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The transition to becoming a newly qualified nurse: a reflection

Robyn Hardacre and Lesley Hayes

School of Nursing and Midwifery, Faculty of Health Sciences, Staffordshire University.

Abstract

This work outlines a piece of reflection that was presented by one individual as part of a level 6 undergraduate viva voce assessment, which took place close to the point of qualification. Using a reflective model as a guide, its purpose is to demonstrate and articulate professional development in preparation for qualification, and it demonstrates how reflection can be used to consolidate and identify further development required by the newly qualified nurse.

Keywords: newly qualified nurse; preceptorship; professional development; reflection; transition

Introduction

For a number of years nursing students at Staffordshire University have undertaken the development of a portfolio of evidence, which has been summatively assessed in year two and three of their award. This portfolio encompasses evidence that demonstrates the student's own professional development during their journey towards qualified nurse status. This wide-ranging evidence includes assessment documents which are completed in practice by mentors, documents to support learning in theory and practice such as SWOTS, action plans and learning contracts, and reflective writing that facilitates deeper understanding of significant clinical experiences.

Students can find the transition stressful (Gerrish 2000, Whitehead and Holmes 2011), and on completion of their award, and having achieved qualified nurse status, can lack confidence (Clarke and Holmes 2007). It has therefore been common for students on the award to consider, through reflection, the challenges faced by them during this transitional period, in order to understand the feelings they are experiencing and to identify how they can address these in order to successfully prepare themselves for their first nursing role. The reflection below is one such example. It was presented for summative assessment, by one student, as part of the third year viva, which takes place only a few months prior to qualification. Bowers (2015) whilst focusing on nursing outlines the key purposes of reflection: assisting fusion of theory and practice and developing critical insight of self and events. The expectation is that achieving these goals supports planning, personal development and thus achieves a real improvement in practice. In order to demonstrate the insight and deep learning that can be achieved through reflection, and the personal and professional growth that can arise from active engagement with the reflective process, the reflective work is presented below, with only minor edits being made to enhance the flow of the work. Although this reflection was completed prior to the new Nursing and Midwifery Council (NMC) revalidation process being launched it still has resonance and its principles remain intact (NMC 2015a).

This is the reflection of one student, and was undertaken for the purpose of personal and professional development. Although it could be argued that the opportunities for future learning may not be transferrable to other students, it provides insight into the potential of reflection, in supporting the transition to a newly qualified nurse.

Transition to Newly Qualified Nurse

Although nursing courses have many stressors and psychological strains (Pulido-Martos, Augusto-Landa and Lopez-Zafra, 2012), this is a small window into the reality shock that Newly Qualified Nurses (NQNs) face when transitioning from a student to a registered nurse (Stacey, 2010), resulting in high numbers of NQNs leaving in their first year (Health Education England, 2014). To tackle this, I have completed a reflection regarding issues I may face as a NQN, and considerations that I will have to take into account, so I can address these in practice. I have used the Driscoll and Teh (2001) model of reflection as it is an open reflection that does not constrain me to focused questions, but allows me to explore issues in both breadth and depth.

WHAT

There are benefits to supporting NQNs through what can be an extremely challenging transition for the NQNs, the employer, the patient and the nursing profession (Green, 2014). It is important for the NQNs, as once support offered from their university is cut off, the NQNS can feel isolated and lack confidence (Bjerknes and Bjork, 2012), leading to psychological issues such as stress and anxiety, and issues in the workplace, such as reduced working efficacy, as the NQNs lack the confidence to complete all jobs required, or do so with hesitance and inefficiency (Maxwell et al, 2011). This lack of support causes many nurses to leave the profession, leading to high costs for the employer as high turnover requires expenditure for recruiting and hiring, whilst also being costly for the NHS in the training of nursing students (Twibell, 2012). However, there is also potential benefit arising from limited support. If a NQN is 'thrown in at the deep end', this can enhance autonomy and ultimately confidence as the realisation develops that coping is possible (Hollywood, 2011). It can also motivate NQNS to independently and experientially increase their skills and knowledge meaning these are more likely to be retained and underpin professional growth (Hollywood, 2011). This 'survival of the fittest' proposes that it is emotionally and intellectually capable nurses who remain after this early weeding out process (Health Education England, 2014).

