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Becoming willing to role model. Reciprocity between new graduate nurses and experienced practice nurses in general practice in New Zealand: A constructivist grounded theory

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Summary Graduate nurses in general practice became a feature of New Zealand's health care system in 2008 following an expansion of the New Entrant to Practice Programme. General practice in New Zealand comprises general practitioner business owners who employ nursing and administration staff. Practice nurses are an ageing workforce in New Zealand, it is imperative therefore to attract younger nurses into general practice. This paper reports a section of the findings from a constructivist grounded theory study which examines the use of information by practice nurses in New Zealand. Initially data were collected using the ethnographic technique of observation and field notations in one general practice. Theoretical sensitivity to the value of role models was heightened by this first phase of data collection. A total of eleven practice nurses were interviewed from six general practices. One practice nurse agreed to a second interview; five of the interviewees were new graduate nurses and the other six were experienced practice nurses. The grounded theory constructed from this research was *reciprocal role modelling* which comprises the following three categories, *becoming willing*, *realising potential* and *becoming a better practitioner*. Graduate nurses and experienced practice nurses enter into a relationship of *reciprocal role modelling*. *Becoming willing*, the first core category of this grounded theory features three sub-categories: *building respectful relationships*, *proving yourself* and *discerning decision making* which are reported in this paper. Findings from this

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study may address the reported phenomenon of 'transition shock' of newly graduated nurses in the work place.
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Introduction

A ministerial taskforce in 1998 recommended that one of the business units of the Ministry of Health, the Clinical Training Agency (CTA), should develop a framework to help the transition of newly graduated nurses into the work environment. In 2006 following the perceived success of a pilot project completed in 2004, the CTA rolled out the New Entrant to Practice Programme (NETP) to all 21 of New Zealand's District Health Boards (DHB). NETP's mission was to provide a safe environment for the graduate nurse in their first year following graduation from university and registration with the New Zealand Nursing Council with the aim of improving retention of nurses in the workforce (Haggerty, McEldowney, Wilson, & Holloway, 2009). An important feature of the programme was the provision of clinical preceptor support throughout the 10—12 months clinical placement of the NETP program (DHBNZ, 2005). It was anticipated that the preceptor would experience increased job satisfaction in their role of developing new staff.

In 2008 the NETP expansion programme was introduced into a number of DHBs with the intention of encouraging newly graduated nurses to experience working in primary health care without having to first gain experience in a secondary care environment (Counties Manukau District Health Board, 2010). Graduate nurses could choose to work in Non-Governmental Organisations (NGOs), Residential Care Facilities (RCFs) and Primary Health Organisations (general practices). At the inception of the New Entrant to Practice Programme, the District Health Boards contributed to the salary of graduate nurses in general practice provided an experienced practice nurse preceptor was available to them.

General practice

General practice in New Zealand consists of small businesses who charge a fee for service provision. Since 2003 most general practitioners have joined a Primary Health Organisation (PHO). The PHO directs money received from the DHB to the general practice depending on the enrolment profile of the population Patients attending a general practice are encouraged to enrol with the PHO the general practice is a member of. The practice then receives a monthly payment for each enrolled patient and can then reduce the patient co-payment (Ministry of Health, 2012). Patients of Māori and Pacific Island ethnicity attract more funding as their health statistics compare unfavourably with the New Zealand European population (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). Improving access to primary health care and reducing inequalities in health between ethnic groups is the intention of the Primary Health Care Strategy (King, 2001). The PHO enacts this strategy as monthly funding for enrolment should significantly subsidise the cost of a visit by the patient to the general practice and so reduce barriers to accessing primary health care services. General practitioners employ practice nurses and administration staff and it was in a number of these general practice environments that the following study took place.

Aim of the study

How practice nurses in New Zealand utilise evidence and what they consider useful information for their practice is not widely described in the literature and was the initial aim of the research. A constructivist grounded theory design was the method of choice preferred by the authors to investigate this phenomenon. As the study evolved, role models became a focussed code that eventually led to the constructed theory of *reciprocal role modelling* between a graduate nurse (GN) and experienced practice nurse (EPN).

