intraprofessional hierarchy, and (v) patient and public complaints. The interrelationships among these five types of sacred stories that contribute to disempowerment or ‘not-mentoring’ are illustrated alongside the discussion.

13.5.1 Disempowerment through paperwork and accreditation

Paperwork and accreditation are closely related to each other. Paperwork refers to all kinds of documentation in written or electronic formats. Documentation can be further divided into two major types. The first one is nursing documentation on the kardex for inter-professional communication. This consists of routine documentation conducted on each shift by the responsible nurse, who is therefore the team leader on the condition of the patient, the nursing interventions that were implemented and the evaluations, and any changes in the patient’s condition. The second type includes various kinds of charts, forms, and checklists. Different hospitals and units have their own written documentation system on patient admissions, daily care, before certain investigations and procedures, upon transfer to other units/hospitals, and on discharge. Accreditation is a measure to sustain and improve the quality of health care services both locally and internationally. Accreditation involves both a self-assessment and an external peer review to assess the performance of a hospital in relation to the established standards and to implement measures for continuous improvement (The Steering Committee on Hospital Accreditation, 2012). Hence, various documents not only have a legal aspect, but are also adopted or developed for continuous self-assessments and external peer reviews, besides being scrutinized by auditors assessing a hospital’s actual clinical performance.

Although most of the NGRN, preceptor, and stakeholder participants understood the above hospital story, they disagreed over its implementation at the operational level,

and perceived it had a disempowering effect on mentoring and good work. Two main problems could be identified and are further explored in the following sections. First, the amount of documentation and auditing that was carried out seemed to be excessive. There was much duplication and the efforts were of questionable effectiveness, to the extent that nurses could not see their value, but complained that being forced to spend time on such activities further limited the time they had for mentoring and patient care. Second, the meaning of paperwork and accreditation seems to have become distorted. Paperwork and accreditation, therefore, can be viewed as a sacred hospital story, as frontline workers cannot resist but are expected to conform to the prescriptions imposed by administrators, which has shaped their practices. This view of paperwork and accreditation contrasts with the findings reported in a local study, the potential benefits enhance solidarity because passing the hospital accreditation is recognised as a common goal among hospital staff (The Chinese University of Hong Kong, 2011).

13.5.1.1 Excessive, duplicating, and 'effective' documentation and auditing

The NGRN, preceptor, and stakeholder participants frequently complained that the requirements for documentation were excessive and that much duplication took place. They thought that the efforts were of questionable effectiveness and did not take into consideration holistic situations. They did not see the value of the hospital story, which has eaten into their already limited time and disempowered them from mentoring and doing good work. The phase 'total paper care' was commonly used by them to satirize the situation in which a large proportion of their time was being spent on paperwork, rather than on total patient care, a concept of good work cultivated in nursing education that emphasizes the holistic needs of patients. As nurses cannot put up much resistance against this sacred hospital story, they might have to prioritise their finite time to get their tangible paperwork done, before turning to more intangible work such as mentoring and communicating with patients to understand and meet their holistic needs. The following is an example from a senior nurse, who assumed the dual responsibilities of being a shift in-charge or team leader, as well as a preceptor at an acute medical unit where new admissions were frequent and patient turnover high.

> We have placed too much time on documentation. Upon admission I have to fill in five pages of a nursing assessment form, as well as change the patient's clothes, conduct a general health assessment, and check the patient's identity. We also have to oversee new graduates to ensure that they are not doing any harm or making mistakes. There is no balance, and I wonder how much time I can spend with my patients. Good work in nursing means performing bedside nursing [care] of good quality and quality patient communication. (MED, Preceptor 11, FG 4)

It is important to consider the amount of paperwork and auditing that needs to be done with the holistic health care situation under the shaping of another sacred hospital story of a nursing shortage that has led to a heavy patient load for each nurse. While the current average nurse-to-patient ratios in the morning and afternoon are 1:11 and 1:12, respectively (Hong Kong Information Service Department, 2013b), many NGRN participants were taking care of up to 16-18 patients with acute, multiple, and complex diseases. Meanwhile, the work of the nurses was also shaped by the monochromatic time structure of routines and the nursing culture of efficiency. For instance, Debby's story revealed the lack of communication between auditors of various aspects of health care, leading to the problem of too many audits being conducted during a certain period of time instead of being evenly distributed in a well-planned auditing schedule.

Take the story of another NGRN participant as an example. The pile of forms and charts for each patient admitted to the neuroscience unit consists of more than 20 sheets of paper (an admission assessment form, a neuro-observation chart, a general observation chart, a fall risk form, a pressure sore assessment form, medication charts, nursing prescription forms, nursing care plans, etc.). Many of these forms have to be reassessed every day or even at every shift. However, these documents often mean that the NGRN, preceptor, and stakeholder participants have to do a lot of 'ticking and signing', as they have to conform to the hospital story, even as they question the effectiveness of such an exercise in improving the quality of patient care (an issue that will be discussed later). Even though nurses only need 30 seconds to complete and check each of the forms, about ten minutes needs to be spent on completing the forms and charts for each patient on each shift. This means that 100 minutes are already consumed merely on ticking, signing, and completing all these forms even if a nurse only has ten patients. More time has to be spent on the first

type of nursing documentation, which has to be written in paragraph format on the patient's kardex. Even if a nurse manages to finish writing the 10 paragraphs of nursing documentation in 20 minutes, this has already taken up at least two hours of her time, therefore, more than one-fourth of her eight-hour shift is spent merely on paperwork. Meanwhile, there is other routine work that needs to be attended to in terms of nursing care, including monitoring vital signs, administering medications, caring for wounds and catheters, attending to the diaper round, tube feeding, the doctor's round, and concurrent new patient admissions. This may be the reason why some NGRN participants, such as Edwin and I, often grasp the time to communicate with our patients intermittently during all of this routine work. This is known as quasi-formal communication to address both the physical and psychosocial needs of patients, and it is often unplanned and integrated into a nurse's routine (Chan, Jones & Wong, 2013). This also shows that limited space is provided for the more intangible part of nursing and mentoring. For instance, Debby had to squeeze the time to contact each private hospital to find one that provides computer tomography at a price that her patient could afford.

The paperwork is not only excessive, but the fact that much of it seems to involve duplication further diminishes their meaning to frontline nurses. For instance, Ning noticed that two seemingly different assessment forms were redundant and measured highly similar constructs – the patient's mobility and fall risk. The newly developed Red Dot Mobility System is for minimizing injuries to health care workers arising from the manual handling operations that they perform, while the intention behind carrying out a fall assessment is to prevent patients from falling. As nurses saw no value and meaning to what appeared to be duplicate paperwork, 'ticking and signing' became a ritual that nurses carried out robotically (Jarvis, 1999). The need to attend to such a ritual that disempowered them from taking care of and communicating with patients in a less hasty manner. It is doubtful whether each problem that is discovered must be addressed by identifying solutions such as designing a new assessment form, without considering and analysing the situation as a whole. It might then be discovered that a new form may not be needed, but that an old one could be revised, or even that restructuring could be carried out and a radical transformation achieved. The situation also seems to reveal that a top-down system of management still prevails, with poor communication between administrators and frontline nurses. It is

doubtful frontline nurses were involved in developing the new form. Even when they were involved in the meeting, it may also be questioned whether it was safe for them to voice their concerns.

The issue of the effectiveness of the paperwork, particularly of some assessment forms, also seemed to have disempowered rather than empowered frontline nurses from enhancing the quality of their care. Alarmingly, Debby seemed to be disempowered by the powerful hospital stories of paperwork. She saw no point in raising questions and shifted from thinking and questioning to accepting and ignoring the conflicting stories. She self-mentored to retell 'positive' stories of the hospital that she felt helpless to change or resist, otherwise cognitive dissonance might have resulted. Agnes gave another example of such disempowerment. A new pain assessment form was introduced as standardized documentation in the N/PICU, even though not all patients have a wound that causes them pain, which needs to be assessed and appropriate pain relief given. As a result, the nurses once again were required to write 'not applicable' robotically on each shift, in another seemingly meaningless ritual. Furthermore, some patients could not communicate and the assessment of their pain depends on the subjective assessment of the nurses. However, the instruction given on the assessment form was ambiguous, leaving it open for each nurse to have her own interpretation. It is also unclear when paediatric patients were allowed to self-evaluate their pain. This led Agnes to question the validity and reliability of the form, as the different interpretations of pain experienced by the neonates might affect the continuous evaluation of the pain and the effectiveness of the pain relief.

> Pain is very subjective, while I am expected to rate it based on my perception, which might not be valid. I have to tick [indicate pain] if the neonate is irritable, crying, or twitching, which can mean feeling hunger instead of pain. This approach is not reliable. Also, some colleagues felt confused about whether the score is to be given by the paediatric patients or by the nurses. (N/PICU, Agnes, 2nd interview)

Hospital stories of paperwork and accreditation were not only questioned by the NGRNs, but also by the preceptor and stakeholder participants. In recent years, a modified early warning system (MEWS) has been introduced at the HA to detect patients who are deteriorating and whose condition requires an urgent need for active

interventions and enhanced communication between health care professionals via the MEWS score (HA, 2014c) (Table 9.1). The effectiveness of the MEWS to early warning health care professionals has been questioned and vigorously discussed in one of the preceptor focus groups (FG 4). The use of the MEWS seems to have undermined the personal practical knowledge of nurses, especially experienced nurses. Once again, frontline nurses did not seem to understand or be involved in the design of any new approach, which may have mitigated past adverse incidents. In contrast, the hospital document reported that the MEWS had excellent outcomes, contributing to a significant drop in the crude hospital mortality rate in the ICU, and was welcome by hospital staff (HA, 2014c).

> **Preceptor 8 (MED)**: Come on MEWS! The patient is already desaturating, how could it [MEWS] early warning me? The heart rate is already very fast, how could it [MEWS] early warning me?
> **Preceptor 10 (SURG)**: You should be calculating and the MEWS score is inadequate to early warning you yet. (Everyone was laughing.)
> **Preceptor 11 (MED)**: Too many stupid and time-wasting methods.
> **Preceptor 8**: Why do we have to use a number to replace all the monitoring that we have learnt in nursing?
> **Preceptor 11**: This is actually professional instinct.
> **Preceptor 10**: Maybe the MEWS is more appropriate for new graduates who don't have common sense yet.

The above stories of experience were consistent with the findings of a cross-sectional survey conducted in 10 public hospitals in Hong Kong, in which nurses indicated that doing paperwork is a time-wasting exercise, many of the charts are meaningless and redundant, and the audits are too frequent. Alarmingly, they were attributes of the work environment that were related to the nurses' dissatisfaction with their job and their intention to leave, and therefore should not be overlooked (Choi, Cheung & Pang, 2013).

13.5.1.2 Distorted meanings of paperwork and accreditation

The meaning of paperwork and accreditation to monitor and identify areas for improving the quality of care was revealed to be distorted in the stories of the NGRN, preceptor, and stakeholder participants. For instance, a fall assessment is carried out to prevent incidents of patients falling during hospitalization. However, this hospital story seemed to be distorted at the operational level, as falls were prevented by using diapers so patients can stay in bed, but a patient's basic needs and his/her dignity was

ruined. The nursing officer quoted below perceived that patients at risk of falling should be assisted to go to the washroom or be given a bed pan; however, she often saw nurses and HCAs applying diapers to prevent falls and for the sake of convenience. This echoed the call made by some researchers who advocate rediscovering the 'human side' of nursing, involving not only an emphasis on physical safety, but on a person-centred approach (Fawcett & Rhynas, 2014).

> I dislike what the HA is doing with excessive paperwork of an inch in thickness, which gives a feeling of window dressing [Chinese: 門面功夫]. Good work in nursing means fulfilling the basic needs of patients with their dignity being respected by the health care workers instead of claiming that I have poor mobility and forcing me to put on a diaper and asking me to urinate on it if needed. (NEURO, Nursing Officer 3, FG 1)

In a similar vein, the auditing seemed to be conducted in an over-simplified and fragmented manner, instead of in a way that would guide practitioners to provide person-centred patient care.

> There is a great discrepancy between our perception of good work in nursing and those of the upper hierarchy. It's like doing homework that is very superficial. All of the auditing has been done; the infection rate and incidence of falls have decreased. Giving you various forms to tick, tick, tick and tick… For us in the lower hierarchy [the frontline], we found that all of these forms were redundant. Adequate human resources and the quality of nursing care are most important things. (MED, Preceptor 11, FG 4)

Alarmingly, both the NGRN and preceptor participants were discouraged and disempowered from reporting the true story, which might have contributed to a search for meaningful ways to improve the quality of patient care. However, they were encouraged to tell a cover story and lie with statistics. They seem to be empowered to treat numbers and statistics and disempowered to treat patients, often by seniors and administrators who spent time and effort in making the written documentation sound reasonable during accreditation. For instance, Ning used a Chinese idiom, 'Putting the cart before the horse' (Chinese: 本末倒置), to describe the distorted meanings of paperwork and accreditation. She had discovered that her senior nurses had asked the team leader to change the fall risk score from low to high after an incident in which a patient fell, to make the incident look explainable. If all of the above conflicting stories of good work are not resolved by out of concern for

honesty and integrity, miseducative experiences will continue to occur and knotmentoring will not be achieved.

13.5.2 Disempowerment through nursing shortages and human resource management

The management of human resources in response to the nursing shortage has the quality of sacred story to disempower NGRNs from mentoring for good work. It was not uncommon for the unit to employ three to six NGRNs to fill the vacancies and one preceptor even had 11 new graduates in her medical unit, while in general each unit has only about 20 nurses. Severe imbalance between junior and senior nurses was revealed. Various forms of disempowerment were mentioned earlier while illustrating the first two narrative threads; they are summarized briefly in this section. First, a nursing shortage was used to rationalize the unmatched duties of the NGRNs and their assigned preceptor, while preceptors were often over-extended by being forced to assume the dual responsibilities of both a preceptor and a team leader/shift in-charge nurse. Some preceptors stated that they had failed to maintain the standard of care provided by the new nurses, contributing to 'not-mentoring' and possibly miseducative experiences unless these were transformed to educative ones during debriefing.

> Working as the shift in-charge with four NGRNs of 2011, I could only ensure that the most critically ill patients were safe. I find that standards in our unit are deteriorating. I had to turn a blind eye to some situations, such as substandard documentation, infection control, and even slight delays in giving intravenous antibiotics. (MED, Preceptor 8, FG 4)

The exhaustion of senior nurses was further aggravated by the clinical rotation system, which seems to have contributed to the growing attrition rates and to the imbalance between senior and junior nurses. This further disempowered NGRNs from learning from or being knotmentored by these experienced nurses, who possess valuable personal practical knowledge. One exhausted preceptor participant asked to leave the chaotic medical unit to transfer to the geriatric unit, where the staff turnover rate was low, hence lessening the need to mentor.