Regardless, poor support cannot be condoned. It has negative effects on patient care, with potential to reduce the quality of care or result in harm, due in part to poorly supported NQNs being less likely to ask questions or seek advice believing this indicates they are not coping or are not capable (RCN, 2014). This is compounded by NQNs feeling they are not sufficiently trained and lack sufficient clinical skills at the point of registration, in addition to their perceived belief of high expectations for NQNs to be as competent as experienced nurses (Draper, 2013). This can damage the image of the nursing profession, resulting in increases in errors or decreases in the quality of patient care ultimately reduces the public's confidence in nursing (Peate, 2012). Yet, NQNs are not sufficiently supported, and have often been the victims of bullying in circumstances where more experienced nurses may not appreciate staff who require additional assistance, or feel that new staff are not good enough (RCN, 2005). Bullying can also be from managers, if the NQNs' values conflict with their own, leading to isolating alliances and NQNs feeling incompetent (Lowenstein, 2013). This can increase the stress of transition by creating a toxic environment, reducing morale, confidence, and the NQNs' sense of value (Tapping, Muir and Marks-Maran, 2013).

Whilst trying to find a place within the team and coping with the stresses caused by starting at a new workplace, NQNs also have fear and anxiety caused by the responsibility and accountability they are given as a registered nurse (Draper, 2013). Nurses must deliver autonomous, competent care and are accountable for the standards of this care, any omissions, as well as needing to justify decisions made (Scrivener et al, 2011). This requires

competency in many skills which, often, NQNs are not sufficiently trained in (Draper, Sparrow and Gallagher, 2009). This results in long term issues as NQNs are afraid of making errors and of having litigation brought against them (Magnusson et al, 2014). Not only is there apprehension at the point of qualification, it has also been observed that around half way through the NQNs' first year, there is a 'confidence crisis', when NQNs become aware of their lack of competencies which, without support, can cause the NQNs to question their capabilities to continue practice (Hole, 2009). However, if sufficient support is provided this can become a positive experience, with it being used as a motivator to improve competency and patient care (Miller and Blackman, 2009).

Regarding accountability, NQNs need to understand the need to report errors and whistle-blow, as it is mandatory for practitioners to raise concerns if they observe anything putting patients or others at risk of harm (Whistleblowing Helpline, 2015). However, such lack of training and support is a barrier to reporting of errors or whistleblowing, as NQNs are unaware of the correct procedures to follow to protect themselves and their practice, and are hesitant to do so for fear of consequences such as losing their position, bullying and anger from patients or colleagues (Mathieson, 2013). Regardless of these requirements, NQNs have been found to be insufficiently trained to understand accountability, leading to: nurses working outside their competencies; poor error reporting; poor time management derived from failure to delegate due to fear of failed accountability; over-checking tasks undertaken by health care support workers; reducing work relationships and efficiency (Hall and Ritchie, 2010).

Additionally, when having to come to terms with all of these issues of accountability, poor or absent support and a limited skillset, NQNs have additional demands as they must establish a professional portfolio, as it is mandatory for every practitioner to maintain a lifelong, up to date record of their continued professional development (CPD)(Casey and Egan, 2010). This has requirements that include at least 35 hours evidenced over three years of relevant, evidence-based learning applicable to practice, with the implementation portrayed (NMC, 2010). However, many skills required to conduct meaningful CPD, such as reflection, are advanced skills that require support, training and experience to develop (Lynch et al, 2009). Additionally, whereas employers previously offered opportunities to continue learning such as study days and courses, increasingly the funding for these has been reduced to focus only on mandatory training, greatly reducing the support NQNs gain from the employer (Alsop, 2013). Where wider training opportunities remain other prohibiters continue to have impact; barriers include reduced staffing levels where the lack of available staff reduces the ability to cover shifts and release nurses to attend study days (Woodward, 2012).