Grounded theory

Grounded theory is a very popular methodology and methods package which has been described extensively in the literature (Annells, 1996; Birks & Mills, 2011; Bryant & Charmaz, 2007; Charmaz & Mitchell, 2001; Cutcliffe, 2000) since its discovery by Glaser and Strauss (1967). Philosophically grounded theory methods have been likened to being situated on a methodological spiral, extending from post positivism to constructivism (Mills, Bonner, & Francis, 2006). We chose to use Charmaz's (2006) constructivist grounded theory methods for this study. Charmaz's approach to obtaining data for a grounded theory is one that acknowledges the role of the researcher as integral to the research process throughout and a part of the process of constructing the resultant grounded theory. The researcher is not an objective instrument of data collection as posited by Glaser and Strauss' (1967) in their original text.

Method

The researcher and first author (KH) is a nurse practitioner in a general practice located in South Auckland New Zealand. Following approval by Monash University Standing Committee on Ethics in Research involving Humans, KH initially recruited members of this general practice to partake in the first phase of the study in September 2009. During this time ethnographic techniques including observations, conversations and the documentation of field notes were used to collect data with the aim of raising KH's theoretical sensitivity to the substantive area of enquiry.

Following this phase, advertisements were distributed to recruit other practice nurses to the study. Unstructured interviews were conducted with practice nurses who had volunteered in their workplace which gave KH the opportunity to also observe the participant's work environment. A total of 12 interviews took place with one practice nurse interviewed twice following a change of work location. This

second phase of data collection commenced with an experienced practice nurse in an alternate general practice to KH's in November 2009. The final practice nurse interview took place in August 2011. Of the participants, five were new graduate nurses (GN) in their first year following registration and six were experienced practice nurses (EPN) who had been working in general practice for over three years. Throughout the two year data collection phase, KH continued to work in her own general practice, and as she became increasingly theoretically sensitive to developing categories through concurrent data collection and analysis, she was able to observe and validate her evolving theory by observing and clarifying incidents in her own general practice. This practice is consistent with Glaser and Strauss' original study reported in the book *Awareness of Dying*. Each of these authors describe how they continually checked the descriptive detail with their participants and then applied their insights and sociological knowledge to conceptualise and contrast different participants' experiences (Noerager Stern & Porr, 2011).

Theoretical sensitivity is a defining concept of grounded theory and has been described as an ability to recognise elements of the evolving theory in the data (Charmaz, 2006; Glaser, 1978). Following recognition of these elements, the researcher then theoretically samples to test them with other participants. There are three important components of developing theoretical sensitivity: insight into the researcher's history and experiences, the various techniques the researcher employs to enhance the acquisition of theoretical sensitivity, and that the researcher's insight into their own level of theoretical sensitivity develops as the study progresses (Birks & Mills, 2011). The act of acquiring theoretical sensitivity during this study has been described elsewhere (Hoare, Mills, & Francis, in press), but includes storyline which was first described by Strauss and Corbin (1990) and later developed by Birks, Mills, Francis, and Chapman (2009) and Birks and Mills (2011) who maintain this grounded theory method is under-used in presenting constructions from grounded theories even though it is very effective.

Rigour and trustworthiness is evidenced in this research through dated memos, fieldnotes, documented meetings with the research team and a manuscript entitled *Dancing with Data* (Hoare et al., in press). This manuscript explicates in full the steps taken to construct the final grounded theory.

Findings

The grounded theory constructed in this study is *reciprocal role modelling* which is comprised of three categories; *becoming willing*, *realising potential* and *becoming a better practitioner.* The following storyline presents our interpretation of our findings. *Reciprocal role modelling* starts with both the GN and EPN *becoming willing* to engage in a relationship, this important category will be described in detail later and is the focus of this article. To ensure clarity of the whole theory a synopsis of the other two main categories is presented in this article (see Fig. 1). The evidence to support these categories is reported elsewhere. At the end of the *becoming willing* phase, the GN is able to recognise the EPN's specific strengths but also begins to realise that other team members have their strengths too. The GN then engages in a process of *discerning decision making* when sourcing information for practice and may access information from other team members to refute or support the information she has received from the EPN. If both the GN and the EPN have spent enough time together and have moderate levels of confidence in themselves and each other, the next phase *realising potential* begins. At this point the GN's growing confidence allows the sharing of information sourced electronically with the EPN, who by now also feels sufficiently confident in her relationship with the GN, to be open to new ideas.