> Before I left, there were only three to four mentors and the rest were all juniors. Working as the shift in charge on call day [in the unit for admitting new patients] with two new graduates, I was taking two teams of patients in helping them to complete their work. With the ongoing new admissions, I have no time to teach slowly if the new graduates don't ask questions. We have no mentoring now. I wouldn't be able to mentor them progressively like before. We had seven new graduates one year, but all of them have left. (MED, Preceptor 4, FG 2)

Second, the shortage of nurses also disempowered NGRNs from attending the hospital's orientation programme, despite the fact that their seniors often complained about their lack of competence and practice readiness. Third, with the nursing shortage problem NGRNs had a shorter transitional period and faced a steeper learning curve when compared with past graduates, who were often pushed to work beyond their practice readiness. Collectively, the first three forms of disempowerment might jeopardize the NGRNs' mentoring for good work and patient safety. Fourth, as their need for mentoring to do good work had not been adequately met by the hospital's orientation programme, their preceptors, and senior nurses, many NGRNs were left to self-mentor or to experience 'not-mentoring'. Meanwhile, the important capacity to self-mentor or reflect might also diminish if the shortage of nurses becomes severe, leading to a heavy patient load, overwhelming and exhausting the NGRNs. This was revealed in Debby's story. Debby stated that she did not have a chance to think during busy periods, but simply worked based on her instinct, contributing to her repeated sense of loss. Fifth, the voices of NGRNs talking about their interests and professional development were not being heard. They were assigned to a unit with a nursing shortage, which seemed to conflict with the story of supportiveness told by the hospital. Last, given the problem of a nursing shortage and inadequate preparation with respect to the pedagogy, some senior nurses hesitated to scold or point out the mistakes of the NGRNs, out of concern that they would resign, possibly putting patient safety at risk. Both the NGRN and preceptor participants expressed the hope that the HA would put more emphasis on retaining nurses, especially the more experienced ones, which is important to ensure good mentoring or knotmentoring to sustain better-quality patient cares.

13.5.3 Disempowerment by the interprofessional hierarchy

From the stories of the experiences of the NGRN participants, it is apparent that the public hospitals under the Hong Kong HA have the characteristics of a bureaucracy; including specialisation, a hierarchical organization, and formal rules (Engeström, 2008). Under the hospital's hierarchy, every entity in the organization except one is subordinated to a single other entity, and each level of management has its authority and responsibilities. Although patient care should be the goal of all health care professionals at different levels of the hospital hierarchy, this might not necessarily be the case. NGRNs at the lower echelon of the hospital hierarchy were shown to have been disempowered by the interprofessional hierarchy between doctors and them. Two plotlines emerged: voices were not being heard and gate keeping was taking place at the ambiguous professional boundary.

13.5.3.1 Speaking up but not being heard

In the participants' stories of their experiences, good work was revealed to have a strong moral aspect, such as whether nurses have the moral courage to advocate for their patients by speaking up. Speaking up is defined as an individual's use of his/her voice to convey to someone in higher authority specific information that might make a difference to patient safety (Sayre et al., 2012). Some NGRN participants related educative experiences of speaking up and having their voices heard. For instance, Nancy had spoken up to the senior nurses and doctor to keep her patient from being harmed by a junior doctor who had lost his temper. However, it was not uncommon for some of their moral actions to not be supported by other senior health care professionals and for their voices to not be heard, with no space provided for further discussion or negotiation. Continuing to use Nancy as an example, in miseducative experiences of hypotensive neonates and gastrotomy site leakages her voice on patient safety was not heard by her seniors. Agnes had also spoken up for her patients when she noticed early signs of deterioration, however, her personal practical knowledge and voice on patient safety were not acknowledged or heard. The stories told by doctors had a disempowering effect, leaving the NGRNs with the sense that they were powerless to safeguard their patients and sustaining their stories to live by. Nancy and Agnes had been self-mentoring via deep reflection, in an attempt to transform their miseducative experience to an educative one by searching for new possibilities to sustain their stories to live by. Thinking narratively,

mentoring NGRNs on how to speak up requires more than one-off training; rather, it is an ongoing process in the midst of educative and miseducative experiences (Law & Chan, 2015), often going beyond the stage of transition in the first few months after registration to the stage of integration (Kramer, Maguire, Halfer, Brewer & Schmalenberg, 2013). In working against the hospital's hierarchy, individual conscience and assertiveness were revealed to be inadequate, while a collective conscience, which requires positive cultural change, was shown to be cardinal. In a cross-national study (Canada, Australia, Ireland and Korea), nurses also reported feeling powerless to influence the decision-making process within the constraints of their obligations and the overwhelming power of physicians (Malloy et al., 2009). However, the disempowering effect of the sacred stories told by doctors in the upper echelon of the hospital's hierarchy on mentoring NGRNs to sustain their good work is rarely discussed in the literature on mentoring.

13.5.3.2 Paradoxical responsibilities

The professional boundary between doctors and nurses seemed to be ambiguous and the responsibilities of doctors and nurses also seemed paradoxical. There were many traps in the complex health care landscape, as was revealed in the stories told by the NGRN, preceptor, and stakeholder participants. For instance, doctors might have prescribed contraindicated medications to patients or put the blood label of a patient in another patient's file. Instead of addressing the root cause of the problem of how to make doctors more vigilant about the traps that they have created that might jeopardize patient safety, the safety measure that was adopted was to have nurses counter-check the work of doctors. This measure might not be effective at ensuring patient safety, as it depends on vigilance of nurses. A large national study conducted in the United States identified the problems that could arise if nurses avoid confrontations with doctors, and merely counter-check their work, with the absence of this crucial conversation contributing to medical errors, a lower quality of care, and a higher turnover of nurses (Maxfield et al., 2005; 2011). However, the paradoxical responsibilities between nurses and doctors seems to have disempowered nurses from pursuing good work or mentoring, as their already limited time was consumed by countering-checking work. Furthermore, doctor-nurse role ambiguity was not confined to the local health care landscape, but was also reported by nurses in Australia and Ireland. They recognised that counter-checking or 'chasing doctors'

is non-nursing duty, yet the expectation is that such work will be done by nurses, which has contributed to nurses feeling that they have 'no time for nursing' (Mooney, 2007; Webster, Flint & Courtney, 2009). It is important to note that this was also one of the factors influencing the decision by nurses to leave their position in Australia (Webster, Flint & Courtney, 2009).

13.5.4 Disempowerment by the intraprofessional hierarchy

The stories told by many NGRN participants about their experiences revealed that they were disempowered by the intraprofessional hierarchy, with influential figures in their units asserting that the 'usual practice' was the only possible or correct way. Under the imposed prescriptions of the 'usual practices', the NGRNs at the lower echelon of the hospital's hierarchy could not put up a fight, and were considered to be doing 'wrong' if their practices deviated from the 'usual' ones. These sacred stories could disempower NGRNs from mentoring for good work, engaging in evidence-based practices rather than merely following the 'usual practices', and searching for ways to improve the quality of care using their creativity. For instance, Agnes was disempowered by the intraprofessional hierarchy, Miss A, in the story of weaning the patient off CPAP to nasal cannula. The hospital document acknowledges the personal practical knowledge of nurses and gives them the autonomy to titre the concentration of oxygen according to the patient's condition. However, Agnes was forced to follow the 'usual' one-to-one ratio by scolding without giving a rationale for doing so. This is also closely related to the other plotline – the use of scolding when 'mistakes' were made. Another cardinal example in which NGRNs were disempowered by the intraprofessional hierarchy is Ning's stories of the use of stomahesive powder.

Although some NGRNs saw new possibilities for improving the quality of care, they experienced strong resistance to change. Their suggestions for changes were often rejected by the influential figures without any concrete reason for doing so. This pressure to conform to the norms of the team or to the values of the influential figure, while struggling to maintain their professional standards, was a stressful experience of the kind that has been reported by nurses in England and Australia in the past two decades (Hutchinson, Vickers, Jackson & Wilkes, 2006; Kelly, 1996). However, it seems that the problem has not been adequately addressed or solved, as some of the

NGRN participants in this study continued to experience powerlessness and disempowerment about speaking up to advocate for patients and make changes for a better future. Others took the initiative to transform their miseducative experiences into educative ones in the personal dimension by searching for new possibilities to sustain their stories to live by. For instance, Ning used the stomahesive powder in secret and later made a request for a clinical rotation with the hope of finding a place where it was possible to speak up for patient safety in public and where evidence-based practice (EBP) was not simply rhetoric (Law & Chan, 2015). While the resistance of senior nurses to making even minor changes for the benefit of patients has been reported (Horsburgh & Ross, 2013), rarely discussed in the literature is its potentially disempowering effect when NGRNs are mentored to work reflectively in searching for ways to improve the quality of care, especially for patients and their family, who may have individual needs.

Preceptor and stakeholder participants generally told a counter story instead of the disempowering one. They seemed to be more open-minded and able to accept alternatives, provided that the principles were not violated and the patients were not being harmed. They are different from the NGRNs' stories of seniors or influential figures. Their voluntary participation in my research study might indicate that they intend to contribute to improve mentoring for the NGRN's role transition and pursuit of good work. Admittedly, there might also be a Hawthorne effect, whereby participants tend to give socially desirable responses (Polkinghorne, 2007).

> As a mentor, I only have to tell my mentee what the principle is and the reasons behind such a principle. You can use this route or that route to reach the same goal provided that the principle is not violated. Don't think that they [know nothing because they] are young and have just graduated; they could be smarter than you in finding a much better way. It is unnecessary to forbid practices that deviate from the normal practice. This might not be the problem of the new graduates. This might be the problems of the mentor. You have to have some space for them to develop their potential. (SURG, APN 4, FG 1)

A preceptor shared the approach she uses to support NGRNs, which involves reassuring them that they are doing the right thing when she encounters NGRNs who are being disempowered by the 'usual practices' that influential figures insist on.

> When you teach, it is better to let them [NGRNs] know there is more than one practice and we accept the others [if the principle is not violated]. I reassure them by saying 'If some nurses scold you for doing wrong, let it go. **I think you are doing fine'**. It's important to reassure them and retain their confidence. (MED, Preceptor 11, FG 4)

This narrative inquiry seems to reveal the importance to increase awareness of the potentially disempowering effect on both NGRNs and senior nurses of following the 'usual practices'. The nurse managers are shown to play a pivotal role facilitating openness to diversity and cultivating appreciation of the unique individual approaches to achieving a shared common goal. By establishing an environment of mutual respect, caring, and trust, diversity will gradually be embraced (Wolff, Ratner, Robinson, Oliffe & Hall, 2010).

13.5.5 Disempowerment by the patient and public complaints

The HA has a complaints system to handle patient and public complaints about the services provided by the hospital or its staff. In the participants' stories of their experiences, patients and relatives commonly bring their complaints to the Patient Relations Officer (PRO). After receiving a complaint, an investigation will be conducted and follow-up actions will be taken, then recommendations will be made for improvements (HA, 2014b). The complaints can also be reported to those outside of the HA, for instance, the mass media. Furthermore, according to my experiences and those of the participants, these complaints can be classified into reasonable and unreasonable ones. Reasonable complaints refer to problematic health care services such as the medical incidents that were explored in Chapter 2. Unreasonable complaints are those that could not reveal any problematic health care services, but potentially revealed different perceptions or different stories of good work told by patients, the public, and health care professionals. Some patients and their relatives were aware of this sacred story and abused the complaints system to obtain extra benefits. However, the following two interview excerpts revealed that unreasonable complaints might stem from unreasonable expectations of receiving private hospital services at a public hospital where the resources are finite but the demand unlimited. They used the metaphors of a restaurant and hotel when telling stories of conflict and articulated their disagreement with the idea that a business model of customer service should be applied to public health care. This conflict between a business-focused

approach and the culture of caring had also been reported by nurses in the United States (Deppoliti, 2008).

> Good work in nursing can be realised when the human resources are adequate. If there are 30 to 40 tables at a restaurant but only two waitresses, you can't provide good work. Frankly speaking, the quality of the service corresponds to the price that is paid. The *cha chaan teng* [Chinese: 茶餐廳, which means a tea restaurant that provides low-priced Canto-Western Cuisine] is different from the restaurant at a hotel. You wouldn't complain if a fork was placed directly on the table at a *cha chaan teng*. They are expecting the services of a private hospital at the price of a public hospital. (MED, Debby, 1st interview)

> I strongly disagree that the business model of customer service should be directly applied to health care. A hospital is a place for treating illnesses, not a hotel that provides a luxury service. (SCBU, Nancy, Email on 2 November 2011)

Although there is a complaints system, minimizing complaints can be viewed as a sacred hospital story. The participants agreed that hospital management and administrators would understandably like to confine and resolve any complaints to the unit level, and minimize all complaints that might catch the attention of the public. Even though the NGRN participants were rarely involved in complaints reported to the PRO, their professional identities and practices were shown to have been shaped by this hospital story and how others lived this story of the hospital. Different stories of the complaints system told by different parties in the complex health care landscape seemed to have empowered patients and relatives, but could have disempowered NGRNs from mentoring and sustaining good work. Two interrelated plotlines emerged: blaming and the unsupportive attitudes of management towards complaints and inadequate debriefings after complaints.

13.5.5.1 Lack of support but blamed for any complaints made

The blaming and unsupportive attitudes of management towards complaints, along with the mistrustful and disrespectful attitudes of some patients and the public, seemed to have shaken the NGRNs' professional identities and disempowered them from mentoring for good work. From the stories of the experiences of the NGRN, preceptor, and stakeholder participants, it seems that the mistrust and disrespectful attitudes have been shaped by social changes, which have led to an increased emphasis on the rights of patients and individualism, exacerbated by the negative

images created by the mass media (Gillett, 2012) and also by the past negative experiences of patients and their relatives who have come in contact with the health care system. In fact, the lack of respect from patients and their families is not unprecedented and confined to Hong Kong – similar findings have been reported by nurses in Canada, Ireland, Australia, and South Korea (Malloy et al., 2009). Despite the NGRNs' efforts to provide good-quality care for patients within a demanding work environment, they experienced more disrespectful and aggressive behaviours than appreciation. They could not deny feelings of unfairness, discouragement, dispiritedness, and powerlessness. This also caused some NGRNs to ask the question 'Who are we?', which revealed their shaken sense of professional identity. 'Doctor's handmaid' was the phrase used by NGRNs in Australia to describe the role conflict that they experienced with the medical profession (Kelly & Ahern, 2009). An NGRN participant in this study even used the term '*mui tsai*' (Chinese: 妹仔) to describe her low perception of her professional self, meaning that she is a domestic servant to not only doctors, but also to the patients and their relatives. Instead of seeing herself as a health care professional working in partnership with doctors, patients, and their relatives, she seemed to perceive herself as occupying a subservient and powerless position in the hospital's hierarchy and complaints system. Many of the NGRN participants were in need of support from their colleagues and supervisors in a context where patient's rights were being taken to an extreme, while the rights of nurses seemed to be easily overlooked. However, they seemed to receive very little support from their supervisors.

