

WORK-ROLE TRANSITION: FROM STAFF NURSE TO CLINICAL NURSE EDUCATOR

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Abstract

This article presents the findings of a study describing Clinical Nurse Educators' experiences, as they recall their transition from staff nurse¹ to the Clinical Nurse Educator role, within a New Zealand District Health Board. Nurse Educator roles influence clinical practice and professional development of nurses, and although designated as a senior role nationally, the complexities and size of the role are poorly understood. A qualitative descriptive methodology utilising transition theory as a conceptual framework underpinned the study. A sample of eight Clinical Nurse Educators from a New Zealand District Health Board were interviewed about their transition from experienced staff nurse to inexperienced senior nurse. Data were analysed using a general inductive approach. Participants found the Clinical Nurse Educator role was more complex than anticipated, with no preparation for the role and sub-optimal orientation periods being provided by the District Health Board. As a result, signs of stress were evident as the enormity of the role became apparent. Consequently, employers need to ensure that appropriate orientation programmes and mentorship are inherent in health care organisations.

Key Words: Transition, leadership, clinical nurse educator, mentorship.

Introduction

The Health Practitioners Competence Assurance Act (HPCAA, 2003) requires registered nurses in New Zealand to provide evidence of competence within a scope of practice as detailed by the Nursing Council of New Zealand (NCNZ). In a competitive recruitment market access to in-house education is

a potential recruitment and retention strategy as nurses seek access to free education in order to meet continuing competence requirements for their annual practising certificates. Many District Health Boards (DHBs) have responded to this by establishing Clinical Nurse Educator (CNE) roles embedded across the various specialty areas, to provide registered nursing staff with ongoing practice education. This article presents a description of

¹Throughout the article the authors will refer to registered nurses employed in non designated positions as staff nurses. Registered nurses in designated positions will be referred to as senior nurses, or a title specific to their role such as clinical nurse specialist.

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CNE experiences as they recall their transition from staff nurse to the CNE role within a New Zealand DHB.

Literature review

There is an imperative for health professionals to participate in continuing professional development throughout their working life, as health is one of the most rapidly changing of all work environments (Siehoff, 2003). A number of authors advocate the need for continued practice development, linking it to improved patient outcomes, as well as to the ongoing job satisfaction of registered nurses (Considine & Hood, 2000; Haines & Coad, 2001). One way of meeting this need is to provide clinically based practice education programmes for post registration nurses. The appointment of a CNE to provide education in the clinical setting is a pragmatic and cost-effective way of dealing with the realities of patient safety, continued professional development and maintenance of competence (Manning & Peach, 2002). The pool of nurses able to fill CNE positions usually come from experienced registered nurses working in clinical areas.

Bridges (2003, 2004), described transition as a normal part of life and integral to any change process. Schumacher and Meleis (1994) identified that the transition from nurse to nurse educator takes time and mentorship. This study found evidence of a high level of role confusion and stress in the early stages of the new role and suggested that stressors could be alleviated through the implementation of a

formal transitional process. The tasks of transition often include learning the vernacular, networking, building role identity, developing key relationships and locating oneself (socialising) within the organisation (Louis, 1982).

Hsiung and Hsieh (2003) suggest that a short formal organisational orientation is generally not enough to get the newcomer through their first year in a new job. Time must also be allocated for experiential learning and socialising as people adjust to their new role. A well organised orientation programme has the potential to reduce staff turnover and a sound preparation for new roles has been shown to positively impact on the transition process (Ragsdale & Mueller, 2005).

In their article, Bass, Rabbett and Siskind (1993) described the transition from staff nurse to clinical nurse specialist (CNS). The CNS role is not dissimilar to the CNE role in that people appointed to either of these positions can feel isolated. In addition, both roles are often involved in the provision of clinical practice education and are designated as senior nursing positions. Findings from this study identified that participants demonstrated their ability to undertake the tasks associated with the CNS role by being present at work for long hours and being seen as hard working. In a study on nurse specialist roles, Bamford and Gibson (2000) noted that in the United Kingdom there is a history of ad hoc development of senior nursing positions, many of which lack clear job descriptions, titles or direction. There is a dearth of published literature on the transition

from experienced registered nurse to CNE both internationally and within New Zealand.