The GN, is an unconscious expert in information use and demonstrates to the EPN websites and computer programs — manipulating technology confidently and competently. Meanwhile the GN, whose very way of being incorporates the use of computers, websites, smart phones and technology has no idea that the EPN may be realising that they (the GN) have strengths that will enhance her practice. The GN is an unconscious expert in finding information and does not recognise this as a skill. To the GN being able to use technology is as natural as breathing. Deploying this unconscious expertise to the EPN realises her potential to the EPN and others in the team. There is a light bulb moment when the EPN realises that the GN's skills are well developed in information sourcing and can tap into sources of information they never knew existed. Conversely, the GN aspires to become as competent as the EPN in vaccinating, giving injections, taking cervical smears, dressing wounds and many other clinical skills the EPN demonstrates on a daily basis, so that they (GNs) can become 'proper' nurses.

The final phase of the grounded theory, *reciprocal role modelling*, is *becoming a better practitioner*. The GN has now been a major influence on the EPN to the point where she has started to think differently about accessing and using information. The EPN now routinely uses the computer to access information and to prepare presentations for information sharing, whilst thinking differently about how to access continuing professional development. The EPN no longer slavishly attends face to face education sessions that may have no relevant content for her and instead is starting to think 'outside the box' and theorise about different ways to sort and access information. The EPN is becoming a critical thinker.

Meanwhile the GN on realising that accessing information is a skill that they already possess start to think about how they can help other team members to apply evidence in clinical practice. The GN has learnt from their role model the EPN how to communicate effectively and still 'checks in' with the EPN about the best methods for disseminating information. The EPN and GN are now fully engaged in a relationship of *reciprocal role modelling*.

Each of the categories of *reciprocal role modelling* are dimensionalised by time and confidence. If the GN has not spent sufficient time with the EPN, the first category of *becoming willing* may not occur. An investment of time, will contribute to building levels of confidence which are particularly important in the second phase of *recognising potential*. If both the GN and EPN have high levels of confidence in each other, they will maximise both the deployment of and access to their expertise. Additionally, conditions

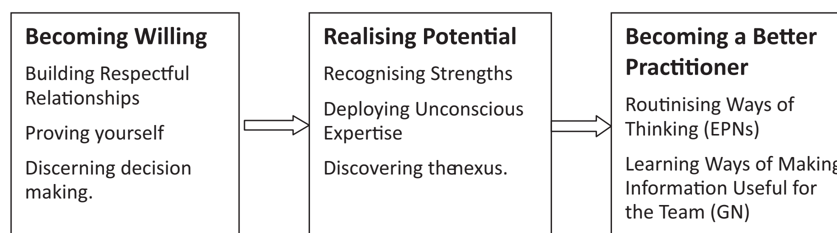

Figure 1 The categories and sub-categories of *reciprocal role modelling*.

of *reciprocal role modelling* are the employment of a GN nurse in general practice on an ongoing basis, and the establishment of a supportive inter-professional learning environment.

Becoming willing

The following findings explain how the category *becoming willing* was constructed from the data. *Becoming willing* has three sub-categories: *building respectful relationships*, *proving yourself* and *discerning decision making*.

Building respectful relationships

Becoming willing begins with both the GN and EPN being willing to build respectful relationships. As a first step, the EPN facilitates opportunities for the GN to work with different members of the team so that the GN can establish herself in a supportive general practice environment.

> EPN 2 'when they first come [to the practice] I actually tend to put them with each nurse for about 3 or 4 days because I think it's important to actually bond, have that bonding time with the [other EPN] nurses, to feel like they're integrated '

Additionally the EPN is empathic towards the GN's feelings and ensures that they 'check in' with the GN so that the GN does not become overwhelmed with their new responsibilities as a registered nurse.