If the management took a blaming and unsupportive attitude towards complaints, the attitudes and practices of some frontline nurses were shown to have been shaped by a desire to minimize conflicts by fulfilling all of the requests of patients and their relatives, even 'unreasonable ones'. Such attitudes and practices had raised questions on the part of many NGRN participants about their professional standpoints and even their professional identity. Within the limited resources at public hospitals, they generally agree that good work is done in prioritising services according to the needs of the patients, based on the patients' vulnerability and level of dependence, by drawing on the nurses' personal practical knowledge rather than on the patients' and relatives' potential to make complaints. For instance, Debby mentioned that she assigned patients to hospital and camp beds according to their needs and condition.

Ning also questioned how long some patients at the acute hospital neuroscience unit should stay if they do not have any health care problems, which was related to their complaints to the PRO. However, under the hospital's sacred story of minimizing complaints, frontline staff were often not supported or trusted, but immediately blamed before any thorough investigations were made by their supervisors. This is closely related to the narrative thread about the use of scolding, blaming, and gossiping. The NGRN participants quoted below were unable to resist the shaping of the conflicting stories. They experienced a great sense of unfairness and helplessness and seemed to be disempowered from sustaining their stories of good work, hence contributing to 'not-mentoring' rather than knotmentoring. The lack of managerial support in the face of patient complaints was also reported by nurses in Hong Kong in another qualitative study (Choi, Pang, Cheung & Wong, 2011).

> The nurse managers didn't support us, but merely viewed the complaint as having been caused by poor arrangements on the part of the nurses... I had hoped that they would take an objective and neutral stance when listening to us. However, they worry that patients will exaggerate the issue, which could affect the hospital's reputation. We are helpless and being placed in a position of disadvantage. (MED, Debby, 1st interview)

> The higher officials and management won't evaluate whether or not the complaints are unreasonable, and consider your difficulties given the situation. They don't support us but merely blame us for doing something wrong or for having poor communication skills even if the complaints are unreasonable. That's why every staff member is scared of complaints and tries his or her best to entertain the relatives [even when their requests are unreasonable]. I have to follow though reluctantly, otherwise discrepancies might occur and relatives will complain again (PAED, Virginia, 1st interview)

In a similar vein, the stakeholder participants below also acknowledged the disempowering effect of management's unsupportive attitude towards complaints, which was based on management's concern about the power of the mass media. The use of avoidance was mentioned, which is discussed in the next plotline.

> **APN 4**: An old lady passed away on the second day upon admission. Her son, who seems to have some mental disorders, had been protesting at the entrance to the hospital each day in the past few months. Along with his mother's portrait, he held up banners stating '**Doctor X has committed malpractice in causing a patient's death!**'. Although the patient had been assigned to Doctor X, he had never taken care of the patient as the patient was admitted on Sunday, which was his day off. The son could only recognise the name of the doctor written over the patient's bed. The hospital's chief executive

disagreed that the son should be kept from protesting, despite the disturbance he was causing to the hospital's operations. He didn't want to convey the sense that the hospital is oppressing a disadvantaged minority. Therefore, we only filed a report to the police once, when the son broke into the doctor's office. Doctor X was overwhelmed, and later transferred to work at another hospital.
Nursing officer 3: This management creates even more stress to frontline staff.
APN 4: Everyone tries to avoid unnecessarily doing anything extra.
Nursing officer 3: It was thought that avoidance would minimize problems. (FG 1).

13.5.5.2 Inadequate debriefings after complaints

Inadequate debriefings after experiencing conflicts and complaints from patients and the public could disempower NGRNs from mentoring and pursing good work in nursing. Becoming involved in a complaint is an unhappy experience. It can be miseducative and shake the NGRNs' sense of their professional identity and hinder their pursuit of good work in the future. NGRNs might experience this sense of disempowerment even when they are not being blamed or scolded, and the complaint is later found to be unreasonable after the investigation. They are in need of debriefing or opportunistic mentoring to be able to transform the miseducative experience into an educative one. However, it seems that this need for mentoring is often overlooked by the senior nurses or WMs. For instance, a patient's relative scolded Ning and later made a complaint about her. The relative had made a telephone inquiry at night, while the WM had recently reminded the nurses of the rule that should be 'NO DISCLOSURE OF PATIENT INFORMATION ON THE TELEPHONE'. Fortunately, she was not scolded by her seniors. However she experienced a great sense of unfairness and powerlessness after the incident, and vowed to avoid or to minimize talking with relatives in the future. This showed that the experience was a miseducative one, as a decrease in nurse-patient communication could impede understanding of the needs of patients or their relatives, and hence the doing of good work, which could create more misunderstandings and conflicts. Nurses, especially NGRNs, might have inadequate self-reflective learning and often used avoidance to cope with the experience of being subjected to or observing unreasonable conflicts and complaints, which was consistent with the literature (Miller, 2006). It is alarming to note that an NGRN participant, Wing, had made a request to the operating theatre with the hope of minimizing interactions and

conflicts with patients who are usually sedated. Another NGRN, Virginia, left the HA 18 months after registration, and the feeling of disempowerment that she experienced as a result of the complaints system was one of the reasons for her resignation. Therefore, debriefing to transform a miseducative experience into an educative one seems to be of paramount importance to reassure the nurses and to make them see new possibilities for shoring up their shaken sense of professional identity.

Another NGRN participant, Debby, was preventing her patient, who was attempting to pull out a newly inserted urinary catheter for acute retention of urine, from doing harm to herself by applying limb restraints. Coincidently, the patient's relatives arrived, and scolded Debby for an hour. The following interview excerpt could have stimulated questions about how debriefings are conducted and what are the intention behind such debriefings are. Could the debriefing provide not only opportunistic mentoring, but also convey a sense of supportive from managers to frontline nurses?

> It is meaningless to discuss anything with the higher officials, as they would simply ask us to empathize with the unhappy relatives of a hospitalized family member. However, it is unnecessary for the relatives to take out their bad temper on the nurses. Many nurses have become dispirited. (MED, Debby, 1st interview)

The final story captures the two plotlines, in that Virginia was disempowered by the sacred story of the complaints system along with the unsupportive attitudes of her seniors and the inadequate debriefings. The recounting of her story was further discussed in two stakeholder focus group interviews, where many stakeholders agreed with Virginia's prioritisation because in that situation it was more important to administer medication than to weigh the diaper. Nevertheless, they perceived the act of the shift in-charge in finding another colleague to help as supportive and felt that it was a way of resolving conflict and preventing a complaint. One WM suggested that the NGRNs reflect on their tone of communication and wondered whether an adequate explanation had been provided. Another APN challenged Virginia for having a narrow outlook and perceived that the act of the shift in-charge was aimed at preventing complaints that require much effort to resolve. These responses were further discussed with Virginia in our second interview. She could not totally agree that the act of the shift in-charge was supportive, but interpreted it

as a questioning of her professional judgement and sense of priorities. *'It seems to convey a feeling that I am doing wrong, as I am refusing the mother.'*

> For instance, the child needs a strict balance of intake and output. The mother asked me to weigh the diaper while I was administering oral medication. I replied that I would help after completing the administration of medication. I did not think weighing the diaper was urgent at that moment. The mother challenged, 'Aren't you asking me to wait?' The shift in-charge was scared, as we all knew that the mother could be a troublesome person who always scolds and complains. She asked someone to help the mother to weigh the diaper. (PAED, Virginia, 2nd interview)

This further supports the potential importance of debriefing in turning a miseducative experience into an educative one, especially when the negative emotion might have lowered the reflective capacity of the NGRNs. She could be reassured about the soundness of her judgement and prioritisation, yet acknowledge that the conflict can be resolved using a team instead of an individual approach. Given the concern over the need to be appreciated and supported, and the shaping of the macro stories – hospital story of its complaints system and use of scolding, once again, the potential of appreciative inquiry (Cooperrider, 1986) to relieve the nurses' sense of disempowerment was revealed. Further research is needed in the hope that appreciative inquiries can be used eliminate 'not-mentoring' and cultivate a culture of knotmentoring for sustaining good work in a complex health care landscape for the benefit of patients, relatives, health care professionals, and hospitals.

13.6 Summary

This chapter provides a richer understanding of the complexity of mentoring NGRNs not only for their transition, but also for sustaining good work in a busy and dynamic health care landscape. NGRNs are in need of ongoing mentoring throughout their first two years of clinical practice in transition and in their pursuit of good work in the midst of educative and miseducative experiences. Although each hospital provides a rather comprehensive preceptorship programme for supporting NGRNs, this narrative inquiry revealed that everyday clinical practices may not be consistent with the hospital story and may even convey the sense that support and care are lacking when some of the intricate details are overlooked. Apart from the often invisible preceptoring, three other types of mentoring – self, opportunistic, and peer

mentoring – interrelatedly contribute to many of the NGRNs' educative experiences. A new term – knotmentoring – was coined to capture the complexity of the NGRNs' mentoring experiences, giving a sense of the non-linear, unstable, unpredictable, partially improvised, loosely formed, and transient nature of those experiences. Knotmentoring is a pun that could also mean 'not-mentoring', when the knot of mentoring formed in different contexts is miseducative to NGRNs and others involved in sustaining their good work. Two taken-for-granted assumptions about practice readiness and scolding were shown to contribute to not-mentoring. Unlike previous literature on mentoring, which focused on the stable relationship between mentor and mentee and their relationship with the organization mainly from a functionalist perspective, this narrative inquiry identified many hidden aspects of the competing or even conflicting hospital and unit stories that could have disempowered NGRNs from mentoring for good work in a complex health care landscape. This further points to the need to foster a supportive, positive, and appreciative learning environment to cultivate knotmentoring for good work, while resolving the many competing and conflicting stories that contribute to not-mentoring. Otherwise, NGRNs may suffer from another layer of shock when they get the opposite of the supportive that they expected, and experience tension, a shaken sense of professional identity, and an increased intention to leave. All of which could ultimately jeopardize patient safety and good work in nursing now and possibly in the future as committed patient advocates and positive role model could not be retained to mentor future generations of nurses.

PART FIVE

CHAPTER FOURTEEN

LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

14.1 Introduction

In this narrative inquiry, I set out to understand the meanings of mentoring NGRNs for their transition and to sustain good work, through different stories of experiences that were lived, told, relived, and retold in a complex health care landscape. Mentoring has been one of the most frequently suggested strategies for facilitating both the transition of NGRNs and good work in nursing, as if it were a panacea. However, the concept of mentoring in nursing practice remains ambiguous and confused in the literature, which has not caught up with the expanding types of mentoring currently in practice. The aim of this narrative inquiry was to gain a deeper understanding of the following research puzzles:

1) What were the experiences of NGRNs in the first two years of transition and pursuit of good work?
2) What was the NGRNs' perception of their 'mentoring' experience during their transition and pursuit of good work?
3) How their stories of experience and meanings of 'mentoring' may help us to see new possibilities and address 'mentoring' in the support of NGRNs' learning in transition and their sustenance of good work?

This final chapter of the dissertation begins with a discussion of the limitations of the study. The subsequent section provides implications for some new/renewed understandings, practice and education, and future research.

14.2 Study limitations

Two limitations of this narrative inquiry should be considered when interpreting its findings. The first limitation arises from the data collection method adopted for composing field texts, as field observations may reveal further inconsistencies in the stories of the participants' experiences, and offer another layer of exploration. Field observations were relinquished out of concern for the difficulty of obtaining ethical

approval from different public hospitals. Although in this study only health care professionals were interviewed outside of their working hours and workplace, and not any patients or relatives, the process of obtaining ethical approval took a considerable amount of time. Nevertheless, as I am an insider in this complex health care landscape, I was able to compensate for this limitation. I was an NGRN myself three years earlier than my NGRN participants, with experience working at the neuroscience unit, surgical unit, and accident and emergency department (AED). I worked as a part-time RN at the AED during weekends throughout the entire period of the inquiry, and I often had opportunities to transfer patients to different specialties. This enabled me to observe, reflect, and ask follow-up questions with the participants or other health care workers. My practice experience influenced both the research process and its content, and contributed to my understanding of the participants' stories of their experiences. For instance, an NGRN participant, Agnes, told me that she felt at ease about sharing her stories and feelings because I am also a young nurse who has had similar experiences. Meanwhile, I guarded against my pre-understandings and assumptions through reflexivity, constant reflections, and regular discussions with my chief supervisor and member-checking with the NGRN participants. Situated in the same health care landscape under the shaping of the potentially conflicting stories of others and the broader sacred hospital/unit stories, I found myself aware and empathetic of the challenges experienced by NGRNs and senior nurses at the frontline of mentoring not merely for the transition, but also for good work. This practice empathy and my narrative histories must be considered as having the potential to influence the breadth and depth with which the participants approached their disclosures and the telling of their stories.

Second, the findings of the inquiry are not meant to be generalised to all NGRNs, but to generate valuable insights from the rich particularities of participants' stories of their experiences. It is important to note that the purposive sampling of NGRN participants were of those who had been recommended for pursuing good work. They might have greater moral awareness, courage, and maturity than the average NGRN, which led to their speaking up despite repeated miseducative experiences and self-mentoring to search for ways to sustain their stories of good work. Furthermore, the NGRN participants were all young, single adults, ranging in age from 22 to 25 in the first interview, who had obtain their first diploma or degree in

nursing. The findings of this narrative inquiry might not be directly transferable to other NGRNs of different generations and educational backgrounds, particularly the recently developed master's in nursing programme for students whose first degree was not in nursing. However, the participants' stories raise our awareness of any taken-for-granted assumptions in the midst of cultivating a positive mentoring environment for all NGRNs.

14.3 Implications for new/renewed understandings

Seven new or renewed understandings emerged in this narrative inquiry after uncovering some of the taken-for-granted assumptions in the complex health care landscape. They include contrasting stories of the preceptorship programme, self-mentoring, opportunistic mentoring, knotmentoring, practice semi-readiness, the use of scolding as a way of mentoring, disempowering mentoring, and good work by sacred hospital/unit stories. Their implications and recommendations are explored in the next section.