Research design

Aims

The aim of the study was to describe nurses' experiences as they transition from staff nurse to the role of CNE.

Research Methodology

Qualitative description formed the methodological foundations for this study. Descriptive research is non-experimental and utilised in both qualitative and quantitative studies to observe, portray, and describe characteristics of phenomena or groups (Polit & Tatano Beck, 2008). Tarzian and Cohen (2006) identify that qualitative descriptive research allows researchers to explore areas of interest where there is little theoretical or factual knowledge available. Sandelowski (2000) takes this notion further claiming that qualitative descriptive studies have the capacity to be transformational as long as the event under investigation is presented in ways that are readily understood by recipients of the research.

Methods

Ethical issues

Ethical approval was sought and approved by Northern X Regional Ethics Committee. All participants were fully informed of the proposed research and participation was voluntary. Written consent was obtained after participants had the opportunity to read the information sheet and have any questions answered. The right not to take part, to withdraw from the study and to

have the tape switched off at any time was included in the consent process. Participant anonymity was ensured through the allocation of pseudonyms. Pseudonyms were also used to mask the identity of organisations.

Participants

A purposive sample of eight CNEs from a large DHB participated in the research. The selection criteria for this study were registered nurses working as a CNE, who were employed as a senior nurse for the first time and were within their first six months to two years as a CNE. They also needed to be employed a minimum of 0.8 FTE as a CNE within a designated clinical area. Inclusion criteria were set to ensure each participant was experiencing a full range of responsibilities in the role, not sharing responsibilities or only undertaking a portion of the role due to a part-time status.

Data collection

One semi-structured interview of approximately one hour duration was used to collect data. Interviews were tape recorded and transcribed by the researcher. Transcripts were not returned to the participants for accuracy checks. Angen (2000) believes that on reading returned transcripts, participants may have changed their minds, or feel uncomfortable about what they said during the interview, leading to confusion rather than confirmation. A semi-structured interview process (Drever, 2003), gave the participants the opportunity to voice how they felt about their experiences with minimal interference from the researcher.

Data Analysis

Thomas's (2006) general inductive approach was utilised to sort and organise the data collected. The underlying assumption of this approach "... is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the constraints imposed by structured methodologies" (Thomas, p.238). The process of analysis identifies patterns emerging from the data and the relationship between those patterns (Darlington & Scott, 2002). In the present research a process of cutting and pasting segments of the text occurred. These segments were then grouped into categories. This method served the purpose of organising and condensing the large amount of data generated from the interviews. Upper level and lower level categories were developed resulting in five main themes and nine sub-categories.

Theoretical Framework

Bridges' (2003, 2004) transition framework was utilised to present the findings of the study. It is an approach which acknowledges that in any change there is also a personal journey of transition, enabling a person to merge the old self with the new self and assist in coming to terms with a new situation. The framework is based on the application of three phases; endings, neutral zone and beginnings.

Endings

Bridges (2003) believed that all transitions begin with an ending or a letting go of old relationships and ways of being. Endings are linked

to a grieving process, a natural sequence of emotions such as anger, bargaining, anxiety, disorientation and depression.

Neutral Zone

The neutral zone is both a positive and negative time. Bridges (2003) depicted the whole broken into pieces, a time where anything can happen, people are unsure and feel vulnerable.

Beginnings

Bridges (2003) described beginnings as involving, "New understandings, new values, new attitudes and new identities" (p.58).

This framework is appropriate to utilise in the present study due to its clarity, simplicity and pragmatic approach, not only as it relates to the organisational socialisation process, but also to the personal journey inherent in each of the participant's interviews as they transitioned from staff nurse to CNE.