> EPN 6 'our new grad at the moment she in some ways was a little bit more confident when she was a student than she is in the first few weeks and I said that's because of an over whelming sense of responsibility that's just been whacked on you because you've got a badge on your chest. So we've talked about that with her and encouraging her that she can do it.'

The EPN also coaches and encourages the GN to work with other members of the team so that they become confident at working with the doctors and other nurses and subsequently feel able to ask them questions. A supportive interprofessional learning environment is contingent on both doctors and nurses acknowledging the learning needs of the GN and offering teaching support:

> GN 4 'the ones (doctors) that I've worked with are really helpful. They also tell you if I'm stuck or if I've got any questions just ask.'

Working in a supportive interprofessional learning environment leads to the GNs being able to become discerning in their decision-making about who to seek information from. They form respectful relationships with other members of the team whose expectations of them as a GN are appropriate. The GN is nurtured. In turn the GN responds to this supportive interprofessional learning environment by being enthusiastic:

> GN 3 'we get along with the doctors really well and even the doctors will come to us and ask us things as well and its yes it's really really good it doesn't feel like in the hospital where there's a big hierarchy kinda thing whereas in primary health care you're much more on an even level with the doctors . . . I'm just loving primary health care.'

This enthusiasm leads to a positive atmosphere, the GNs are nice to be around because they are vibrant, willing to help and have a thirst to learn. At the same time, GNs acknowledge the vast clinical practice experience of the EPNs and are in awe of their skills.

> GN 3 'I ask them (EPNs) probably about 6 questions a day . . . they generally have a huge knowledge base because they've been working in primary health care for so long that they know all the different places to go, all the places to refer people to or just knowledge in general really and everything.'

The GN craves the opportunity to practice clinical skills, which the EPN recognises. The unbridled enthusiasm of the GN, daily acknowledgement of the EPN's skill and their willingness to be helpful reinvigorates the EPN. They smile inwardly at the GN's ardent interest in and eagerness to learn clinical skills. The EPN feels confident in their ability as a clinical nurse, having received such positive feedback from the GN. The EPN will watch the GN at lunchtime texting, and observe their adeptness using the computer, there will be a realisation by the EPN that the GN has both a strong theoretical knowledge base and the ability to access information easily:

> EPN 5 'they haven't done a lot of clinical practical stuff and they're craving that sort of stuff but in terms of their knowledge, their intellectual knowledge, they're bright, far better than I ever remembered being.'

Because of the respectful nature of their relationship, if an occasion arises where the GN knows about the most recent research evidence regarding a particular condition, they are tactful in the way they impart their knowledge to the EPN:

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GN 3 'I mean they do use [evidence for practice] especially for immunisations ... they use all their evidence based stuff and so we use all of that ... [as well, but] it was quite interesting, cause one of my goals ... was something about using evidence based practice and one of the nurses was sort of like, ohhh I don't know what evidence based practice is ... because it's a completely different way that they've been taught compared to me and I'm like well you're using it every day and she's like no I'm not and I'm like yeah no you definitely are because otherwise it wouldn't be up to date and it wouldn't be yeah the best practice either I spose so, it's quite interesting what sort of people perceive evidence base practice to be.'

The above illustrates the tactfulness of the GN in reassuring the EPN about her use of evidence-based practice. Because of their respectful relationship, the EPN felt comfortable to admit to the GN that she had no knowledge of evidence-based practice. The GN recognised that the EPN did use an evidence-base relating to immunisations, because the EPN followed guidance from the immunisation advisory centre's update newsletter. The GN was able to translate what evidence-based practice meant to the EPN using an example that the EPN would be familiar with. There was no evidence of power over the GN by the EPN in the above example, rather what is apparent is the respect that the GN pays to the EPN when they could have been scathing about their unfamiliarity with evidence-base practice.

Proving yourself

The second sub-category of *becoming willing* to engage in *reciprocal role modelling* is *proving yourself*. The EPN proves herself to the GN by exhibiting a vast array of nursing skills, which encompass the areas of clinical, communication and knowledge about the general practice environment. If there has been insufficient time for the GN and EPN to *build a respectful relationship* in which they have established a moderate to high level of confidence in both themselves and each other, the subsequent sub-category of *proving yourself* will not unfold. The following is an example of a GN who only works in a general practice on a casual basis and so had not had time to establish a respectful relationship with the EPN:

KH 'have you ever had any incidences where you felt you knew more about something than the practice nurse that you were working with?'