14.3.1 Contrasting stories of the preceptorship programme

Each hospital has its story of the preceptorship programme, with the four common key components being preceptorship, cluster/hospital orientation, simulation training, and clinical rotation. These four components are commonly found in literature on the evaluation of programmes, which focuses on discussing their positive outcomes (e.g., Banks et al., 2011; Latham et al., 2008, 2011, 2013). However, the NGRNs' stories of their everyday experiences are inconsistent with the hospital story as stated in the hospital's documents, notably in cases where the NGRNs could not work with their assigned preceptor or attend the orientation due to a shortage of nurses. The NGRN participants' experiential understanding of the preceptorship programme was 'abstruse, vague, and insubstantial', which was in contrast to the overall satisfaction with the programme generally reported in the literature. Different people, such as NGRNs, preceptors, senior nurses, and ward managers, had contrasting stories of the preceptorship programme under the shaping of their different narrative histories, assumptions of practice readiness and scolding and blaming, and the broader problem of a nursing shortage. This narrative inquiry confronts the extant literature, in which the graduate nurse transition programme is regarded as something of a

panacea. The findings provide valuable insights, showing that the hospital story of the preceptorship programme might be too static and ideal to fit in the larger complex and dynamic health care landscape in which other competing and conflicting stories are interwoven. Without careful attention to intricate details at the operational level, particularly about what NGRNs need and how they can be better supported, conflicting messages of lack of support and care might instead be conveyed. There are both tangible and intangible aspects to good work in nursing, such as empirical and ethical knowing, respectively (Carper, 1978). However, the hospital story of the preceptorship programme seems to emphasize the tangible knowledge and skills that NGRNs need to function, while the intangible aspect seems to be inadequately addressed and too often depend on self-mentoring on the part of the NGRNs.

14.3.2 Self-mentoring

Self-mentoring was revealed to be important to the process of transition and sustaining good work in the stories of the experiences lived and told by all of the NGRN participants, as well as in the preceptor and stakeholder participants' stories of mentoring. It involves both the tangible and intangible aspects of good work. Self-mentoring involves reflecting on one's experiences and referring to one's personal practical knowledge (Connelly & Clandinin, 1988) to realise that it is insufficient to solve the problem in the present situation. It was this awareness of knowledge deficits that motivated NGRNs to take the initiative to address their need of further mentoring, often by asking their senior nurses or peers, hence leading to opportunistic and peer mentoring, respectively. Self-mentoring was sometimes triggered by mentoring events in which NGRNs were being influenced in important ways after they engaged in self-reflection (Angelini, 1995; Darling, 1985a). For instance, after Edwin and Heidi's patients expressed their appreciation, they gained an experiential understanding about the importance of communication, being present, and psychological and spiritual care. Heidi relived and retold stories of empathy related to her father's death and her ex-colleague's comparisons and judgemental comments, and the insights she gained from them. These mentoring events often triggered self-mentoring for some important yet intangible aspect of good work, which did not seem to receive much emphasis in the hospital story of the preceptorship programme, which focused on tangible knowledge and skills. The

participants' self-mentoring, especially about some aspect of ethical knowing (Carper, 1978) such as speaking up for patient safety, may also have embodied the process of the Confucian notion of *ren* (Chinese: 仁) or self-perfection, the object of lifelong moral striving (Coopamah & Khan, 2011). It is interesting to note that self-mentoring is rarely discussed in the mentoring literature on nursing. The 'self' has been recognised to play a role in the mentoring experience of hospital staff with more than five years of experience; however, no further information has been provided about this self-mentoring in the grounded theory (Angelini, 1995). Self-mentoring was regarded by a scholar on mentoring, Darling (1985g, 2007) as a process of how we make choices and connections with others, and teach and guide ourselves through active self-involvement and self-reflection. The under-exploration of self-mentoring might be related to the rather rigid and narrow definition of mentoring as a relational phenomenon limited to a one-to-one mentor-mentee relationship (Bozeman & Feeney, 2007; Crow, 2012; Jakubik, 2008). The emphasis on self-mentoring in this study might be related to the purposive sampling of the NGRN participants, who demonstrated intention to pursue good work. Thus, they might have greater moral courage and maturity than the average NGRNs. This might have led them to sustain their stories of good work despite repeated miseducative experiences, such as speaking up to a higher authority to advocate for their patient through self-mentoring, which is in fact a tall order for NGRNs at the lower echelon of the hospital hierarchy.

14.3.3 Opportunistic mentoring

Opportunistic mentoring refers to unplanned mentoring, which takes place by chance and depends on whether the NGRN was aware of his/her knowledge deficits and mentoring needs. Opportunistic mentoring has two main antecedents. First, when the NGRNs became aware of their knowledge deficits through self-mentoring and were able to ask the right person the right questions at the right time in a busy context, getting the right answer might not only have resolved the present situation, but also guided their practice in future similar situations. Second, their senior nurses recognised the NGRN's knowledge deficits after discovering the mistakes that they had mistakes, which might have jeopardized patient safety. If opportunistic mentoring triggers a systematic and comprehensive teaching-learning process, the knowledge and certainty gained in that context can guide NGRNs in the present and

future, hence becoming an educative experience. Opportunistic mentoring echoes with the accidental mentoring recognised in a grounded theory of mentoring novice nurses in rural areas in Australia (Mills, Francis & Bonner, 2007; 2008a; 2008b). It is a short-term relationship that provides guidance and support to a novice nurse, and is directed at developing specific clinical skills and handling incidents. It may also further develop into a long-term mentoring relationship and even deep friendship if the two parties share values and interests, and time is allowed for the relationship to develop further. This resembles Heidi's stories of developing a friendship from repeated mentoring opportunities with her referee, a senior nurse but not her assigned preceptor.

14.3.4 Knotmentoring

A new term – knotmentoring – was coined to capture the complexity of NGRNs' mentoring experiences in a complex health care landscape by making reference to the concept of knotworking (Engeström, 2008). Apart from the often invisible preceptoring, three other types of mentoring – self, opportunistic, and peer mentoring – interrelated in their contribution to many of the educative experiences. Depending on the different people with their different narrative histories (like a thread), different knots of mentoring are tied, untied, and retied at different times in different places with different events happening. The learning in each knotmentoring contributed to the personal practical knowledge of each party involved and added to their threads of narrative history, in shaping future experiences and knotmentoring when interacting with others at different places and times. The literature on mentoring in nursing often focuses on one particular type of mentoring relationship, for instance, a formal mentoring programme (e.g., Beecroft, Kunzman & Krozek, 2001; Leigh, Douglas, Lee & Douglas, 2005), or an informal mentoring relationship (e.g., Mills, 2009; Ryan, Goldberg & Evans, 2010). However, there seemed to be a lack of holistic understanding about the NGRNs' mentoring experience for good work. The findings show a need for a new understanding to catch up with the expanding types of mentoring and their complex, non-linear, unstable, unpredictable, partially improvised, loosely formed and transient relationships in everyday practice in the health care landscape. The findings offer new insights indicating that mentoring may not be confined to a particular person or group of people, but takes place when each involved person contributes to the educative or miseducative

experiences of others to sustain their good work. It might be important to ask how knotmentoring could be cultivated to mentor and support NGRNs to sustain their stories of good work. In contrast to the dominant functionalist perspective of mentoring, which focuses on organizational efficiency and equilibrium (Crow, 2012), the findings offer new insights showing that sustaining good work for the well-being of both the care providers and recipients can be the key goal, instead of maintaining the organization's status quo. The existence of a power relationship is not assumed in knotmentoring, nor is the reciprocal nature of mentoring for good work overlooked. What is acknowledged in knotmentoring is that an individual's personal practical knowledge encourages practitioners to take an active role in sustaining, searching, re-searching, and exchanging stories of good work in a complex health care landscape

14.3.5 Practice semi-readiness

Practice semi-readiness is also a newly identified state that falls between practice unreadiness and readiness. It refers to a state in which a nurse is only semi-ready for independent practice, having certain knowledge deficits and requiring opportunistic mentoring or other support. In contrast to practice unreadiness, the nurse is able to recognise his/her knowledge deficits in seeking opportunistic mentoring and/or responding to cues in the clinical situations and seeking the appropriate clarifications. While it is known that different stakeholders possess different perceptions of practice readiness (Wolff, Pesut & Regan, 2010; Wolff, Regan, Pesut & Black, 2010), the findings expand our understanding to the new state of practice semi-readiness of senior nurses, in contrast to NGRNs' state of practice unreadiness. This is important for increasing awareness of taken-for-granted assumptions about practice readiness and the resulting confusion, potentially shaped by the NGRNs pre-registration employment experience as temporary undergraduate nursing students (TUNS) in the same unit. It is hoped that the increased awareness will foster opportunistic mentoring or broadly knotmentoring for good work in the future. The confusion between practice unreadiness and semi-readiness seems to echo Kragelund's (2011) concept of collective not-conscious disjuncture, in which both the mentee and mentor are unaware of a potential learning situation.

14.3.6 Use of scolding as a way of mentoring

Scolding is used as a way of mentoring; however, negative consequences and 'not mentoring' could result unless such hidden aspects as opportunistic mentoring and an established relationship of trust are present. This study offers new insights to understand why the use of scolding seems to be ingrained in nursing, instead of exploring the issue from the perspectives of workplace incivility and violence as is the case in the dominant literature (e.g., Duchscher & Myrick, 2008; Horsburgh & Ross, 2013). This different perception of the use of scolding might also shed light on how intergenerational differences influence the mentoring experience of NGRNs, thereby filling part of the knowledge gap identified in the literature (Earle, Myrick & Yonge, 2011).

14.3.7 Disempowering mentoring and good work by sacred hospital/unit stories

Many hidden aspects of the competing or even conflicting hospital and unit stories that could have disempowered NGRNs from mentoring for good work in the complex health care landscape have been identified in this study. This is in great contrast to the literature on mentoring, which often focuses on the stable relationship between mentor and mentee, and their relationship with the organization, mainly from a functionalist perspective.

14.4 Implications for nursing education, practice, and policy

The findings of this narrative inquiry uncovered new possibilities to improve nursing education, practice, and policy, particularly the current hospital preceptorship programme. The cluster/hospital orientation and simulation training might enhance a hospital's ability to meet the mentoring needs of NGRNs if the knowledge and skills that are taught capture the complexity and fluidity of the health care situations. For instance, the cultivation of the competence of NGRNs to manage multiple patients and events, instead of a single, simple, and static task, disease, or patient. More emphasis might have to be placed on some troublesome knowledge (Meyer & Land, 2006; Perkins, 2006) commonly identified to be weaknesses of NGRNs, for instance, delivering a well-integrated handover and managing marginal abnormalities, emergency situations, and conflicts with patients and relatives. As NGRNs might have already gained the knowledge from their practice, and may not see the point of

the orientation if it is conducted after registration, it seemed important to focus on the time at which the orientation is offered. It also seemed paramount to acknowledge the existence of competing and conflicting stories and prepare NGRNs psychologically and skillfully, and even create space for reflection and dialogue to transform any miseducative experience into an educative one and reassure those suffering from a shaken sense of confidence and professional identity. Examples of the competing or conflicting stories are the stories of scolding as an effective way of mentoring experienced by some senior nurses in individual units and the stories of non-blaming advocated by hospital administrators. For the discussion session of the preceptorship programme, many NGRN participants valued a bi-directional and open approach to communication between new graduates and hospital administrators. It might be important to create a space for NGRNs to express their voices and concerns, even though the administrators who were involved might not have the authority and power to implement any changes, such as some disempowering sacred hospital/unit stories. However, the safe and open space that is created might provide an opportunity for different parties to reflect on and appreciate each other's perspectives and constraints and engage in open dialogue to search for new possibilities. It may even enhance the NGRNs' trust and sense of belonging to their institutions and possibly their intention to stay. As for preceptorships, despite any reported benefits, it might be time to reflect whether they fit today's complex and dynamic health care landscape, which is beset by a severe nursing shortage, as the dyads could not even work and learn together. In a similar vein, clinical rotations, despite broadening the NGRNs' clinical exposure and personal practical knowledge, might be an additional stressor to NGRNs, preceptors, other senior nurses, and ward managers. This narrative inquiry increased our mindfulness about the importance of ensuring flexibility to accommodate the changing conditions of the health care landscape.

Knotmentoring

This narrative inquiry offers invaluable insights on knotmentoring in a dynamic health care landscape in which nursing shortages are a problem. If knotmentoring is cultivated, it would be of benefit to sustaining good work. There are two main layers to knotmentoring. First, with regard to the personal dimension of knotmentoring, those who have identified the importance of self-mentoring could be empowered to recognise their knowledge deficits and search for appropriate ways to meet their

mentoring needs, such as self-revision, enroling in courses, and seeking help from others. Thinking of the dimension of personal-social interaction, as the health care landscape might be shaped by other competing and conflicting stories, the empowerment of self-mentoring might not be confined to the NGRNs' first two years of practice, but extended throughout a lifetime of professional and personal development (Darling, 2007), to transform any miseducative experience into an educative one and reaffirm any shaken sense of professional identity.

Reflecting on my relationship with my NGRN participants, many of them felt safe sharing their stories of self-mentoring and benefited by seeing new possibilities through our dialogue, leading me to think of a 'good work community'. This is a community for nurses with similar values and beliefs to share, reflect, and learn from each others' self-mentoring in the safe and open space that was created, which echoes with Craig's (1999) knowledge community. Appreciative inquiry (Cooperrider, 1986) could be incorporated, as NGRN participants recognised the importance of support and appreciation. It is hoped that each member of the community would be empowered to sustain their stories of good work, thereby preventing them from feeling a sense of loss and exhaustion, and from working robotically without the empathy of the patients, the patients' relatives, and their co-workers in a busy and chaotic health care landscape with many other competing and conflicting stories. It is hoped that this good work community could also gradually shape other conflicting stories lived and told by others, such as the use of scolding without the all-important opportunistic mentoring.

The second layer of knotmentoring emphasizes the cultivation of supportive attitudes and awareness of the importance of opportunistic mentoring among all frontline health care workers, instead of confining the responsibility to assigned preceptors. The need for opportunistic mentoring is not merely confined to some tangible parts of nursing, such as some practical skills, but also extends to some intangible ones such as empathy or communication for establishing trusting and therapeutic relationship with patients and their families. It is hoped that by encouraging dialogue with NGRNs and other senior nurses, the knowledge deficits of NGRNs could be more easily unveiled instead of being discovered after mistakes are made and patient safety is jeopardized. Ward managers and senior nurses are encouraged to conduct

debriefings or opportunistic mentoring with the NGRNs after any incidents, such as complaints by patients or relatives, which might be miseducative experiences that have to be transformed into educative ones. Otherwise, the NGRNs' sense of professional identity might be shaken, and their intention to leave might be enhanced, all of which could ultimately jeopardize patient safety and good work in nursing now and possibly in the future as committed patient advocates and positive role model could not be retained to mentor future generations of nursing.