SO WHAT

One system used to aid transition from student to registered nurse is preceptorship; the use of qualified, experienced nurses to aid the NQNs to settle into their job roles and strengthen their competencies (Draper, 2013). This is done by providing NQNs lists of required skills, and working with the NQNs to apply their knowledge on these skills to practice, whilst also providing support and guidance to problem solve and analyse strengths and weaknesses so these can be addressed (Ripley and Hoad, 2011). Preceptorship started after research identified the need to protect nursing by supporting the future workforce (DH, 2010). Although it has been reported as equivocal (Currie and Watts, 2012) significant benefits have been reported and it is an expected part of settling into the registered nurses role. Where preceptorship is used, NQNs' confidence and competence has increased, patient care has improved and fewer errors are made (Twibell, 2012). Therefore, DH (2010) suggests that preceptorship should be offered to all NQNs, however, access to preceptorship is limited or non-existent in areas, leading to poor support (Hollywood, 2011). Barriers to preceptorship include confusion of the role of the preceptor, due to lack of knowledge of preceptorship from the NQNS' and lack of formal training for preceptors (Hollywood, 2011). This leads to

mismatched expectations of help, which increases the feelings of poor support for NQNs (Whitehead, 2001). This effect is also caused if the preceptor is 'toxic', in that they use their position to disempower or undermine the NQNs. Preceptorship also has barriers in that it requires time to meet, or complete the paperwork (Whitehead, 2001). However, even with these barriers, NQNs still feel they benefit (Marks-Maran et al, 2013). There is also organisational ignorance as to the role of preceptorship that has an effect on how effectively it is used, evidenced by differing views that argue whether preceptorship should or should not address gaps in educational knowledge (DH, 2010). One argument is that it should increase public confidence of nurses, however, the opposing view is that staff should already be sufficiently trained, and preceptorship should be an aid to applying and increasing skills, not to learn them (Whitehead, 2001). This portrays a lack of definition of the preceptor's role, which must be addressed so expectations can be standardised and roles clarified (DH, 2010).

Another form of organisational support is that of having supernumerary status, in which NQNs work alongside a peer or mentor, allowing the NQNs to have a role model, so they can know what is expected of them, whilst giving them time to increase familiarity with policies, documentation and the team, though still allowing them to carry out nursing duties (Tavengwa, 2011). This results in better care as NQNs are supported, can share knowledge and seek advice, whilst allowing them to begin to apply theory to practice in new situations (Morrell and Ridgway, 2014). This also allows for clinical governance of the NQNs, as they will be supervised, so areas in need of improvement can be seen (Maguire, 2013). However, for some NQNs, this can be constraining; nonetheless, for most NQNs this is an invaluable opportunity that facilitates effective transition (Tavengwa, 2011).

Preceptorship and supernumerary nursing also has benefits addressing accountability issues for NQNs (Ripley and Hoad, 2011). As nurses are accountable for standards of care provided, preceptorship and supernumerary status allow these to be developed, increasing NQNs' confidence regarding their competence and aiding them to take responsibility for the care they provide (Twibell, 2012). Despite this, it is important for NQNs to increase their competence individually to meet the standards expected of them, such as knowledge of health needs, treatments, holistic care and care delivery (NMC, 2015b). Although learning these will be aided by support from the workplace, it is the NQN's responsibility to self-assess their abilities and improve these as necessary (RCN, 2011a). To achieve this, the NQN requires knowledge of the set standards, though auditing can help NQNs see if these standards have been met (Plant, Pitt and Troke, 2010). Once the nurse is competent, care is safer and standards higher (Green, Dickerson and Blass, 2010). This learning can be difficult due to time obligations, however, it is increasingly important as nursing roles change, affecting the skills expected of nurses (Handley and Dodge, 2013). Learning can be through various means such as the use of simulations or information databases, however, learning theory does not always allow the practical application of knowledge and support to develop this is necessary (Benner et al, 2011).