Findings

The aim of this study was to describe the perceptions and opinions of nurses as they transition from staff nurse to the role of CNE. Data and categories are presented using Bridges (2004) framework and supported using quotes from participants. Each quote has been selected to present a snapshot of the data contained in each category. A summary of the themes and categories are presented in Table 1. The following three sections are titled, endings, neutral zone and beginnings.

Table 1.

Themes and Categories Presented Using Bridges (2003, 2004) Transition Framework Ophthalmology.

Endings

• **Entering transition**

- Thinking back; why the nurse chose to apply for the CNE role
- Went in blind; unaware of what the new role would entail

• **Getting started**

- Orientation/ disorientation; lack of orientation and employer understanding of the role
 - More than expected; the role holds extra unexpected responsibilities
-

Neutral Zone

• **Chaos and turmoil**

- Communicating in a new way; changing relationships, managing old friendships and developing a new network
- Finding support; finding people to mentor and support

• **Overwhelmed**

- Learning to negotiate, intra role conflict; managing differing agendas for the role
 - Stress levels; physical and emotional impact
-

Beginnings

• **Opening doors**

- Adjustment, reflections and new identities; embracing the possibilities created when the old identity merges with the new.
-

Endings

Entering transition

Thinking back

The participants all indicated a general interest in practice education prior to applying for the CNE position. For example, taking on practice education roles as a staff nurse through to enjoying precepting and orientating staff.

One of my favourite jobs was actually supervising and precepting students and new grads so I always really liked that and ... enjoyed making their time on the ward a happy time and being able to support them (Frances).

Went in blind

Even though participants had all experienced a practice education component in their staff nurse roles, they were unaware, on applying for the CNE role, what it actually entailed. Consequently, participants felt they 'went in blind':

I didn't have very many clear expectations of what the role would involve, I sort of thought I would go in there and shake things up, get some education on board and get things going a little bit (Bobbie).

Emily describes how she had worked quite closely with a CNE as a senior staff nurse but in reality had only seen a small part of the CNE role and

consequently had no concept of what the role entailed.

When the other CNE was here I had no idea what she did, ... apart from she did my IV test and would make sure you did an annual update day ... and if you wanted to do a course then you went to see her, but like I had no idea about the magnitude of her job (Emily).

Getting started

Orientation or disorientation?

None of the participants in the present study received an appropriate orientation to their new CNE role. One of the main issues was that not only were the new CNEs unsure of their roles but it appeared that the people who were charged with providing the orientation were less than interested. Participants felt that their frustrations with their orientation period could have been alleviated by having opportunities to spend time with their predecessors, however this was either not possible because the person had left or the time that was offered was not long enough.

My orientation was pretty much 'there's your office go for it'. I was given a preceptor who was a very nice person but not particularly accessible ... I feel I haven't had clarity of my role explained, yes its pretty much find out as you go along. Silly things like how to book venues, I hadn't a clue until I came to book a venue and it's like, who do I ask. I had to find that out from someone else ... (Bobbie).

I mean I was given an orientation booklet – I didn't actually think this was very good. I don't think we

adhered to the guidelines within the orientation booklet either ... I thought it was a complete waste of time because when we did meet I think we spent most of the time talking about her children [the preceptor] rather than anything relating to work (Lynair).

More than expected

Participants were surprised when appointed to the position of CNE that the role contained numerous extra responsibilities that they had not expected nor considered.

... When I was looking to do this role I had no idea. I thought it was just going to be an educator for the unit, teaching and educating the staff here, which is fine but there's this whole host of other things that you're meant to be involved with as well which I had no idea about (Emily).

Participants identified counselling or pastoral duties, as well as having to contend with intra-team conflicts as being commonplace extra responsibilities that were part of their new CNE roles.

People trust you enough to come in blurt their life story out in front of you, so I go ok I've got the nurse educator role and I'm a counsellor too (Zoë).

Yes it's bigger than I thought it would be for sure, a lot bigger yeah, but some of that's because there is no one else to do it. I mean problems with dynamics within teams and areas of conflict and bullying and stuff like that. I seem to have to deal with that because there's nobody else to do it (Lynair).