To cultivate knotmentoring instead of 'not-mentoring', it might be beneficial to increase the awareness of nurses of different ranks of the importance of opportunistic mentoring and different taken-for-granted assumptions; for instance, the negative consequences of the use of scolding and awareness of the differences between the state of practice unreadiness and semi-readiness. Nevertheless, it does not seem likely that nurses will increase their awareness if that which is taken-for-granted is imposed like pre-digested materials or hospital guidelines in isolation from the narrative histories of people and places (Dewey, 1938). It might be more fruitful if nurses are encouraged to engage in reflection, story telling, and dialogue, or even in the use of the affirmation, appreciation, and positive dialogue of appreciative inquiry (Cooperrider, 1986) to decrease their taken-for-granted assumptions and transform any miseducative experiences into educative ones. This training might not be confined to hospital in-service training, but possibly offered in both the undergraduate and postgraduate levels to cultivate knotmentoring. Although a nursing shortage still exists, with the increasing supply of NGRNs and the suspension of pregnant mainland women (HA, 2012; HK Information Service Department, 2012), this might be the right time to improve the current preceptorship programme and focus on knotmentoring to increase the retention of nurses, so as to address the problem of the large number of nurses who will reach retirement age in 2018.

Telling consistent stories of hospital and unit

Disempowerment of good work and mentoring by sacred hospital/unit stories might be alleviated by having an alignment of the different stories of hospital and unit live and told by different parties in the complex health care landscape. Alignment might be achieved when frontline staff are involved and their voices and concerns are

understood by administrators and managers when designing any guidelines and protocols. Also, the findings of this narrative inquiry revealed the importance of developing the guidelines by taking into consideration the holistic health care landscape and the potential tensions created with other existing plotlines. When implementing any new policy, it might be beneficial if frontline nurses are well informed of its narrative histories and allowed the space to give feedback to further refine the policy. With the concern about the dynamic and complex health care landscape, guidelines may not be directly applicable to each situation, hence it might be important to remind frontline staff that the guidelines can be followed with flexibility to ensure the best interests of patients, families, and health care professionals. It might be more constructive if higher authorities could adopt a non-blaming attitude and emphasize open bi-directional communication. Otherwise, frontline staff might comply in public, but oppose in private, with the original meanings gradually being distorted, as was the case with some paperwork. It might be important for the administrators and management to treat complaints as learning opportunities and take appropriate actions to re-educate the staff members involved and other employers, and fix any systemic errors. If a complaint is found to be unreasonable and invalid, it is important for the hospital to support the staff member who was involved and evaluate the system to prevent services from being abused through the complaints system. Civic education is necessary to remind members of society about their rights and responsibilities, as well as the roles, responsibilities, and limitations of the public health sectors. It is hoped that, rather than perpetuating another vicious cycle of defensive nursing against mistrustful and disrespectful attitudes and behaviours, collaboration between patients, relatives, and health care professionals can be promoted. Apart from using accreditation to restore the trust of the general public, the nursing profession could collaborate with the mass media. Human beings seem to have a tendency to remember negative stories and scandals rather than positive ones. More effort might be needed to collaborate with the mass media to achieve more balanced reporting of both positive and negatives stories and increase public transparency. It is hoped that sharing positive stories of the health care professionals and appreciating their efforts will lead to therapeutic collaboration among patients, relatives, and health care professionals for better quality of care.

14.5 Implications for future research

The complexity of mentoring for good work in nursing is revealed in this narrative inquiry. To generate achievable clinical and educational changes, there is need for a further appreciative inquiry to determine whether knotmentoring can be fostered for good work in nursing and the well-being of both care givers and recipients. As simulation is gaining popularity, its relationship with the cultivation of troublesome knowledge commonly encountered by NGRNs in general and unique to each unit could be further scrutinized. I found that it is common for young nurses to vent their emotions on Facebook. This lead me to think that social networking might be a new possibility for cultivating self-mentoring and a good work community because of its popularity among Generation Y (Bell, 2013; Hendricks & Cope, 2013) and because the busy health care landscape might have decreased the self-mentoring capacity of NGRNs. Social networking has been used among medical students to teach clinical reasoning skills with a high degree of active participation in the discussions (Menon, 2012). Further research is needed to explore whether social networking can contribute to sustaining good work by learning from each other's self-mentoring, keeping in mind issues of privacy and confidentiality. Also, further studies on knotmentoring and 'not-mentoring' in local and overseas health care landscapes are needed for cross-cultural comparisons; an even richer understanding might be gained by including field observations.

14.6 Conclusion

Beginning from my past mentoring experience as an NGRN, this narrative inquiry explicates the complexity of mentoring NGRNs for the transition and for good work in a dynamic health care landscape. The research texts were generated from the stories of experiences lived and told by different parties (i.e., newly graduated registered nurses, preceptors, senior nurses, ward managers, and doctors), and through multiple methods of collecting data (i.e., unstructured individual interviews, journaling, focus group interviews, and document analysis). This has contributed to a more holistic understanding of the meanings of mentoring. The findings substantiate the view that there is a pressing need to improve the current hospital preceptorship programme to foster self-mentoring and knotmentoring for good work that will fit better with the dynamic health care landscape. Various conflicting hospital/unit

stories that disempowered good work and mentoring were also identified. They include paperwork and accreditation, nursing shortages, inter-professional and intra-professional hierarchies, and patient and public complaints. Unless those conflicting stories on the complex health care landscape are resolved, NGRNs might continue to experience ‘not-mentoring’ instead of knotmentoring for good work, which might create tension, shake their sense of professional identity, increase their intention to leave, and even jeopardize patient safety. It is hoped that the new possibilities imagined in the narrative inquiry space can provide support to NGRNs in their efforts to sail towards their beacon of good work in stormy seas and rainy weather.

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Beecroft, Kunzman & Krozek, 2001, United States	Nonrandomized control group pretest-posttest design, Non-specific	Internship, 6 months	A children's hospital, Interns n = 50; Control group n = 28/45 new graduates without internship	An average of 716 hours of guided clinical experience with a one-on-one preceptor & 224.5 hours of classroom time; A mentor to sponsor the new graduate into the nursing profession; Skills training laboratories; Debriefing & self-care sessions for discussion about difficulties encountered during the internship, & to provide strategies to deal with these difficulties; Clinical rotation	Longitudinal data is collected from Intervention group before, 6 & 12 months & group control within 24 months after professional registration; (1) Corwin's Nursing Role Conception Scale: Control group has significantly more disagreement with the ideal situation than the interns; (2) Schutzenhofer Professional Nursing Autonomy Scale: NSD between intervention & control group on professional autonomy; (3) Skills Competency Self-Confidence Survey: Interns have increasing mean total score over 12 months. The final score is the same as the control group who already have 24 months of experience; (4) Slater Nursing Competencies Rating Scale: NSD for interns, no data provided for control group; (5) Organizational Commitment Questionnaire: Score of interns at 6 & 12 months are comparable to that of control group; (6) Anticipated Turnover Scale: The final score of interns is comparable to that of control group; (7) Actual turnover rate: 14% for interns & 36% for control group; (8) Estimated Return on investment: 67.3%
Owens et al., 2001, Australia	Programme Evaluation; Non-specific	Internship, 2 months or 3 months for specialty	5 Hospitals, n = 75 new graduates over 2 years; n= 23 preceptors; 15 Patient care directors	Preceptor training (learning styles and communication skills); Matching of new graduate with primary preceptor by ward manager; Didactic information with precepted clinical experience & competency-based learning, interpersonal communication skills; using variety of instructional methods small & large group discussions, role play, demonstration/return demonstration, cognitive testing, case studies, self-directed learning modules, simulations, & videos, peer learning	Participant satisfaction of the programme; Clinical competency & performance evaluated by new graduates, preceptors, patient care directors (Low response rate of 25%) Overall retention rate: 88%

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Greene & Puetzer, 2002, United States	Programme evaluation, Nursing process as a template for mentorship experience	Mentorship, 12 months	A hospital, New hire, No. of participants not reported	Assignment of mentor/preceptor, Structured formal discussion between mentor & mentee for providing feedback, which was more intensive at the beginning with decreasing frequency & duration across 12 months.	Evaluate mentees' performance by mentor/preceptor using the Competency based outcome tools with no result provided Suggestion of adding a job descriptions for mentor with position & compensation & providing formal training & guiding for mentors; New graduates attrition with 18 months decreased from 21 to 5 after programme implementation, while No. of new hires is unknown
Leigh, Douglas, Lee & Douglas, 2005, UK	Programme evaluation, European Foundation for Quality Management model	Preceptorship, 7 months	A Hospital, n = 27/34 Preceptees; N = 7/12 ward managers	3 weeks orientation, 6 months on the job supervision by an experienced & committed preceptor/mentor, Specialty-specific training	Post-programme questionnaires for preceptees & their managers: Preceptee's perspective: An increase in reported levels of confidence & competence of preceptees after programme implementation; 2) ward manager's perspective: Favourable perception of preceptee's competence upon programme completion; 3) Reduction in turnover rate from 24% to 1% over 3 years
Beecroft et al., 2006, United States	Programme evaluation, Borich & Jemelka	Residency, 12 months	A children's hospital, Resident-mentee, n = 285/318 over 5 years	Assignment of a mentor of different areas but with similar clinical ground & have a non-evaluative relationship (Familiar with the mentor pool & resident-mentee can have 3-4 choices of mentor prior assignment)	Self-developed Survey: 83% Satisfactorily matched; 80-90% agree that mentor provide guidance & support; 50% perceived mentor is a stress reducer, 28-43% attained socialisation through mentoring; 54% maintain regular contact with mentors
Herdrich & Lindsay, 2006, United States	Programme evaluation, Action-learning principles	Residency, 12 months for medical/surgical nursing; 6 months for cardiac/critical nursing	2 hospitals n = 14 new graduate nurses	Structured learning sessions & precepting/mentoring processes, learner assessments, Reflective learning session; a community learning design based on action learning methodology in a professional practice community, evaluation methods, & key partnerships & relationships (Adjunct to existing orientation processes)	Comparing component at baseline & end of programme: 1) Recruitment: Doubled application, less than 1% vacancy, 2) Retention rate: 90% at 24 months, 3) The Basic Knowledge Assessment Test with 12% average improvement, 4) Improved Six-dimensional scale on professional development, 5) Diminished job stress, 6) Little change in job satisfaction, 7) Critical thinking: 41% improvement in the Critical Thinking Inventory (12 months residency), 1.5 points average improvement in Watson–Glaser scores, Reflective journals shows an increasing depth of questioning & complexity of problem solving experience

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Krugman et al., 2006, United States	Programme evaluation; descriptive, comparative study, Benner	Residency, 12 months	6 Hospitals, No. of NGN not reported	Training of Baccalaureate-prepared clinical preceptor, Hospital orientation, Preceptoring, Standardized residency curriculum (leadership, patient outcomes, professional role development, critical thinking & communication), Specialty training, Monthly resident seminars (with interactive case studies for group discussion), Peer relationships, clinical narratives (reflective inquiry in group), Graduation ceremony presented with recognition certificate	Longitudinal evaluation at baseline (T0), 6 (T1) & 12 (T2) months post-hire: 1) Gerber Control Over Practice Scale: High perceived control at T0, dipped at T1 & improved at T2; 1) McCloskey – Mueller Satisfaction Survey: Job satisfaction dipped slight at T1 & improved at T2; 3) Casey–Fink graduate nurse experience survey: Self-reported stress are highest at T0 & decreasing over time, self-perceived organizing & prioritising outcome are lowest at T0 & improved over time; 4) Retention rate: 92%
Halfer, 2007, Chicago, United States	Programme Evaluation, Benner, Knowles, Kramer	Orientation / Internship (4-9 months varies across specialties)	Paediatric hospital, 84-117 NGNs hired	Training & monetary compensation of preceptor, Classroom learning, PALS certification, precepting, RN interns can select a mentor, mentoring (outside workplace), peer support group, clinical rotations, code debriefing	NGN turnover improved from 29.5% to 12.3%, Annual cost savings of $707,608, Improved nursing satisfaction in annual employee opinion survey for all employees
Newhouse, 2007, United States	Quasi-experimental, posttest only, control group design, Donabedian	Internship [Social & Professional Reality Integration for Nurse Graduates (SPRING)], 12 months	A hospital, N = 212 SPRING interns over 3 years	Educational support for preceptors, 10 education seminars, Preceptoring, Clinical rounds by a part-time SPRING nurse educators to meet SPRING interns, preceptors & ward managers	Longitudinal evaluation at baseline (T0), 6 (T1) & 12 (T2) months post-hire compared with comparison group: new nurse graduates hired before implementation of SPRING: 1) Organizational Commitment Questionnaire: Organizational commitment dipped at T1 & improved at T2; 2) Modified Hagerty-Patusky Sense of Belonging Instrument: Sense of belonging dipped at T1 & improved at T2; 3) Anticipated Turnover Scale: Highest at T0, Dipped at T1 & increased slight at T2; 4) Retention rate: 88.9% (335/377) at 12 month, 87.1% (256/292) at 18 months, 90.1% (228/253) at 24 months, higher than the comparison group but NSD [Response rate: 46% (73/159) at T0, 74% (237/321) at T1, & 70% (212/304) at T2]

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Williams et al., 2007; Goode & Williams, 2004; United States	Programme evaluation, Dreyfus model, Benner's Expertise in Nursing Practice	Residency, 12 months	12 Hospitals, N = 679 residents	A core curriculum (Leadership, Patient outcomes, Professional role & Critical thinking), General orientation, preceptor-guided clinical experience, access to a resident facilitator for additional guidance, specific clinical course work unique to the nurse resident's practice site & specialty.	Longitudinal evaluation on hire, 6 & 12 months post-hire using five measures, while findings are not reported: 1) Casey-Fink Graduate Nurse Experience scores to indicate transition from advanced beginner to competent professional nurse: In all 12 hospitals, statistical significant improvement in the total score, ability to organise & prioritise, communication & leadership over time, statistical significant reduction of stress over time, Perceived support improved significantly across time in one group of sites, while another group of sites has NSD, 2) Gerber Control over nursing practice scale: perceived control demonstrated a V-shaped pattern, the mean at T0 & T2 higher than that at T1; 3) McCloskey Mueller Satisfaction Scale scores: total score, subscale on professional opportunities, & control-responsibility also demonstrated a V-shaped pattern, 4) Turnover rate: 12%
Halfer, Graf & Sullivan, 2008; United States	Programme evaluation; Non-specific	Mentoring / Internship; 12 months	A Children hospital; Comparison group: N = 84 NGNs; Intervention group: N = 212 NGNs with mentorship	Structured orientation with a paediatric curriculum; Clinical preceptor who mentored the new nurse to job functions & assisted with unit socialisation; Unit-based clinical educators monitored each new employee's progress with weekly learning goals & clinical performance; Paediatric advanced life support, neonatal resuscitation provider courses, & the emergency nursing paediatric core curriculum were also provided to NGNs within the first 6 to 12 months post-hire	Compare the outcomes of 2 cohorts of new graduate nurses: one before (comparison group) & one after programme implementation (intervention group) with data collection at 3, 6, 12, 18 months: 1) Halfer-Graf Job/Work Environment Nursing Satisfaction Survey: Overall job satisfaction of intervention group was significantly higher than that of comparison group; 2) Turnover rate: 12% for intervention group & 20% for comparison group (Low yet non-specific response rate at 18 months)