For the nurse to be accountable, they also need to be aware of their responsibilities such as error reporting or whistleblowing, as nurses have a duty of care to prevent foreseeable harm (Mullen, 2014). For this, NQNs need to have awareness of legislation and the expectations outlined within their Code (NMC, 2015c). If observing something is outside these laws/standards, the NQN must know how to address this in a professional manner (RMT, 2015). This may be by informing a senior member of staff such as a ward manager, so that the issue can be dealt with efficiently on a local level, or taking the issue further until it is addressed (Hole, 2009). Without training and knowledge regarding whistleblowing, effects can be dire as issues may grow and persist such as in the case leading to the Francis Inquiry (2013). However, NQNs do not have sufficient training, and many do not know that they can ask their union for advice or have protection from possible consequences by the public disclosure act (RCN, 2011b). This training also extends to the need to know correct error reporting requirements for NQNs (Covell and Ritchie, 2009). Many NQNs hesitate before

reporting errors due to the fear of the blame culture in the NHS (Muha, 2014). However, not reporting errors can lead to anxiety and feelings of inadequacy, and prevents errors from being tackled systematically (Domrose, 2011). Correct training in error reporting procedures can assist NQNs to feel supported to admit errors, increasing candour and honesty in the profession and assisting NQNs to speak up when they notice others make errors, aiding them to advocate for patients (Peate, 2010).

To allow nurses to act with the necessary autonomy and accountability, continuing professional development (CPD) needs to be utilised to assess competency, maintain evidence-based, up to date knowledge and to identify areas for development (Peate, 2012). This is usually done through the use of a portfolio to establish which CPD learning activities have been completed, such as reflections, clinical supervisions or e-learning (Duffy, Dresses and Fulton, 2009). E-learning is increasingly popular as it bypasses barriers of training courses by being flexible, cheaper and still providing certificates as evidence (Woodward, 2012). However, simply having evidence of learning is not sufficient, NQNs must show how this knowledge will be implemented to improve practice (HCPC, 2013). The way in which this is undertaken for re-registration with the NMC will from April 2016 be via revalidation which has the ultimate aims are ensuring the maintenance of professionalism and patient safety (NMC, 2015a).

One specific way to improve practice is through reflection, as critical reflection of an event allows understanding of influencing factors and personal thoughts and feelings (Timmins and Duffy, 2011). However, effective reflection requires time and commitment both of which can act as barriers (Soutter-Green, 2013). Nonetheless there are many benefits to completing reflection; it may identify considerations not previously explored; increase self-awareness; reduce stress; and directly address practice issues (Price and Harrington, 2010). Schon identified ideas of reflection in action (whilst in practice) and on action (retrospectively analysing practice). Both have relevance with the former being useful by identifying issues as they occur, giving a sense of what feels right or wrong so that this can be addressed later (Hibberd et al, 2014). Alternatively, the latter whilst potentially being slightly diminished by having to recall feelings, allows for calm exploration of an issue so that deep understanding can be gained (Sharples, 2009). When reflecting, it can be important to incorporate reflective models, as they give reflection depth and purpose, allowing for methodical analysis of an event (Nuttal, 2013). However, reflection must be completed with caution as NQNs may be too critical of themselves, so reflection must be balanced regarding positive or negative attributes (Jasper, Rosser and Mooney, 2013). NQNs can also have a sense of 'lost innocence', if issues are found with no solutions, leading reduced confidence and a sense of failure (Bulman and Schutz, 2013). For NQNs, it is essential to know their own limitations, so it can be accepted that not every issue will have a solution available (Casey and Egan, 2014).

Also part of CPD is clinical supervision which is beneficial to NQNs as it offers support and aids to improve competence simultaneously (Fowler, 2013). Clinical supervision can have many focuses, such as being restorative by exploring concerns, providing some counselling and improving sense of value for NQNs (Wigens and Heathershaw, 2013); formative, to increase the skills and competence of the nurse and assist them to self-assess and reflect on their capabilities (Lynch et al, 2009), or normative, to improve standards and ensure that requirements of their practice are met (Wigens and Heathershaw, 2013). As with reflection, clinical supervision is improved with reflective models, as they give purpose to the supervision much in the way a contract can, by preventing the supervision from becoming a 'get-together' (Soutter-Green, 2013). The supervisor can empower the NQNs and aid them to understand their accomplishments as well as the areas they need to improve (Bond and Holland, 2011). However, NQNs may find clinical supervision difficult as it requires them to be open to challenging and requires time commitments and preparation, especially if they have little knowledge as to the benefits of clinical supervision or the use of clinical supervision in CPD (Hollywood, 2011). However, the benefits of clinical supervision have been established by the

NMC, who state that every nurse should have access to clinical supervision (Chilves and Ramsay, 2009), and so it is vital NQNs are shown the benefits, such as reduced stress/anxiety, improved morale and decreased turnover which improving many aspects of healthcare (Cassedy, 2010).