Neutral Zone

Chaos and turmoil

The neutral zone can affect self confidence and self esteem, and is a time all participants identified as being chaotic and at times overwhelming as they adapted to their new role as a CNE.

Communicating in a new way

Internal promotion enables organisational knowledge to be maintained however, it can make people feel uncomfortable initially. Zoë alludes to some of the tensions that exist when trying to maintain collegial relationships with people who once were her equal but to whom she now was senior.

It is also about your stepping into this senior role now and your buddies on the floor, it's really hard to maintain friendships, but be a leader as well ... you're kind of taking a step outside that clique (Zoë).

Right at the start having to think about writing letters to chivvy them up and get them [portfolios] handed in and everything and it was like 'oh god I've got to write a letter to her' and she was a really good friend and now here I am writing them a letter saying hand it in 'or else' type of thing, that made me feel really uncomfortable to start with (Emily).

Communicating with old friends in new ways and distancing oneself from daily conversations can be difficult. Consequently, there is a need to develop and form new relationships as Zoë eloquently explains ...

You find yourself in a quandary,

oh I still want to be buddies with my buddies on the floor because I really like them, but there's certain things I am going to be told that I can't let on that I know anything about to other people and that can be quite difficult and you're kind of caught in this ethical situation where you've got your buddies, that you were quite close with on the floor saying 'oh that damn nurse ra ra ra' kind of thing and you know what's going on over here, but you can't actually say anything (Zoë).

Finding support

It was hard for some participants to find themselves back in the position of novice. One way of coping with the chaos and turmoil associated with being a new CNE was to find a mentor and develop networks that provided the support needed. Frequently these were other more experienced CNEs who filled support and mentoring roles.

Other CNEs are very important in terms of support and learning ... they are great because they have been on the road for such a long time and I have heaps to learn from them and I just think 'my god they are so confident' and things like that ... so I think 'oh when am I going to be like that' and yesterday somebody told me 'oh it took me a good three years for me to be really you know, able to put my shoulders back and walk'. I thought 'oh my god that long'! (Lila).

The organisation where the data for this study were collected held meetings at which all CNEs could get together and participants felt these

were beneficial.

You still need to reach out to the bigger group for help, in my case often ... I've memorised the phone numbers if I need to ask for help they are usually little detail things not major things but it is so good that they [CNEs] are on the other end of the phone (Barb).

Overwhelmed

Having to learn a new set of skills, developing new relationships and adjusting to being in a senior nursing role, all of which took up significant amounts of time contributed to participants feeling overwhelmed.

Learning to negotiate, intra-role conflict

Intra-role conflict (Glen & Waddington, 1998) occurs when people within organisations have different agendas for what the role holder should do. This culminates in an increased workload for the incumbent, frequently with tasks that do not appear in the person's job description.

You get roped into doing things and that's not really what you're supposed to be doing (Frances).

As evidenced in the following excerpt, establishing role clarity can be challenging and difficult to negotiate especially when new to the job and 'wanting to please'.

... and then the charge nurse rings up and says 'can you cover for lunch breaks on the floor' and you're like 'yep no worries', then you hang up the phone and kind of resent it a wee bit, because you go, 'well so are you going to come in and do my work'? (Zoë).

Bobby attempted to address the issue of intra-role conflict by insisting on the development of a service level agreement outlining her expectations of the CNE role and those of the organisation. Though a good idea in principle, she had problems completing it, presumably as it was not a priority for, or in the interests of, the other parties.

One step I went to do was to do a service level agreement so we all got together and looked at what their expectations were, what my role entailed now and see how we can marry the two up and sort of make a collective agreement ... this is my role boundaries, but we've not actually finished that process yet. I've not, I need to say that people haven't been that enthusiastic about completing it, apart from me (Bobbie).