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Nugent, 2008, United States	Programme evaluation, non-specific	Orientation, 3 months	Acute care facility, N = 150 Baccalaureate graduate nurses	1st month: Orientation & teaching unit working with clinical educator & co-assigned to multiple nurses; increasing patient assignment from 1-2 low-acuity patients on day shift, to 3-4 patients on evening shifts; 2nd & 3rd months: Returned to home unit (Where they were hired), assigned with preceptors to take care of more complex patients	Open-ended evaluation form for 1st month orientation 1) Gaining independence & increasing workload, while some felt overprotected as students by staff who hesitate to release responsibility; 2) Generally positive comments in working with multiple preceptor; 3) Gained increased confidence in going to home unit
Scott & Smith, 2008, United States	Programme evaluation, non-specific	Mentoring (Successful Transition & Retention - STAR), 12 months	N = 25 new graduate nurses	Orientation, Clinical preceptor, Group mentoring by 3 clinical nurse specialists with Ward visit, Quarterly 8-hr meeting with group of new graduates, 24 on-call anytime, Nurse preceptor class for new graduates, Graduation ceremony	Focus group & Open-ended survey Improved self-confidence & perceived competence, 50% want extending programme to 2 years, 62% intended to stay, New graduates turnover improved from 30.7% to 20%, Greatest dissatisfaction with staff & supervisory relationship, Total cost of programme delivery $8150
Young et al., 2008, United States	Quasi-expérimental pretest & posttest design, Non-specific	A Structured orientation, 1.5 months	A hospital, N = 23/25 NGNs completed both pre & posttest	2 8-hour Classroom instruction weekly (Lecture, demonstration & return demonstration of nursing skills, & role playing), Clinical experience guided by a designated preceptor on the nurse's unit, Programme coordinator offers support to NGNs & preceptors,	Pretest on the first day of orientation & posttest at the end of orientation 6 months later: Nursing Role Conceptions Instrument – 3 subscale: Professional, bureaucratic, & service: 1) Professional role conception scores were the lowest of the 3 subscales with pre & posttest scores were identical; 2) Bureaucratic role conception scores slightly higher than that of professional role conception & with similar pre & posttest scores; 3) Service role conception scores were markedly higher than the other 2 subscales with similar pre & posttest scores; 4) Role discrepancy scores between ideal & actual nursing behaviour were lowest in the bureaucratic subscale, while that of professional subscale were slight higher. Role discrepancy score in the service subscale were highest & the only analysis that demonstrates statistical significant difference, which improved after the orientation

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Bratt, 2009, United States	Programme evaluation, Academic-service partnership, theories of learning from practice & action-reflection cycle	Residency, 15 months	51 urban & rural hospitals, n = 1100 new graduates, n = 400 trained preceptors	Preceptor & clinical coach training, monthly daylong educational sessions (high-fidelity human patient simulator, small group reflective discussion, presentation of core concepts, & storytelling, to facilitate learning from experience through continuous cycle of taking action & reflecting on action), after the preceptor orientation period, residents work independently without oversight by preceptor, they are mentored by clinical coaches with every 2-4 weeks to foster self-awareness & learning and	1) Retention rate: 79-97% at 2 years, mean average retention rate of all site: 84% (Prior programme implementation, NGN turnover exceed 50%); 2) Qualitative data generated from programme completers: nurse residents expressed decreased sense of isolation, enhanced self-assurance & ability to 'think like a nurse', increased capacity to manage their workload, newfound confidence in the ability to recognise patients' impending demise, improved intra & inter professional relationship, & appreciation of the importance of learning continually; 3) Cost-benefit ratio: the average organizational cost was approximately $62,00 for each nurse residency participating in the programme, using the replacement costs as the nurse's annual salary, $62,140, the programme become cost-neutral in merely preventing one NGN from leaving.
Vermont Nurse Internship Project, 2009, United States	Programme evaluation, Lenburg	Internship, 2.5 months	Hospitals, No. of participants not reported	Statewide, standardized approach to preceptor development, Internship curriculum, Individual learning modules & educational workshop, one-to-one preceptorship support, recognition & reward of preceptors, Weekly meeting between interns, preceptors & clinical educators; Patient assignment increased progressively under the direction of the clinical educators	Retention rate: 93%

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Kowalski & Cross, 2010, United States	Programme evaluation, Non-specific	Residency, 12 months	2 hospitals, N = 55 nurse residents	Monthly resident development day (professional development, multicultural competency and end-of-life care), Quarterly patient simulation 1st 3 months: Orientation & working side-by-side with a preceptor in the unit, 4-12 months: Preceptor changed to be sponsor & mentor & not working with residents on the same shift, Directed by Residency Coordinator	Longitudinal evaluation at 3 & 12 months post-hire except measurement 1: 1) Preceptor Evaluation of Resident form: at 3, 6, 8 weeks & 3, 6, 8 months with statistical significant positive improvement on preceptor's clinical evaluation score; 2) Pagana's Clinical Stress Questionnaire: Significantly decreased 'Threat' score but 'Challenge' has NSD; 3) Spielberger's State-Trait Anxiety Inventory: Anxiety decreased across time but not showing statistical significant difference; 4) Casey-Fink Graduate Nurse Experience Survey: Significant improvement in communication/leadership but not in support, patient safety or professional satisfaction; 5) Retention rate: 78% (1st year) - 96% (2nd year)
Aaron, 2011, United States (Illinois)	Programme evaluation, Benner	Preceptor programme Varying duration depends on preceptee's long-term care experience	Long-term care facilities, N = 10 preceptees	Preceptoring (No detail is provided)	1) Hospital Competencies (Preceptees) (No actual finding is provided); 2) Evaluation by director (Preceptor) (No actual finding is provided); 3) Retention rate: 100% (first 6 months); 4) Improved annual resident, family & staff satisfaction; 5) Improved residents' Minimum Data Set Coordinator; 6) Annual Saving of $150,000

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Cottingham, Di Bartolo, Battistoni & Brown, 2011, United States	Programme evaluation, non-specific	Community-based mentoring programme (Partners in Nursing), 12 months	Various health care facilities, N = 19 new graduates (protégés), 21 mentors, 3 faculty advisers	Preparation of mentors, Weekly meeting between NGRNs & mentor, flexibly through email or texts, Monthly face to face group meeting, Monthly professional development programme for NGRN & mentor, Supported by 3 faculty advisers, Faculty advisers & mentors were paid stipends, Community outreach & 3 TV interview programmes to spread about the message of nursing shortage & current initiative	1) Interaction workshop for evaluating the quality of meetings between participants whether meeting their expectations; 2) Evaluation of the monthly seminar with the topic healthy work environment most highly valued; 3) Quarterly online survey on nurses' satisfaction with the profession & programme, perception of personal growth; 4) One-time focus groups for all participants & steering committee. Overall positive comments on the programme. Time is a commonly raised barrier in all measures, especially in attending the monthly seminars. Schedule conflicts affects participation in weekly meetings & monthly seminars. No significant correlation between job satisfaction & programme. (Unknown response rate) 5) Retention rate: 100% in second year; 6) Programme cost $8852; 7) Estimated return on investment ranged from 17% only on direct recruitment cost to 454% of the maximum estimated turnover costs.
Hatler et al., 2011, United States	Programme evaluation, Donabedian	Dedicated Transition Unit Project, 12 months (first 2-3 months orientation)	A hospital, N = 30 NGNs; N = 24 clinical scholars, N = 300 patients	Training of clinical scholars using e-learning system, NGNs work with clinical scholars with increasing patient assignment up to 4 by week 4 of orientation, high-fidelity Human Patient Simulation (HPS) every 2 weeks during their orientation under the guidance & evaluation of the clinical scholars, A nurse educators coordinated among NGNs, clinical scholars, preceptors & nurse managers, regular meeting every week in the first 4-6 week of orientation, followed by monthly meeting with NGN for 12 months in monitoring the entire process	1) Subscales of Essentials of Magnetism scale: job satisfaction of staff nurses on relationships between nurses & physicians, autonomy & control of nursing practice improved after the implementation (No inferential statistics were provided); 2) Absentee rates for DTU RNs were reduced by 19%; 3) Weekly evaluation of NGN confidence shown slight drop initially & graduate increase over 6-8 weeks, evaluation of NGN's performance in the HPS, Lasater's Clinical Judgment Rubric to evaluate the development of NGN (No actual data are provided); 4) Retention rate: 94% at 6 months post-hire; 5) Patient overall satisfaction with care slightly improved (2%) after implementation, particularly in nursing staff's ability to anticipate patient needs (7%); 6) Clinical outcomes for patients with acute myocardial infarctions showed slight improvement in compliance with guidelines (1%); 7) Total estimated costs: $150,000; Total saving: $800,000 in retaining 10 NGNs; Estimated ratio of costs to benefits at 1:5.

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Latham et al., 2008, 2011, 2013, United States	Quasi-experimental, non-control group design used pre- and posttests / Programme evaluation, non-specific	Mentoring (Nurse Supporting Nurse), 12 months	2 Hospitals, N = 89 frontline direct care RN mentor, N= 109 RN mentee over 5 years	Most mentors were already prepared as a preceptor in a regional preceptor education programme; Speed meeting with all mentors before mentee making 3 choices of mentor, 2 educational sessions for both mentor & mentee, Mentor's monthly online semi-structured journal about mentee meeting content & outcomes & using self-reflection & self-awareness to grow & develop & model self-directed learning, Ongoing quarterly (2008) & monthly (2013) mentor support group meeting; Semiannual meeting with hospital & nursing management teams, Mentor compensation & stipend, A hospital liaison to liaise between the hospital & the university	Longitudinal evaluation at baseline & 3 years later 1) Sociometric analysis: Show that some RNs might be informal leaders in the unit but others do not perceived enjoyment in working with them; 2) Memletics Questionnaire (learning style preferences) & Jung Typology Test (personality) online questionnaires modified from Kolb Learning Style & Myers – Briggs instruments: no correlation between the paired mentor & mentee; 3) Occupational stress; 4) Cultural competence tool, 5) Nursing Services Questionnaire (level of perceived professionalism & support): all 3 measures were found to be unreliable or insensitive which were commented as no congruent with qualitative data; 6) Decisional Involvement Scale (Nurse perceptions of actual & preferred distribution of authority for decision about nursing practice & work environment): Statistical significant differences between mentors' pre- & post-test results, Most nurses wanted more influence over RN working conditions than what was currently requested by administration; 7) Professional practice environment scale (Perception professional work environment): Statistical significant differences between mentors' pre- & post-test results; 8) Mentor journals: revealed underlying concerns include (a) authoritarian management that RNs hesitate to speak out in worrying about repercussions & have to tolerate negativity, (b) communication problems between physicians & nurses e.g. has to go through the charge nurse / not responding to issues about patient care, & (c) lack of support for breaks during work hours. Self-developed Mentor survey: Identified many success without specification of the findings; Mentors became more engaged not only in supporting fellow nurses, but on average became 'informal mentor' of up to 8 colleagues; 9) Written, vote-based surveys for all frontline RN: voted for peer support & leadership that indicated the introduction of mentoring practices changed nurses' perceptions about fellow team members' support & their informal leadership ability. 10) Hospital-wide data of patient & nurse satisfaction, nurse vacancy & retention rates, & patient safety data relating to fall & pressure ulcer prevention & proper use of restraints – no specification; 11) Hospital 1: 80% decrease in vacancy rates; Hospital 2: improved retention by 21%; 12) Cost savings comparable to 134 full-time, annual salaries ($100,000 per RN replacement charge)

Appendix I. A summary of the supportive programmes for new nurse graduates working in the clinical setting (Continued)

Author(s), years & country	Design / Theoretical framework	Programme Name & Period	Setting / Sample	Programme Component	Measure(s) / Major Findings
Banks et al., 2011, Scotland	Programme evaluation, non-specific	Flying Start NHS, 12 months	N = 334 NGNs, Community &/or Acute settings	Web-based programme: Clinical skills, Policy Teamwork, Reflective practice, Safe practice, Professional development, Research for practice, Career pathways; Allocation to a mentor	Online survey: More than half of NGNs reported that programmes had been useful in terms of clinical skills development & confidence, especially those who had protected time. 25% had not been allocated with a mentor in first 6 weeks. Overall, mixed satisfaction with the programme, participants in the community setting tend to be more satisfying than those in acute one
Rae, 2011, Scotland	Programme evaluation, Early career investment principle	Fellowship, Non-specific duration	N = 99 Recently RNs & midwives, 2007-09	Flying start NHS, master's degree, action learning, Mentorship, clinical coaching.	Action learning was considered crucial to enable fellow to work in a challenging & complex healthcare system Lack of understanding about the role of the clinical coach which is changed to mentor
Marks-Maran et al., 2013, & Muir et al., 2013 United Kingdom	Programme evaluation, Knowledge & skills framework	Preceptorship, Non-specific	A hospital, n = 44/90 Newly qualified nurses (preceptees with less than 6 months experience)l N = 40/90 preceptors with 9 purposively selected for individual interviews	Preceptor training; follow-up hour-long trouble shooting session for preceptors, preceptor guidebook	Preceptee perspectives: Use of questionnaires & supported findings with reflective journals & audio recording with mainly descriptive statistic in percentage of strongly agree & agree provided: Overall satisfactory or positive findings from the preceptee participants in terms of their (1) engagement with their preceptors; (2) impact of the preceptorship programme on their learning needs in communication, personal & role development, professional relationship & clinical skills; (3) their perceived value of the preceptorship programme to themselves, their managers & other colleagues; (4) Sustainability in the aspect of whether they would recommend the preceptorship programme to a colleagues & they themselves becoming a preceptor in the future Preceptor's perspectives: Use of questionnaires & supported findings with 9 individual interview with mainly descriptive statistics provided Overall positive findings from the preceptors in terms of (1) their perceptions of the preceptorship on preceptee's (1) the personal development; (2) role development; (3) communication skills development; (4) clinical skill development; (5) professional relationship development; (6) their perceived value of preceptorship programme to the organization; (7) their perceived value of preceptorship to their own professional development (Criticism: Low response rate: 48.9% for NQN; 44.4% for preceptor; no comparison between the perspectives of preceptors & preceptees were made)

Key: Benner: Benner's novice to expert (1984), Borich & Jemelka: Borich & Jemelka's educational decision model (1982); Donabedian: Donabedian's model of structure, process, & outcome; Knowler: Knowles' adult learning principles (1970), Kramer: Kramer's reality shock (1974), Lenburg: Lenburg's Competency Outcomes Performance Assessment model; NGN: New graduate nurses; NSD: No significant differences; Nursing process: Planning, implementation, evaluation.