NOW WHAT

As I am now more aware of the wide-ranging support available and my future responsibilities, I will ease my transition to NQNs by seeking and undertaking a range of opportunities that will assist me to develop safe and effective practice. These will include:

- Seeking support such as preceptorship or supernumerary status to reduce stress of transition and ensure consolidated and enhanced competency (Hole, 2009).
- Continuing to remain competent by conducting ongoing learning that is evidence-based to ensure I provide best practice care (Sharples, 2009).
- Reflecting upon the learning I conduct, to show how it is relevant to the care I provide, as is necessary with CPD (Alsop, 2013).
- Familiarising myself with legislation relevant to nursing to ensure I work within the boundaries expected of a qualified nurse (RCN, 2014).
- Establishing a regular supervisor to support and aid in my professional development, with a contract to ensure I get the most out of clinical supervision opportunities (Soutter-Green, 2013).

Summary

This comprehensive reflection utilises a reflective model to support the exploration of key issues occurring for one student during the transition to NQN and demonstrates the key role a reflective model can play in supporting deep reflection and subsequent learning for novice reflectors (Bowers 2015). The discussion of these issues illustrates both the complexity and tensions that can be experienced by students undergoing the transition from student to registered nurse. Grappling with the expectations of a newly qualified nurse can be challenging, and a reflection with the purpose of identifying potential solutions and actions can, as illustrated, help students explore their feelings around transition and to build understanding and confidence in relation to these, and the forthcoming expectations of employers, peers and patients. Subsequently, an action plan can be created to implement both original and 'tried and tested' solutions, allowing the NQN to be prepared in their approaches to the potential barriers they may face when commencing their first nursing role. This reflection is successful in these and clearly articulates the need for support such as preceptorship to guide this process.

References

Alsop A (2013) *Continuing Professional Development in Health and Social Care.* (2nd Ed. Oxford: Wiley-Blackwell.

Benner P, Hooper-Kyriakidis P and Stannard D (2011) *Clinical Wisdom and Interventions in Acute and Critical Care: A Thinking-In-Action Approach*. (2nd Ed). New York: Springer Publishing Company.

Bjerknes MS and Bjork IT (2012) *Entry into Nursing: An Ethnographic Study of Newly Qualified Nurses Taking on the Nursing Role in a Hospital Setting.* [Online] Available from: http://www.hindawi.com/journals/nrp/2012/690348/. [Date Accessed: 25/02/15].

Bond M and Holland S (2011) *Skills of Clinical Supervision for Nurses*. Glasgow: Open University Press.

Bowers S (2015) *Bowers Reflective Model*. The Journal of New Writing in Health and Social Care 1. (2) pp 31 - 37. [Online] Available from: http://www.staffs.ac.uk/academic_depts/health/research/journal_of_new_writing_in_health_and_social_care_issue_2.jsp. [Date Accessed: 25/10/15].

Bulman, C and Schutz, S (Eds) (2013) *Reflective Practice in Nursing*. (5th Ed) Oxford: Wiley-Blackwell.

Casey DC and Egan D (2010) The Use of Professional Portfolios and Profiles for Career Development. *British Journal of Community Nursing* vol.15, no.11 pp.547 – 542.

Cassidy, P (2010) *First Steps in Clinical Supervision.* Glasgow: Open University Press.

Chilves R and Ramsey S (2009) Implementing a Clinical Supervision Programme for Nurses in a Hospice Setting. *International Journal of Palliative Nursing* vol.15, no.12, pp.615 – 619.

Clark T and Holmes S (2007) Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies* vol.44, pp.1210 – 1220.