Stress levels

Working long hours was a common issue for the CNEs when they first started in the role. All participants exhibited commitment to the role and the organisation, wanting to achieve in their roles and establish their credibility.

I would stay here hours and hours and hours, oh gosh, just incredible ... and just thinking I should have done better and I should have finished this by this time and probably unrealistic expectations of myself (Barb).

The CNEs all exhibited commitment and wanted to demonstrate worth, which caused them to feel stressed, and at times like impostors, as they felt they didn't have the skills for the job.

I mean I'm pretty quick on picking up on things, I mean if someone tells me something then that's fine I'll run with it, but to constantly be finding out these things or that you've missed this you've missed that, it just makes you feel like you're really not doing a very good job, completely de-skills you (Emily).

Frances brought up an issue which called for a significant personal adjustment.

I was stressed ... the transition too from rostered shifts to Monday to Friday... I honestly went from insomnia to narcolepsy just about (Frances).

Though Frances made light of the issue, Chloe found that her physical health and wellbeing were affected by the transition to a CNE role.

I got really stressed out. I was working late, I lost weight so I guess you could say I didn't really cope that well initially for the first few months ... where I mean, were just quite, quite full on (Chloe).

Beginnings

Opening Doors

In this, the final section, participants had begun to relinquish their old identity as an experienced registered nurse and had begun to embrace their new role as a CNE. Considerable adjustments had been made, meaningful lessons learned and new identities developed.

Adjustments, reflections and new identities

The following excerpt identifies how Zoë has readjusted from initially

working long hours to now being in a position to achieve balance in her life.

You've got to have balance in your life and I think when I first started my balance was all work, no play and now I'm just trying to even it up ... I have come to accept that sometimes now you just need to leave work unfinished until the next day (Zoë).

Emily has made the transition from staff nurse to CNE and is able to recognise her new identity as a senior nurse. What initially was a shock is now comfortable and she recognises in her current role her input is valued.

You get a better understanding of the big picture because you are party to more of the management sort of things that go on. You know as a staff nurse you don't get invited to the management, the service management meetings here, so you don't know, well, I knew probably 25% of what was going on in this unit, but thought I knew everything when I was out there and I didn't at all. You know, you become the CNE, you get invited to the management meetings and meetings they have with other service managers and your input is valued. However, I spent the first year [in this role] with my mouth open, thinking 'God I never knew that was going on ...' (Emily).

In the following excerpt Chloe is able to see that some of the skills learned as a CNE are transferable to other senior nursing roles, for example developing an understanding of how organisations operate.

I think [I have learned] about the politics of roles, not just mine but everyone else's and how they interrelate ... What I have learned so far in this role would definitely put me in a good starting base, yes, good start in another senior role, because you see how other people manage things and you see how managers work and different styles and you learn whether you want to take that on board or whether that's something you don't actually want to do, so ... yes I think it's definitely, I guess going into any senior role would help prepare you for another senior role as opposed to from a staff nurse, it's a lot smaller step [going from senior role to another senior role] (Chloe).

Discussion

The transition from experienced registered nurse to the senior nursing position of CNE was challenging and difficult for the participants. The challenges and difficulties experienced by participants largely related to a lack of understanding and preparation for the change in role and status. This was further compounded by sub optimal orientation programmes or, in some instances, none at all being offered to this group of people. Participants tried to manage the transition to their new role by working harder and longer, however this only led to feeling stressed and heightened levels of anxiety.

Physical and emotional signs of stress were initially problematic for participants. This is supported by Mateo and Fahje (1998) who found that

working long hours, and taking work home on weekends, were not unusual patterns of behaviour in people new to CNE roles. Increased sick leave taken and a corresponding decrease in productivity were also found to be common occurrences during transitional periods, particularly in the neutral zone phase (Bridges, 2003). However as evidenced in the results section, participants in the current study did come to terms with being promoted to CNE and were able to function appropriately in their new role.