Appendix II. A Summary of Narrative Key Terms

Narrative Terms	Description
Competing stories	Refer to stories that are in tension with one another but both continued to co-exist on the professional knowledge landscape (Clandinin et al., 2006). The term is closely related to but different from another term, conflicting stories.
Conduit	Nurses can be viewed as in a conduit, with their practice being shaped by others, which limited their creativity, independence and autonomy (Connelly & Clandinin, 1994).
Conflicting stories	Refer to two stories that are in tension to an extent that can no longer exist together on the professional knowledge landscape. One story must give way to another, which could lead to the living of a secret story in secret and safe place such as the in-team place and telling of a cover story in public and unsafe place such as the out-of-team place (Clandinin et al., 2006). The term is closely related to but different from another term, competing stories.
Cover story	Cover story in a similar vein to the secret story, can be good or bad and is told when there is conflicting stories on the professional knowledge landscape, or conflict between the individually and socially constructed narratives along the personal-social interaction dimension of the narrative inquiry space (Clandinin & Connelly, 2000). For instance, there is a disjuncture between the sacred stories handed down to nurses through the conduit. Cover stories are often told when nurses move out of their safe and secret in-team place to the relatively unsafe and public places such as the out-of-team place on the landscape. Telling of cover stories enables nurses whose nurse stories are marginalized by the hospital stories, unit stories, and story of hospital or unit, to continue to practice and to sustain their nurse stories (Clandinin & Connelly, 1996). Telling of cover stories also maintain a sense of continuity with the dominant stories of hospital or unit that are shaping a professional knowledge landscape (Clandinin et al., 2006).
Educative experience	Experience that is conducive to growth, not only physical, but intellectual and moral, for instance, a perception of the efficacy to pursue good work in nursing in the future, is an educative experience (Dewey, 1938). The term is closely related to another term, miseducative experience.

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
Field text	Field texts refer to the narrative thinking of data, which is a term to indicate that the texts are co-created in the field is experiential and intersubjective between the participant and researcher rather than objective texts found and discovered by participants or researcher (Clandinin, 2013). Although narrative inquirers would try their best to collect everything down, they acknowledge that this is impossible. Narrative inquirers enter the field with their research purposes and which influence what they attend to by foregrounding some aspects and not attend to the other aspects that are push less visible in the background (Clandinin & Connelly, 2000). Field text conveys a sense of deliberate selection and interpretation. Although unstructured interview or conversation is commonly used in narrative inquiry and participants lead the interview, narrative inquirers also acknowledge their influences on the inquiry. They are aware of their verbal and non-verbal responses, such as a question, a smile or even an eye gaze could have influence the participants further response in giving more detailed explanation or changing their responses. The terms field texts, therefore, capture the interpretative, selectivity and contextualization. Narrative inquirer not only would be aware of what is said and not said, but reflecting why something is said and not said. In contrast to research text, field texts are close to experience and tend to be descriptive about particular events. They have a recording quality and are generally not constructed with reflective intent (Clandinin & Connelly, 2000).
Hospital stories or unit stories	Usually teaching stories handed down across generations in telling health care professionals the ways of the world according to the experience of the elder generations. The hospital stories or unit stories potentially shape the practices, identity and lives of the health care professionals, hence potentially shaping the stories of nurses and nurse stories (Clandinin & Connelly, 2000). The nurses' freedom, creativity and knowledge might be limited by the hospital stories or unit stories (Connelly & Clandinin, 1994). This is in fact the cultural control in a profession, one of the set of forces that shape the actualization of good work (Barendsen et al., 2011). Some of the hospital stories or unit stories were in conflict with some NGRN participants' nurse stories of, which opened up new questions about the meanings of mentoring NGRNs for good work.

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
In-team place	This is a term coined by me for nurses in the health care context, while taking reference to the term in-classroom place used by Clandinin and Connelly (1996) when thinking narratively of the professional knowledge landscapes of teachers. This classroom space seemed equivalent to the cubicles in the hospital units, however, the term in-team place is used instead. As all patients in the unit are generally divided among the nurses, hence team leaders in the unit. A team leader is responsible for a number of patients (varies across different specialties and day and night shifts), which may not be confined to one cubicle, but across multiple ones. Patients under the care of two different team leaders could also be situated in the same cubicle. The space within the nurse's team, which could be further confined to the space behind the privacy curtain with each patient are named as in-team place, which is relatively safe and secret. It is generally free from scrutiny, where nurses are free to live their own nurse stories when compared with the out-of-team place (Clandinin & Connelly, 1996).
Living, Telling, Retelling and Reliving Stories	Refers to the narrative thinking of the inquiry experience in narrative terms that aims at beginning a new story for both the researchers and participants (Clandinin & Connelly, 2000). Under the influence of Deweyan (1938) view of experience, narrative inquirer is interested to see the growth and transformation in experience. Throughout the inquiry, it is important for both participants and researcher to tell their stories, it is even more important to retell and relive new stories that allows growth and changes or Dewey (1938) called an educative experience. Therefore, in the construction of narratives of experience, there is a reflexive relationship between living a life story, telling a life story, retelling a life story and reliving a life story (Clandinin & Connelly, 2000). Meanwhile, it is danger for the retelling stories that are not conducive to growth or Dewey (1938) called a miseducative experience.
Miseducative experience	An experience that stops or distorts the growth of further experiences as a result of decreased sensitivity and responsiveness (Dewey, 1938). For instance, a perception of decreased efficacy to pursue good work in nursing in the future. The term is closely related to another term, educative experience.
Narrative	Narrative refers to the method in studying the patterns of experience through the stories of those lives and writes narrative of experience, known as the research texts of narrative inquiry.
Nurse stories	Stories lived and told by a nurse, which are found in expression in the practices (Clandinin & Connelly, 1996). They are indeed the personal practical knowledge of a nurse which is potentially being shaped by ongoing experience when nurses interact with themselves and others in the landscape.

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
Out-of-team place	This is a term coined by me for nurses in the health care context, while taking reference to the term out-of-classroom place used by Clandinin and Connelly (1996) when thinking narratively of the professional knowledge landscapes of teachers. The out-of-team place refers to the space outside the in-team place, such as the nursing station, hospital corridor, and room of ward manager. It is a place filled with knowledge funneled into the health care system and imposed prescriptions with other people's vision of what are right for patients and their families. Various implementation strategies are used to push research findings, policy statements, plans, and improvement schemes by researchers, policy makers and senior administrators down the conduit into the out-of-team place with the intention to alter the practices of nurses, the stories of nurses, stories of unit, stories of hospital, and ultimately the lives of nurses, patients and their families. Nurses can be viewed as in a conduit, with their practice being shaped by others, which limited their creativity, independence and autonomy (Connelly & Clandinin, 1994).
Participant	The term participant is used instead of other related terms such as informant, respondent, or even sample and subject. There are two main reasons for selecting the term participants. Firstly, narrative inquiry as a relational and collaborative inquiry, is not merely studying on, but studying with the participants, as well as studying the relationship between participant and researcher. This means the researcher is not fully controlling the inquiry process with a power and hierarchical difference between the participant and researcher. That is why unstructured interview data collection method is used instead of the semi-structured or structured one. Both participant and researcher are co-participating and contributing to the inquiry. It also acknowledged that the co-participants are influencing each other in the inquiry process. The second reason is similar to that of the use of the term research puzzle. The other terms such as informant, respondent, sample and subject convey a sense of certainty and clear definability, and the expectation of solutions to research questions. In contrast, the term participant conveys more of a sense of participation and co-participation for continual inquiry into the research puzzle in seeing new possibilities or even other new research puzzles. Participant is treated as a person, as an embodiment of lived stories, rather than as an exemplar of culture or other formal category (Clandinin & Connelly, 2000).

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
Personal practical knowledge	Conceptualizes the knowledge that nurses gain through experience. Personal practical knowledge is found in the person's practice with a moral, affective and aesthetic way of knowing life's educational situations, but not in textbooks and cannot be adequately developed in nurse education programmes. The knowledge is procedural about knowing-how rather than knowing-what, personal that is embodied in a nurse's practice and is derived from a nurse's personal and professional history (Dwyer & Garvis, 2012). It captures the narrative thinking of experience especially the notion of continuity and interactions. Personal practical knowledge is in the [nurse's] past experience, in the [nurse's] present mind and body, and in the future plans and actions and how nurses understand rules or practical principles that embodied purposes in a deliberate and reflective way. There can also be their reconstruction of meanings as personal philosophy that are contextualized in terms of [mentoring] situation (Connelly & Clandinin, 1988).
Professional knowledge landscape	Is a landscape metaphor used to capture the complexity of the health care context for nurse's personal practical knowledge in terms of individual nurse knowledge, the health care landscape and the way in which this landscape relates to public policy and theory or in narrative term known as sacred story. The landscape allows narrative thinking about space, place, and time filled with diverse people, things and events in different relationships that are interwoven and continuously changing. It captures the multiple layers of meanings that depend on individual stories and how individuals are positioned on the landscape, and the landscape's own narrative history of shifting values, beliefs and stories (Clandinin & Connelly, 1996). Thinking narratively, the landscape has a history with moral, emotional and aesthetic dimensions (Clandinin & Connelly, 1995). The landscape is composed of two fundamentally different places, the in-team place and the out-of-team place. These two terms are coined by me for nurses in the health care context, while taking reference to the terms in-classroom place and out-of-classroom place used by Clandinin and Connelly (1996) when thinking narratively of the professional knowledge landscapes of teachers. The landscape metaphor allows thinking about the important and epistemological dilemma associated with living and created when nurses are crossing between the in-team and out-of-team places on the health care context that can be understood narratively in terms of secret and cover stories (Clandinin & Connelly, 1995, 1996, 1999).

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
Research puzzle	Research puzzle refers to the narrative thinking of a particular wonder, generally known as the research problem or research question. However, a research problem or question tends to convey that the outcome and expectation of the inquiry is a definite answer, which seems to conclude the inquiry with close end in limiting further exploration of other possibilities. Using the term research puzzle convey more of a sense of a search, a re-search, a search again. The sense of continual reformation and uncertainty embodied the transactional ontology and evolutionary epistemology of narrative inquiry (Clandinin & Connelly, 2000).
Research text	Reconstructed and rewritten of field texts by asking questions concerning the meanings, significance and purposes repeatedly (Lindsay, 2006). They are composed by positioning the field texts along the three dimensions space of narrative inquiry in looking for patterns, narrative threads, tensions and themes either within or across an individual's experience and in the social setting (Clandinin & Connelly, 2000). The research texts do not give final answer, which is not the goal of narrative inquiry. They intended to engage and resonate with readers in remembering and rethinking their experience alongside the inquiry experience, and wondering alongside participants and researcher to see new possibilities and new insights (Clandinin, 2013).
Sacred story	Also known as a sacred theory/practice story. This is a theory-driven view of practice shared by policy maker and theoreticians. It can be good and bad, which can be expressed in the form of a story of hospital or a story of unit (Clandinin & Connelly, 1996). However, it is a pervasive view that often went unquestioned and taken-for-granted and is assumed to be the only way which influences practitioners by changing the hospital and unit practices, story of the hospital and unit, and even hospital stories and unit stories (Connelly & Clandinin, 1999). Sacred story acts as imposed prescriptions can shape the out-of-team places on the professional knowledge landscape easily when throw down through the conduit (Clandinin & Connelly, 1996). Sacred story may conflict with the nurse stories that lead to the living of secret stories in the in-team places and telling of cover stories in the out-of-team places. Sacred stories could also be viewed as the social control in shaping the attainment of good work in nursing (Barendsen et al., 2011).

Appendix II. A Summary of Narrative Key Terms (Continued)

Narrative Terms	Description
Secret story	Secret story can be good or bad. A result of conflicting stories as the nurse stories are in tension and incongruent with the other stories on the professional knowledge landscape. Secret story is lived in safe and secret places, such as the in-team places, generally free from scrutiny, where nurses are free to live their own stories of practice. These lived stories are essentially secret ones that are told only to others who are trustworthy in safe and secret places which are free from retribution or potential damage to the nurses' reputation and professional development, as there is conflict between the individually and socially constructed narratives (Clandinin & Connelly, 1996, Clandinin et al., 2006). The term is closely related to another term, cover story.
Stories of hospital or stories of unit	Stories about the hospital or the unit told by others, such as policy makers, hospital administrators, managers, nurses, other health care professionals, patients, families, mass media, general public (Clandinin & Connelly, 1996). In the same vein as stories of nurses, the stories convey the expectations on the hospital or unit told by a particular party. The stories of hospital or stories of unit could potentially shape the hospital stories or unit stories, especially those told by influential figures such as the head of chief executive of the hospital or the chief of service and ward manager of the unit. The stories told by different parties can vary dramatically, which leads to competing or even conflicting stories.
Stories of nurse	Stories about nurses told by nurses themselves and others, such as policy makers, hospital administrators, managers, other nurses and health care professionals, patients, families, mass media and general public (Clandinin & Connelly, 1996). The story conveys the expectation on nurses told by a particular party. Stories of nurse told by people in the profession and others in the society are in fact the social control and outcome control respectively, the two sets of forces in shaping good work in nursing (Barendsen et al., 2011; Gardner et al., 2001).
Stories to live by	The phrase refers to the narrative thinking of identity by considering the knowledge and context (Connelly & Clandinin, 1999). It is an intellectual thread that facilitates our understanding of the interrelationship of knowledge, context and identity as fluid and shifting (Connelly & Clandinin, 1998). Thinking narratively, stories to live by are fluid and shifting, which are viewed as a living process that is shaped by the social, cultural and institutional narratives (Clandinin, 2013). This can also contribute to the shaping of good work in practice, the personal standard.
Story	Story describes the phenomenon that people by nature lead storied lives and tell stories of those lives.

Appendix III. Guidelines for Recommendation of NGRNs

INFORMATION SHEET

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

You are invited to nominate newly graduated registered nurses to participate on a study conducted by Ms. Law Yee Shui, a post-graduate student of the School of Nursing in The Hong Kong Polytechnic University, under the supervision of Dr. E. Angela Chan and Professor Samantha Pang of the school.

The aim of this study is to delineate the lived transitional experiences of newly graduated registered nurses who are committed to good work and to understand their meaning of mentoring in the local health care context from the perspectives of newly graduated registered nurses, mentors and other health care personnel. Your nominees will be invited to participate in three individual audio-taped interviews over one year, at an interval of six months. Each interview will last about two hours. Your nominees will also be invited to compose free-style journals each month throughout the one-year study period. The aim is to capture the stories of experience and feelings of each month, encourage on-going reflection, facilitate subsequent discussion and reveal any longitudinal changes. The journals will not be limited by any ways of presentation, languages or word counts. All obtained information will remain confidential, and will be identifiable by codes only known to the research team. Participants have every right to withdrawn from the study before or during the study period without penalty of any kind. No potential risks to participants are envisaged.

The obtained information is invaluable to understand the meaning of mentoring newly graduated registered nurses in relation to the experiences of transition and pursuit of good work. The findings will yield insight in developing strategies to facilitate transition and good work in the local health care context. It is hoped that the findings will help to inspire the entire nursing profession that good work is possible.