GN 2 'I don't mean to sound cocky but yeah there was especially around sexually transmitted diseases and erm the practice nurse kind of didn't ask the patient any questions about it he just said look I think I've got this and then she was like right well we'll put you in to see the doctor where in actual fact we could have done some of the assessment and screening around that and you know done tests and all the doctor would have had to do was confirm that that was what was so yeah, but I didn't feel comfortable to say.'

KH 'so you've not had any experiences where you've been able to say 'why don't we just do this?'

GN 2 'Noooo' (emphasising the no)

KH 'Is that because you've not formed a relationship with them because you're just dipping in and out?'

GN 2 'yeah yeah so there's not yeah I think that because I'm restricted in the fact that I'm there on a casual basis whereas I can't kind of put my two cents worth in.'

In the absence of an established respectful relationship, the GN and EPN are unable to prove themselves to each other. The above example illustrates that the GN knew how to screen the patient for their sexual health but felt unable to share their knowledge with the EPN. This represents a lost opportunity for the GN to prove herself to the EPN because the first sub-category of *becoming willing, building a respectful relationship*, had not been realised. The category of *becoming willing* is therefore dimensionalised by properties of time and confidence in both the EPN and GN.

The GN may prove themself to the EPN by demonstrating that they are adept at sourcing information from the Internet or by being a link to the university. The GN is helpful to the EPN. They are willing to do tasks, which in the eyes of the GN are exciting and 'real nursing' that are mundane and routine to the EPN. The GN may start to perceive that they could be useful to the EPN but are still very cognisant of the EPN's clinical nursing experience:

KH 'do you think you have any influence on the other practice nurses here in terms of your information and what you've learnt in terms of going to university?'

GN 5 'Erm I think so yeah because I have that link with kind of academic stuff because I've come through university in the last few years and I can still access the university data bases and stuff and I can be a link. But I also know I rely on them a lot for information from their experience.'

The following memo illustrates KH's developing theoretical sensitivity to the GN's ability and usefulness in accessing information in her own general practice:

The new grad is here now working at the practice and I know she's going to be so good at finding information to support running nurse-led clinics for eczema and asthma. Also T (doctor) has asked her to find out all the evidence around treatment for glue ear. She has volunteered to go and spend some time with the ear nurse specialist and then write up best practice guidelines for the clinic. It's refreshing having a new grad working with me again.

Memos are notes made throughout the research process which help the researcher to analyse their thoughts about the data and are an integral part of grounded theory methods. As illustrated in the previous fragment, memos provide an audit trail of how the researcher thinks about the data at different stages of the research process (Birks & Mills, 2011; Charmaz, 2006; Glaser, 1978). Having a positive young member of the team affirming the EPN, may infuse renewed enthusiasm for their role as an experienced nurse. The GN is starting to prove themself to the EPN as being reliable, helpful and fun, as well as being a potential source of information for practice.

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Discerning decision-making

The final stage of *becoming willing* is *discerning decision-making*. The GN has established early collegial relationships with both the EPN and other members of the general practice team, including other practice nurses, nurse practitioners and general practitioners. The GN will now start to 'pick and choose' who they go to for advice and information. The EPN too discerns that some of their tasks can be delegated safely to the GN. The contribution of other team members in the general practice, to supporting the GN is important for *discerning decision-making* to occur. Team members other than the EPN have to be open to the GN and sufficiently knowledgeable to provide help and advice to the GN. The following data fragment demonstrates how a GN could source information related to caring for a patient during a consultation:

> GN 1 'I might Google it (the condition) (or) do a quick review on the Internet or go and ask one of the other nurses, or if I think it's something that a doctor needs to look at then I'll go and ask one of the doctors to come in and have a look and just get their opinion, and if I sort of don't get something I agree with, I might ask someone else.'