Covell CL and Ritchie JA (2009) Nurses Responses to Medication Errors: Suggestions for the Development of Organisational Strategies to Improve Reporting. *Journal of Nursing Care Quality* vol.24, no.4, pp.287 – 297.

Currie L and Watts C (2012) *Preceptorship and pre-registration nurse education*. [Online] Available from: http://www.williscommission.org.uk/__data/assets/pdf_file/0011/479936/Preceptorship_and_pre-registration_nurse_education.pdf [Date Accessed: 25/10/15].

Department of Health (2010) *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals*. [Online] Available from: https://www.goshgold.org/resources/forms/Preceptorship_framework_2010.pdf. [Date Accessed: 25/02/15].

Domrose C (2011) *Dismantling Nursing's Catch 22: The Potential Positives of Med-Error Reporting often are Overshadowed by the Repercussions to Nurses*. [Online] Available from: http://news.nurse.com/article/20110808/NATIONAL01/108080059#.VO7_aPmsWT8. [Date Accessed: 26/02/15].

Draper J (2013) *Student Nurse's Experiences of Becoming a Registered Nurse*. [Online] Available from: http://www.open.edu/openlearn/body-mind/health/nursing/student-nurses-experiences-becoming-registered-nurse. [Date Accessed: 25/02/15].

Draper J, Sparrow S and Gallagher D (2009) *Crossing the Threshold: Students' Experiences of the Transition from Student to Staff Nurse*. [Online] Available from: http://oro.open.ac.uk/26544/. [Date Accessed: 25/02/15].

Driscoll J and Teh B (2001) The Potential of Reflective Practice to Develop Individual Orthopaedic Nurse Practitioners and their Practice. *Journal of Orthopaedic Nursing* vol.5, no.1, pp.95 – 103.

Duffy M, Dresses S and Fulton JS (Eds) (2009) *Clinical Nurse Specialist Toolkit*. New York: Springer Publishing Company.

Fowler J (2013) Clinical Supervision: From Staff nurse to Nurse Consultant. Part 1: What is Clinical Supervision. *British Journal of Nursing* vol.22, no.13, p.786.

Francis R (2013): The Mid Staffordshire NHS Foundation Trust (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Final Report. [Online] Available from: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report [Date Accessed: 25/02/15].

Gerrish K (2000) Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing* vol.32, no.2, pp.473-480.

Green, S (2014) Competence and the Nurse New to General Practice. *Practice Nursing* vol.26, no.1, pp.42 – 45.

Green T, Dickerson C and Blas E (2010) Using Competencies and Competence Tolls in Workforce Development. *British Journal of Nursing* vol.19, no.20, pp.1293 – 1298.

Hall C and Ritchie D (2010) *What is Nursing?* Exeter: Learning Matters Ltd.

Handley R and Dodge N (2013) Can Simulated Practice Learning Improve Clinical Competence? *British Journal of Nursing v*ol.22, no.9, pp.529 – 535.

HCPC (2013) *Continuing Professional Development*. [Online] Available from: http://www.hpc-uk.org/registrants/cpd/. [Date Accessed: 26/02/15].

Health Education England (2014) *Growing Nursing Numbers: Literature Review on Nurses Leaving the NHS*. [Online] Accessed from: http://hee.nhs.uk/wp-content/uploads/sites/321/2014/05/Growing-nursing-numbers-Literature-Review-FINAL.pdf. [Date Accessed: 24/02/15].

Hibberd JM, Chia SH, Spindler A, Walsh M and Wigginton S (2014) Using Clinical Decision Making and Reflective Strategies to Support Practice. *Journal of Paramedic Practice* vol.6, no.5, pp.232 – 235.

Hole J (2009) *The Newly Qualified Nurse's Survival Guide*. (2nd Ed) Oxford: Radcliffe Publishing.

Hollywood E (2011) The Lived Experiences of Newly Qualified Children's Nurses. *British Journal of Nursing* vol.20, no.11, pp.665 – 671.

Jasper M, Rosser M and Mooney G (Eds) (2013) *Professional Development, Reflection and Decision Making in Nursing and Healthcare*. (2nd Ed) Oxford: Wiley-Blackwell.