If you have any complaints about the conduct of this research study, please do not hesitate to contact Ms. Kath Lui, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Research Office of the University).

Guidelines for nomination and information sheet for potential participants are attached for your reference. If you would like more information about this study, please contact Ms. Law Yee Shui at 3400-8193, or her supervisors Dr. E. Angela Chan at 27664131 or Prof. Samantha Pang at 2766-6409.

Thank you for your interest in participating in this study.
Project team

Ms. Law Yee Shui
Dr. E. Angela Chan
Prof. Samantha Pang

Appendix III. Guidelines for Recommendation of NGRNs (Continued)

Guidelines for Recommendation of Newly Graduated Registered Nurses

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

Good work is a concept initiated by a group of psychologists at the Harvard University in 1995 in identifying individuals and institutions that exemplified good work in journalism and genetics and determining how best to increase the incidence of good work in the society. Work that is both excellent in quality and responsible to the broader society has been the identified definition of good work. In nursing, several exploratory studies were conducted in the United States, Norway and Hong Kong, however, the concept of good work has not been well-defined.

In this study, newly graduated registered nurses who are nominated by their supervisors, senior nursing colleagues and former faculty members in recognising their commitment in pursuing good work in nursing will be recruited to understand their storied experience in transition, pursuit of good work and mentoring. The following are some suggested guidelines for recommendation. This is not an exhaustive list and you are invited to give additional constitution of good work from your perspective.

Inclusion Criteria

- 2010 RN graduates, therefore, those having one year or less of clinical experience after graduation upon recruitment; and
- Employed as full-time registered nurses in any settings and specialties at the eight local public hospitals where ethical approvals were obtained; and
- Hospital- or university-based nursing graduate with a higher diploma or baccalaureate qualification from any local universities or hospitals; and
- Recommended by senior nurses, peers, or former faculty members, who, based on interactions with them and observations of their performance, recognised their dedication to pursuing good work or delivering high-quality nursing care.

Exclusion Criteria

- Graduates convert from enroled nurses
- Graduates from overseas institutions

Appendix III. Guidelines for Recommendation of NGRNs (Continued)

Newly graduated registered nurses who demonstrate an intention to pursuit good work in nursing based on daily observation and interaction (Fischman, Soloman, Greenspan & Gardner, 2004; Gardner, 2010; Garnder, Csikszentmihalyi & Damon, 2001; Miller, 2006):

- Dedicated to provide quality of care
- Striving to optimize the well-being of clients and families
- Willing to learn
- Willing to seek clarification when encountering uncertainty
- Recognise personal limitation and areas of improvement
- Caring
- Responsible
- Respecting the rights of clients
- Safeguarding the best interest of clients
- Demonstrating safe practice according to the evidence-based nursing knowledge, professional conduct principles and nursing ethics
- Striving to facilitate work efficiency
- Striving to maintain a harmonious work relationship
- Other reasons for recommending

Appendix IV. Information Sheet for NGRNs (English version)

INFORMATION SHEET

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

You are invited to participate on a study conducted by Ms. Law Yee Shui, a post-graduate student of the School of Nursing in The Hong Kong Polytechnic University, under the supervision of Dr. E. Angela Chan and Professor Samantha Pang of the school.

The aim of this study is to understand the meaning of mentoring newly graduated registered nurses in the local health care context from the perspectives of newly graduated registered nurses, mentors and other health care personnel. You will be invited to participate in three individual audio-taped interviews over one year, at an interval of six months. Each interview will last about two hours. You will also be invited to compose free-style journals each month throughout the one-year study period. The aim is to capture the stories of experience and feelings of each month, therefore, the journals will not be limited by any ways of presentation, languages or word counts. The obtained information is invaluable to understand the meaning of mentoring newly graduated registered nurses in relation to the experiences of transition and pursuit of good work. The findings will yield insight in developing strategies to facilitate transition and good work in the local health care context. It is hoped that the findings will help to inspire the entire nursing profession that good work is possible.

All information related to you will remain confidential, and will be identifiable by codes only known to the research team. You have every right to withdrawn from the study before or during the study period without penalty of any kind. No potential risks to participants are envisaged.

If you have any complaints about the conduct of this research study, please do not hesitate to contact Ms. Kath Lui, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Research Office of the University).

If you would like more information about this study, please contact Ms. Law Yee Shui at 3400-8193, or her supervisors Dr. E. Angela Chan at 27664131 or Prof. Samantha Pang at 2766-6409.

Thank you for your interest in participating in this study.

Project team
Ms. Law Yee Shui
Dr. E. Angela Chan
Prof. Samantha Pang

Appendix V. Pre-interview Self-Completion Questionnaire

Name	**:**	_____		
Gender	**:**	_____	**Age**	**:** _____
Contact No.	**:**	_____	**Email**	**:** _____
Hospital	**:**	_____	**Specialty**	**:** _____
Position/ Rank	**:**	_____	**Duration in Current position**	**:** _____
Rotation Experience	**:**	_____		
Education Level	**:**	_____	**Programme & Institution**	**:** _____
Mentoring Experience	**:**	_____	**Previous TUNS Experience**	**:** _____
Overseas Clinical Experience	**:**	_____		
Marital Status	**:**	**□ Single**	**□ Married**	**□ Divorced** **□ Widowed**
Religion	**:**	**□ Yes Specific:**		**□ No**

Appendix VI. Consent Form for Audio-Record Interview (English Version)

CONSENT TO PARTICIPATE IN RESEARCH

Making Good:
Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

I _____ hereby consent to participate in the captioned research conducted by Ms. Law Yee Shui, a postgraduate research student, and supervised by Dr. E. Angela Chan and Professor Samantha Pang of the School of Nursing in The Hong Kong Polytechnic University.

The purpose and procedure as set out in the attached information sheet has been fully explained. I understand that this research involved interview(s) which will be audio-recorded and information obtained from this research may be used in future research and published. However, my right to privacy will be retained, i.e. my personal details will not be revealed. I understand the benefit and risks involved. My participation in this research is voluntary. I acknowledge that I have the right to question any parts of the procedure and can withdraw at any time without penalty of any kind.

Name of participant: _____

Signature of participant: _____

Name of researcher: _____

Signature of researcher: _____

Date: _____

Appendix VII. Consent Form for Collecting Monthly Journal (English Version)

CONSENT TO PARTICIPATE IN RESEARCH

Making Good:
Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

I _____ hereby consent to participate in the captioned research conducted by Ms. Law Yee Shui, a postgraduate research student, and supervised by Dr. E. Angela Chan and Professor Samantha Pang of the School of Nursing in The Hong Kong Polytechnic University.

The purpose and procedure as set out in the attached information sheet has been fully explained. I understand that this research involved collection of monthly freestyle journals and information obtained from this research may be used in future research and published. However, my right to privacy will be retained, i.e. my personal details will not be revealed. I understand the benefit and risks involved. My participation in this research is voluntary. I acknowledge that I have the right to question any parts of the procedure and can withdraw at any time without penalty of any kind.

Name of participant: _____

Signature of participant: _____

Name of researcher: _____

Signature of researcher: _____

Date: _____

Appendix VIII. Interview guide with probing questions for NGRNs (English Version)

Beginning

Tell me about your transition from a nursing student to becoming a registered nurse. How is it like to be working as a newly graduated registered nurse?

Broad questions

1) Describe your life after graduation as a newly registered nurse in the hospitals?
2) Please tell me your experience in being supported or mentored as a newly graduated registered nurse.
3) How the mentoring experience is different for you now compared to that when you first begin practicing after graduation?
4) What are the factors supporting or inhibiting the mentoring experience?
5) Do you think mentoring can be effective in facilitating your transition from a student to a registered nurse?
6) Do you think mentoring can be used for facilitating good work in nursing in Hong Kong effectively?

Ice breaking questions

Tell me in your own words the story of your life after graduation. I just want you to tell me about your lives working at the hospital, with or without the help of a mentor or others as if it was a story with a beginning, a middle and how things will look in the future… there is no right or wrong way to tell your story… just tell me in any ways that is most comfortable…

Probing questions

Can you tell me more about that?
What was the experience like for you?
Can you give me a specific example?

Sub-questions

Transition

1) Tell me what happened at hospital after graduation/since our last meeting?
2) Do you expect what has happened? What are you expecting? Both opportunities and obstacles?
3) What stands out in your transition period during your first year as a nurse?
4) How do you feel about the expectations of your new role?
5) Would you describe a time when you were unsure what the right thing to do was and you had to decide?
6) Can you recall any turning points from your experience as a registered nurse?
7) What are the dimensions that influence your transitional experience (Relationships with self and others, orientation process, workplace environment and the entire profession)?
8) How has your perception of nursing changed since you first started?

Mentoring

1) Please tell me your experience as a mentee at the hospital?
2) Were you able to meet with your mentor on a regular basis?
3) What impact has mentoring caused on your experience as a newly graduated nurse?
4) Was having a mentor a stress reducer?
5) What impact has a mentor caused in your life as a registered nurses transiting from a nursing student and in aspiring to good work? Do you value the time and commitment necessary to build effective mentoring relationships with experts or experienced nurses in the field?
6) Do you think you match with your mentor?
7) Did your mentor provide the guidance and feedback you would have liked?
8) What the mentor do right and the many few things they do wrong?
9) How do your past experience as being mentored influence your present experience in mentoring and further experience?
10) Do demands on time limit accessibility to mentors for nurses entering the profession?
11) How patient care influences your mentoring experience / your mentor in mentoring me?
12) How mentoring is influenced by different people, events and the environment?
13) Please tell me whether you have benefited from the mentoring?
14) Are you satisfied with your transitional and mentoring experience?
15) Would you recommend your mentor for a future mentor programme?
16) What are the dimensions that can effectively encourage mentoring? (e.g. personal, interpersonal, institutional, professional and environmental perspective)
17) Would you like to see changes in the mentor programme?

Good Work

1) Please tell me your experience in pursuing good work in nursing?
2) How do you know you are achieving good work in nursing?
3) How can you achieve good work in nursing?
4) How do you learn to perform good work?
5) What factors are influencing the achievement of good work in nursing? (Personal believe and values, role models and mentors, peers, previous pivotal experience, norms of the institutional milieu and periodic support from people, field and domain)
6) What are the challenges that you encountered when you try to perform good work (Personal, interpersonal, organizational, professional and environmental influences)
7) How mentoring can facilitate your aspiration of good work in nursing?

Final Interview:

If you were writing a book about your experience becoming a registered nurse, what chapter titles would you like to use?

Please use a metaphor to capture your first two years of experience in transition and pursuit of good work

Appendix IX. Discussion Agenda for Preceptor Focus Group Interview

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

Discussion Agenda for Preceptor Group

Discussion Topics	
‘Mentoring’ Experience (25 mins)	
Impressive Experience Satisfactory Experience Challenging Experience Conflicts Strategies	Other Influential Factors Personal (Past Experience) Social – Other People Events Environment Ward & Hospital Culture & System
Perception & Expectation (20 mins)	
Mentoring / Preceptoring Mentor / Preceptor Mentee / Preceptee	Impact of TUNS Experience Transition & Need of Support Sense of Burden
Meaning (15 mins)	
Mentoring/Preceptoring Good Work	Mentoring NGRN Mentoring & Transition Mentoring & Good Work
Preceptorship / Structural Supportive Programme (15 mins)	
Preparation & Training Mentor/Preceptor-NGRN Ratio Mentor/Preceptor Workload	Assessment & Evaluation Method Support & Reward Recommendation / Major concern
Paradigmatic Case Discussion (25 mins)	

Appendix X. Discussion Agenda for Stakeholder Focus Group Interview

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

Discussion Agenda for Stakeholder Group

Discussion Topics	
Working & Interacting Experience (25 mins)	
Impressive Experience Satisfactory Experience Challenging Experience	Conflicts Strategies Other Influential Factors
Perception & Expectation (20 mins)	
NGRN Transitional Experience	Impact of TUNS Experience Need of Support
Meaning (15 mins)	
Mentoring / Preceptoring Good Work	Mentoring NGRN Mentoring & Transition Mentoring & Good Work
Preceptorship / Structural Supportive Programme (15 mins)	
Preparation & Training Mentor/Preceptor-NGRN Ratio Mentor/Preceptor Workload	Assessment & Evaluation Method Support & Reward Recommendation / Major concern
Paradigmatic Case Discussion (25 mins)	

Appendix XI. Information Sheet for Preceptor or Stakeholder (English version)

INFORMATION SHEET

Making Good: Understanding the Meaning of Mentoring Newly Graduated Registered Nurses in Hong Kong

You are invited to participate on a study conducted by Ms. Law Yee Shui, a post-graduate student of the School of Nursing in The Hong Kong Polytechnic University, under the supervision of Dr. E. Angela Chan and Professor Samantha Pang of the school.

The aim of this study is to understand the meaning of mentoring newly graduated registered nurses in the local health care context from the perspectives of newly graduated registered nurses, mentors and other health care personnel. You will be invited to participate in an audio-taped focus group interview, which will last for two hours. The obtained information is invaluable to understand the meaning of mentoring newly graduated registered nurses in relation to the experiences of transition and pursuit of good work. The findings will yield insight in developing strategies to facilitate transition and good work in the local health care context. It is hoped that the findings will help to inspire the entire nursing profession that good work is possible.

All information related to you will remain confidential, and will be identifiable by codes only known to the research team. You have every right to withdrawn from the study before or during the study period without penalty of any kind. No potential risks to participants are envisaged.

If you have any complaints about the conduct of this research study, please do not hesitate to contact Ms. Kath Lui, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Research Office of the University).

If you would like more information about this study, please contact Ms. Law Yee Shui at 3400-8193, or her supervisors Dr. E. Angela Chan at 27664131 or Prof. Samantha Pang at 2766-6409.

Thank you for your interest in participating in this study.

Project team
Ms. Law Yee Shui
Dr. E. Angela Chan
Prof. Samantha Pang

Appendix XII. Pre-interview Self-Completion Questionnaire for Preceptor or Stakeholder

Pre-interview Self-Completion Questionnaire

Name : _____

Gender : _____ **Age** : _____

Marital Status : □ **Single** □ **Married** □ **Divorced** □ **Widowed**

Religion : □ **Yes Specific:** □ **No**

Contact No. : _____ **Email** : _____

Hospital : _____ **Specialty** : _____

Position/ Rank : _____ **Years in Current position** : _____

Years in Profession : _____

Highest Education Level : _____

Mentee Experience : ___**Months/Years** **Mentor Experience** : ___**Months/Years**

Mentoring Training : □ **Yes, Specific:** □ **No**

_____ **(Duration)** _____**(Programme)**

Overseas Clinical Experience : □ **Yes, Specific:** □ **No**

_____ **(Duration)** _____**(Venue / Programme)**

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