Laborde (2000) asserts that the appointment of someone to a senior role, such as CNE, is not the end in the transition process but the beginning. Findings from this study clearly highlighted that a formal period of orientation and support was not offered to participants by their employing organisation. Participants felt there was a lack of information provided to them about the CNE role both prior to and following the application process. Giving an applicant a job preview and discussing the job description prior to final selection are effective ways to clarify expectations and reduce stress (Hsiung & Hsieh, 2003).

To offset this lack of formal information and support, the participation in network groups proved useful, enabling the CNEs to meet with others in similar circumstances. During work-role transition, wider relationships should be formed to support the process, as well as communicating with a more experienced colleague, such as a mentor (Wells, Barnard, Mason, Ames & Minnen, 1998). Increased knowledge about transition (Bridges,

2004), accessing a mentor and having the opportunity to reflect, can all normalise the anxieties inherent in moving from expert back to novice (Huffstutler & Varnell, 2006).

Recommendations

The impact of lack of role clarity and an under preparedness for taking on a senior nursing role such as CNE have been highlighted in this study. The CNE role in particular requires considerable skills in clinical policy development, quality assurance activities, leadership, communication, counselling and education and has a vital role to play in managing clinical risk and ensuring clinical competence in nursing practice. Consequently, appropriate orientation programmes are not only vital but should be comprehensive and ongoing (Wanous & Reichers, 2000). Based on the work of Wanous and Reichers we recommend a split orientation approach be offered; initially beginning with generic organisational induction leading on to an individually tailored orientation programme. This is further supported by Hsiung and Hsieh (2003) who assert that developing role identity is integral to any orientation programme and needs to be an ongoing process.

The use of mentorship and networking among clinicians holding senior positions must be recognised as a legitimate mechanism for supporting role transition (Bolton & Roy, 2004; Corning, 2002). The participants in the present study sought and valued networking opportunities, and identified that mentoring occurred on an ad hoc basis. We recommend that the allocation of a mentor who could

appropriately support nurses new to the role of CNE is imperative. In addition, DHBs need to make certain their organisations are committed to ensuring the processes of mentorship and networking are inherent in induction programmes for nurses transitioning into CNE roles. This is supported by Cranwell-Ward, Bossons and Gover (2004) who assert that mentoring and networking are integral components of any leadership development programme.

Finally, leaders within organisations need to understand the phases of transition in order to appropriately support role transition, as well as the recruitment and retention of staff into senior positions. This would include supporting these people through the initial transitional period and ongoing socialisation into their new role. Employers need to be cognisant of the impact of work role transition on CNEs, as well as other employees, and can reduce potential/actual stressors by providing appropriate education and support to these people during this period of professional change.

The transference of findings from this study for use in other settings needs to be undertaken with caution. The study was carried out in one district health board and as indicated by the method, the sample of CNEs was small at only eight participants. In addition, the study was limited to the participants' view of their experiences with no ability to involve the people they professionally interacted with, who may have viewed their contribution differently. Ascertaining the opinions of people who worked with CNEs would offer a different lens with which

to examine the contribution of the role, clarify misconceptions of the role and also offer support to those currently working as CNEs.

Conclusion

In this qualitative descriptive study the experiences of staff nurses were presented as they moved into their first designated senior role as a CNE. The findings have shown that the phases of transition are a normal part of work-role changes, but preparation for

change, increased knowledge of roles, along with mentorship and support can significantly ease the process. To ensure a positive transition into CNE roles employers need to make sure that cultures of mentorship and the provision of appropriate orientation programmes are inherent in health care organisations. Ultimately leaders who have knowledge of transition theory and the commitment to applying it can improve the journey for staff nurses moving into the CNE roles.