Lowenstein LF (2013) *Bullying in Nursing and Ways of Dealing with it*. [Online] Available from: http://www.nursingtimes.net/home/specialisms/infection-control/bullying-in-nursing-and-ways-of-dealing-with-it/5056275.article. [Date Accessed: 25/02/15].

Lynch L, Hancox K, Happell B and Parker J (2009) *Clinical Supervision for Nurses*. Oxford: Wiley-Blackwell.

Magnusson C, Westwood S, Ball E, Curtis K, Evans K, Horton K, Johnson M and Allan HT (2014) *An Investigation into Newly Qualified Nurses' Ability to Re-contextualise Knowledge to Allow them to Delegate and Supervise Care*. [Online] Available from: http://www.surrey.ac.uk/fhms/research/centres/crnme/currentactivity/AaRK%20project/aark-summary-report.pdf. [Date Accessed: 25/02/15].

Maguire D (2013) Progressive Learning: Structured Induction for the Novice Nurse. *British Journal of Nursing* vol.22, no.11, pp.645 – 649.

Marks-Maran D, Ooms A, Tapping J, Muir J, Phillips S and Burke L (2013) A Preceptorship Programme for Newly Qualified Nurses: A Study of Preceptee's Perceptions. *Nurse Education Today* vol.33, no.11, pp.1428 – 1434.

Mathieson SA (2013) *Duty of Candour: A Fear of Whistle Blowing Still Pervades the NHS*. [Online] Available from: http://www.theguardian.com/healthcare-network/2013/dec/09/duty-candour-whistleblowing-pervades-nhs. [Date Accessed: 26/02/15].

Maxwell M Brigham L Logan J and Smith A (2011) Challenges Facing Newly Qualified Community Nurses: A Qualitative Study. *British Journal of Community Nursing* vol.16, no.9 pp.428 – 434.

Miller C and Blackman C (2009) *Learning During the First 3 Years of Post Registration / Post Graduate Employment*. [Online] Available from: http://www.leeds.ac.uk/educol/documents/178413.pdf. [Date Accessed: 25/02/15].

Morrell N and Ridgway V (2014) Are we Preparing Student Nurses for Final Practice Placement? *British Journal of Nursing* vol.23, no.10 pp.518 – 523.

Muha (2014) *Medical Errors: Why Don't Nurses Speak Up?* [Online] Available from: http://www.nursetogether.com/medical-errors-why-people-who-see-somethin. [Date Accessed: 26/02/15].

Mullen C (2014) Accountability and Delegation Explained. *British Journal of Healthcare Assistants* vol.8, no.9, pp.450 – 453.

NMC (2010) *CPD and Practice*. [Online] Available from: http://www.nmc-uk.org/Employers-and-managers/Your-responsibilities/CPD-and-practice/. [Date Accessed: 26/02/15].

NMC (2015a) *What is revalidation?* [Online] Available from: http://www.nmc.org.uk/standards/revalidation/what-is-revalidation/ [Date Accessed: 19/10/15].

NMC (2015b) *Competencies.* [Online] Available from: http://standards.nmc-uk.org/PreRegNursing/statutory/competencies/Pages/Competencies.aspx. [Date Accessed: 26/02/15].

NMC (2015c) *The Code for nurses and midwives.* [Online] Available from: https://www.nmc.org.uk/standards/code/ [Date Accessed: 26/02/15].

Nuttal D (2013) Self Assessing Competence in Non-Medical Prescribing. *Nurse Prescribing* vol.11, no.10, pp.510 – 514.

Peate I (2012) *The Student's Guide to Becoming a Nurse*. (2nd Ed) Oxford: Wiley-Blackwell.

Peate I (Ed) (2010) *Nursing Care and the Activities of Living*. (2nd Ed) Oxford: Wiley-Blackwell.

Plant N, Pitt R and Troke B (2010) A Partnership Approach to Learning about Accountability. *British Journal of Nursing* vol.19, no.11, pp.718 – 719.