The above account exhibits sophisticated critical thinking and reasoned decision-making by the GN, who feels confident enough to pursue many avenues of sourcing information to make the best choice of treatment and care for their patient.

Each of the sub-categories: *building respectful relationships*, *proving yourself*, and *discerning decision-making* are the building blocks which form the first category of *becoming willing* to engage in the grounded theory of *reciprocal role modelling*. The EPN is an assumed role model for the GN, however, unexpectedly, the GN under the condition of a safe interprofessional learning environment, within a respectful relationship, begins to exhibit characteristics of role modelling information use to the EPN. Consider the following quote from a GN who had formed a respectful relationship with her EPN mentor:

> GN 1 'like if you tell her I read this article, or I read this piece of research she has no objection to you doing study and integrating that into her practice.'

This idea of the GN as a role model to the EPN is novel and worthy of further investigation. It has implications for both the perceived theory—practice gap, retention of graduate nurses in the workplace, and getting evidence into practice through knowledge transfer.

Discussion

Our findings suggest that GNs can unexpectedly become role models for EPNs by demonstrating their ability to source information. This finding has implications for the perceived theory—practice gap, first described by Kramer in the 1970s as an educational and workplace dissonance, where new graduate nurses are unable to practice what they've been taught (Kramer, 1974). Building on this theory Boychuk Duchscher (2009) describes transition shock, a phenomenon occurring as nurses move from the known role of a student into the unknown territory of the professional practising nurse. New graduates pre-conceived perceptions of their professional role bears no resemblance to their actual role and the resulting mismatch creates mental chaos and confusion. An inability to transition through this stage results in them leaving the workforce (Beecroft, Dorey, & Wenten, 2008; Boychuk Duchscher & Cowin, 2004). Our study suggests that given the right supportive learning environment in general practice, *reciprocal role modelling* ensues thus minimising this transition shock. The phenomenon of *reciprocal role modelling* allows the GN to demonstrate her expertise in information finding, at the same time as learning how to apply theory to practice from the experienced and clinically skilled practice nurse. Social learning theory highlights the value of positive role models and the importance of seeing good practice in action (Bandura, 1977). Our study illustrates that good practice in action is reciprocated between GNs and EPNs if both parties are willing to enter into a respectful relationship.

Additionally for the EPN, the GN provides an avenue of continuing professional development by introducing them to new sources of information. The International Council of Nurses (ICN) supports lifelong learning and encourages nurses to identify their own learning needs through reflecting on their practice (2006). GN's prompt the EPNs to think about their practice and continuing competence. For a nurse to be deemed competent in the Australian Nursing and Midwifery Council's 'critical thinking and analysis' domain (Australian Nursing and Midwifery Council, 2005), and domain two of the Nursing Council of New Zealand's competencies for registered nurses (Nursing Council of New Zealand, 2007), the nurse must use evidence-based practice (James & Francis, 2011; Nursing Council of New Zealand, 2007). A study in New Zealand in 2007 illustrated that the majority of practice nurses who responded to a questionnaire did not know the two premier sites for evidence-based guidelines available to them (Hoare, Steele, Ram, & Arroll, 2008). Similarly an Australian study of rural practice nurses found that very few had the necessary skills to find and appraise research findings (Mills, Field, & Cant, 2011). These findings have implications for the improvement in health outcomes of the Australasian population.

Conclusion

The GN as a novice clinician learns the art of nursing from the EPN. The GN's learning is enhanced when the relationship has had time to develop. As the relationship strengthens, the GN's skills are recognised and valued by the EPN who feels comfortable accepting the GN as both preceptee and preceptor. The relationship matures to one of mutual respect. Within this supportive environment reciprocal knowledge transfer begins with the EPN role modelling clinical and communication skills and the GN adeptly sourcing and sharing Internet sites of current evidence-based information.

The nursing workforce force is ageing and baby boomers who provide the largest proportion of this workforce will soon be retiring. Retaining new graduate nurses in practice through providing supportive work environments that allow them to demonstrate their knowledge and skills

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at information finding will potentially ease them through transition shock. Subsequently they will continue in their professional role, remain in the workplace and so contribute to addressing the global nursing workforce shortage.

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