References

- Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, 10(3), 378-395.
- Bamford, O., & Gibson, F. (2000). The clinical nurse specialist: Perceptions of practising CNS's of their role and development needs. *Journal of Clinical Nursing*, 9, 282-292.
- Barriball, K. L., & While, A. E. (1996). Participation in continuing professional education in nursing: Findings of an interview study. *Journal of Advanced Nursing*, 23, 999-1007.
- Bass, M., Rabbett, P. M., & Siskind, M. M. (1993). Novice CNS and role acquisition. *Clinical Nurse Specialist*, 7(3), 148-152.
- Bolton, J., & Roy, W. (2004). Succession planning: Securing the future. *Journal of Nursing Administration*, 34, 589-593.
- Bridges, W. (2003). *Managing transitions: Making the most of change*. Cambridge: De Capo.
- Bridges, W. (2004). *Transitions: Making sense of life's changes*. Cambridge: De Capo
- Considine, J., & Hood, K. (2000). A study of the effects of the appointment of a clinical nurse educator in one Victorian emergency department. *Accident and Emergency Nursing*, 8(2), 71-78.
- Corning, S. P. (2002). Profiling and developing nurse leaders. *Journal of Nursing Administration*, 32, 373-375.
- Cranwell-Ward, J., Bossons, P., & Gover, S. (2004). *Mentoring: A Henley review of best practice*. Basingstoke, UK: Palgrave Macmillan.
- Darlington, Y., & Scott, D. (2002). *Qualitative research in practice: Stories from the fields*. Buckingham: Open University Press.
- Drever, E. (2003). *Using semi-structured interviews in small scale research: A teacher's guide* (2nd ed.). Glasgow: The SCORE centre, University of Glasgow.

- Glen, S., & Waddington, K. (1998). Role transition from staff nurse to clinical nurse specialist: A case study. *Journal of Clinical Nursing*, 7, 283-290.
- Haines, S., & Coad, S. (2001). Supporting ward staff in acute care areas: Expanding the service. *Intensive and Critical Care Nursing*, 17(2), 105-109.
- Health Practitioner Competence Assurance Act. 2003. New Zealand Government: Wellington.
- Hsiung, T. L., & Hsieh, A. T. (2003). Newcomer socialization: The role of job standardisation. *Public Personnel Management*, 32, 579-589.
- Huffstutler, S. Y., & Varnell, G. (2006). The impostor phenomenon in new nurse practitioner graduates. *Topics in Advanced Nursing eJournal*. Retrieved August 2, 2006, from <http://www.medscape.com/viewarticles/533648>.
- Laborde, S. (2000). Skills needed for promotion in the nursing profession. *Journal of Nursing Administration*, 30, 432-439.
- Louis, M. R. (1982). Managing career transition: A missing link in career development. *Organisational Dynamics*, 10(4), 68-77.
- Manning, L., & Peach, J. (2002). Educating nurses now and for the future. *Kai Tiaki, Nursing New Zealand*, 8(5), 16-17.
- Mateo, M., & Fahje, C. J. (1998). The nurse educator role in the clinical setting. *Journal of Nursing Staff Development*, 14(4), 169-175.
- Polit, D., & Tatano Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Ragsdale, M. A., & Mueller, J. (2005). Plan, do, study, act model to improve an orientation programme. *Journal of Nursing Care Quality*, 20, 268-272.
- Sandelowski, M. (2000). Whatever happened to qualitative description. *Research in Nursing and Health*, 23, 334-340.
- Schumacher, K. L., & Meleis, A. I. (1994). Transitions: A central concept in nursing. *Image: Journal of Nursing Scholarship*, 26(2), 119-127.
- Siehoff, A. M. (2003). Staff educator RNs; delivering unit based education to bedside caregivers. *Journal for Nurses in Staff Development*, 19, 313-316.
- Tarzian, A., & Cohen, M. (2006). Descriptive research. In J. Fitzpatrick & M. Wallace (Eds.), *Encyclopaedia of Nursing Research* (2nd ed., pp.143-144). New York: Springer.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27, 237-246.
- Wanous, J. P., & Reichers, A. E. (2000). New employee orientation programmes. *Human Resource Management Review*, 10, 435-451.
- Wells, N., Barnard, T., Mason, L., Ames, A., & Minnen, T. (1998). Work transitions. *Journal of Nursing Administration*, 28, 50-56.

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