Price, B and Harrington, A (2010) *Critical thinking and Writing for Nursing Students*. Cornwall: Learning Matters Ltd.

Puliod-Martos M, Augusto-Landa JM and Lopez-Zafra E (2012) Sources of Stress in Nursing Students: A Systematic Review of Quantitative Studies. *International Nursing Review* vol.59 no.1 pp.15 – 25.

RCN (2005) *Dealing with Bullying and Harassment*. [Online] Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0011/78518/001497.pdf. [Date Accessed: 25/02/15].

RCN (2011a) *Accountability and Delegation: What You Need to Know*. [Online] Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0003/381720/003942.pdf. [Date Accessed: 25/02/15].

RCN (2011b) *Nurses Still Afraid to Blow the Whistle*. [Online] Available from: http://www.rcn.org.uk/newsevents/press_releases/uk/nurses_still_afraid_to_blow_the_whistle_-_rcn. [Date Accessed: 26/02/15].

RCN (2014) *Professional Attitudes and Behaviour: Report on Newly Qualified Nurses Focus Groups*. [Online] Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0010/553159/professional-attitudes-behaviours-newly-qualified-nurses-focus-group-report.pdf. [Date Accessed: 25/02/15].

Ripley K and Hoad B (2011) Support for Newly Qualified APs. *British Journal of Healthcare Assistants* vol.5, no.10, p.512.

Royal Marsden Trust (2015) *Whistle Blowing Policy: Raising Clinical and Other Concerns*. [Online] Available from: http://www.royalmarsden.nhs.uk/SiteCollectionDocuments/foi/whistleblowing-policy.pdf. [Date Accessed: 26/02/15].

Scrivener R and Hooper R (2011) *Accountability and Responsibility: Principle of Nursing Practice B*. [Online] Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0005/377357/Nursing_Standard_Principle_B_March11_554KB.pdf. [Date Accessed: 25/02/15].

Sharples K (2009) *Learning to Learn in Practice*. Cornwall: Learning Matters Ltd.

Soutter-Green J (2013) Keeping it Simple: Guidance on Reflection and Clinical Supervision for Aesthetic Nurses. *Journal of Aesthetic Nursing* vol.2, no.3 pp.146 – 148.

Stacey G (2010) *The Shock of Reality: Utilising Reflective Practice Learning to Facilitative Professional Socialisation in Pre-Registration Nursing Programmes*. [Online] Accessed from: www.nottingham.ac.uk/elan/gemmastacey.pps. [Date Accessed: 24/02/15].

Tapping J, Muir J and Marks-Maran D (2013) How First Experiences Influence Newly Qualified Nurses. *British Journal of Nursing* vol.22, no.2 pp.102 – 109.

Tavengwa R (2011) The First 6 Months as an Opthalmic Nurse: The Nurse's Perspective*. International Journal of Opthalmic Practice* vol.2, no.6, pp.282 – 284.

Timmins F and Duffy A (2011) *Writing your Nursing Portfolio*. Glasgow: Open University Press.

Twibell R (2012) *Tripping Over the Welcome Mat: Why New Nurses don't Stay and what the Evidence Says We can do About it.* [Online] Available from: http://www.americannursetoday.com/tripping-over-the-welcome-mat-why-new-nurses-dont-stay-and-what-the-evidence-says-we-can-do-about-it/. [Date Accessed: 26/02/15].

Whistleblowing Helpline (2015) *About Whistle Blowing*. [Online] Available from: http://wbhelpline.org.uk/about-us/what-is-whistleblowing/. [Date Accessed: 26/02/15].

Whitehead J (2001) Newly Qualified Staff Nurse's Perceptions of the Role Transition. *British Journal of Nursing* vol.10, no.5, pp.332 – 339.

Whitehead B and Holmes D (2011) Are newly qualified nurses prepared for practice? *Nursing Times* vol.107, no.19/20, pp.20 – 23.

Wigens L and Heathershaw R (2013) *Mentorship and Clinical Supervision Skills in Healthcare*. (2nd Ed) China: Cengage Learning.

Woodward S (2012) Continuing Professional Development. *British Journal of Neuroscience Nursing* vol.8, no.1, pp.5.