‘The Experience of Sultan Qaboos University Newly Graduated Nurses during their First Year of Practice in the Sultanate of Oman’

A case study

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Abstract

The University of Manchester

Abstract Thesis Submitted by Huda S Al Awaisi for the Degree of Doctor of Philosophy.

Thesis Title: The Experience of Sultan Qaboos University Newly Graduated Nurses during their First Year of Practice in the Sultanate of Oman. January 2012

Background: Studies have demonstrated that new graduate nurses’ (NGNs) transition experience is complex and often negative leading to dissatisfaction with nursing and increased attrition. Many existing studies of NGNs’ transition experience are small, qualitative, concerned with NGNs experiences in the West. No study has been conducted to date examining NGNs’ transition experience in any of the developing countries where the cultural context and nursing education and practice are different to those in the West.

Aim: To explore the experience of NGNs during their transition period in one of the developing countries, the Sultanate of Oman.

Method: Qualitative case study utilising an embedded-single case design was conducted to investigate the transition experience of baccalaureate NGNs graduating from Sultan Qaboos University (SQU) and working at Sultan Qaboos University Hospital (SQUH). Data were collected from the perspective of NGNs and also from the perspective of other key informants using triangulated methods. This includes individual and focus group interviews, observation and documentary analysis.

Results: Four over-arching themes are identified from NGNs’ transition experience in the Sultanate of Oman. These are “Studying Experience”; “Role Transition”; “Working Conditions” and “Status of the Nursing Profession”. This study showed that nursing is not an attractive choice for Omani students to study and pursue as a future career because of its low status. During the transition period, NGNs experienced reality shock which mainly resulted from a theory-practice gap. NGNs had limited practical experience but a high level of theoretical knowledge, which they were unable to utilise in practice. They found the working environment to involve many competing priorities resulting in task-orientation and compromised patient care. This study showed that many NGNs resented their involvement in basic nursing care, which they believed should not be part of their role as degree nurses. Despite the challenges of the transition period, many NGNs remarked that nurses play the most important role at the hospital and they are proud being nurses.

Conclusion: Omani NGNs’ transition experience is complex and similar in many respects to NGNs experience in the West. However, there are distinctive challenges Omani NGNs faced due to the Omani culture, working environment and the status of nursing in Oman.
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Abbreviations

**AFH:** Armed Forces Hospital.

**CI:** Clinical Instructors.

**HCAs:** Healthcare Assistants.

**HN:** Head Nurses.

**ICU:** Intensive Care Unit.

**M:** Managers.

**NGNs:** New Graduate Nurses.

**NMC:** Nursing and Midwifery Council.

**P:** Preceptors.

**PIS:** Participant Information Sheet.

**SNs:** Student Nurses.

**SQU:** Sultan Qaboos University.

**SQUH:** Sultan Qaboos University Hospital.

**MoH:** Ministry of Health.

**UK:** The United Kingdom

**UKCC:** United Kingdom Central Council for Nursing, Midwifery, and Health Visiting.

**WHO:** World Health Organisation.

**2\textsuperscript{nd} Interview:** The 2\textsuperscript{nd} set of interviews (follow up interviews).
Glossary

The Clinical Advanced Course: The final clinical course nursing students have to do at SQU College of Nursing.

Clinical Instructors: Academic clinical teachers responsible for supervising and teaching students during their clinical placements.

The Exit Exam: The final examination of SQU nursing curriculum where students have to sit for both theory and practice.

Expatriate Nurses: International nurses.

Key Informants: Key people who have been interviewed based on their experience working and interacting with SQU new graduate nurses and students.

International Examiners: International teachers who come from international nursing universities to asses SQU students during the exit exam.

Interns: New graduate nurses are called interns during their internship programme at SQUH.

Internship Programme: A support programme offered to new graduate nurses where they work under supervision.

Internship Abroad: A period of the internship programme which new graduate nurses spends overseas.

Medical Orderlies: Porters.

Omanisation: A strategy implemented by the Omani government to increase the number of indigenous/national (Omani) workers.

Preceptors: Clinical nurses responsible for supervising, training and teaching both, nursing students and interns in the clinical area.

Preceptees: nursing students or interns who are supervised by preceptors in the clinical area.
Chapter One - Introduction

Nurses form the largest group of healthcare professionals worldwide (Dall, et al, 2009). However, there is increased attrition of nurses, especially from new graduates, which creates a global shortage and an aging nursing population. This attrition is costly to governments and health organisations (Scott, et al, 2008; Bowles and Candela, 2005). For example, the estimated cost of nurses’ turnover in the USA is around $145,000 per registered nurse (Scott, et al, 2008). Beecroft et al (2001) estimated their organisation loss of one new graduate nurse (NGN) within his/her first year of employment to be around $49,000.

A large number of NGNs intend to leave nursing due to the challenges they face during their transition period (Halfer and Graf, 2006; Lai, et al, 2006; McCabe, et al, 2005; Godinez, et al, 1999). A definition of the concept of the “transition period” and its importance to NGNs’ career will be outlined.

1.1 The Transition Period

In the nursing literature, the concept of the “transition period” has been an area of research for decades. For the purpose of this study, the concept of the transition period is defined as:

“The time the new graduate nurse spends transforming from being a student to the new role of a staff nurse”

The transition period is considered important in the development of nurses’ knowledge and play a vital role in influencing NGNs’ professional and career development and job satisfaction (Salt, et al, 2008; Scott, et al, 2008; Cowin and Hengstberger-Sims, 2006; Goh and Watt, 2003). There are variations in the time individual NGNs might take to transform from being students to becoming staff nurses. Some NGNs require less time to adapt to the new environment and master the role of the registered staff nurse, while other NGNs take longer (Duchscher, 2008; Mooney, 2007; Schoessler and Waldo, 2006; McKenna and Green, 2004; Kelly, 1996).
Many researchers have tried to provide explanations and descriptions of the process of transition for NGNs. In the 1970s, the work of Kramer on exploring the transition period shone a light on the complexity of the transition experience for NGNs. In 1976, Schmalenberg and Kramer developed a model to explain the transition experience of NGNs. According to them, the transition period usually consists of four phases (Figure 1). The first phase is called the “Honeymoon”, which is the stress free phase. The second phase is “Reality shock” which mainly results when NGNs realise the differences between nursing education and real working conditions. This phase reflects the “Theory-practice gap” debate, which will be discussed later. The reality shock phase consists of four major characteristics. These as described by Schmalenberg and Kramer (1976) are “Moral outrage”, “Rejection”, “Fatigue” and “Perceptual distortion”. “Moral outrage” is about work environment values, which are different to what NGNs were taught during their study. The second characteristic is “Rejection” which is shown by the rejection of either the school or workplace values. This leads to the third characteristic, which is “Fatigue” where graduates feel tired and lose motivation to work. The last characteristic of the shock phase is “Perceptual distortion”. This means that NGNs develop negative attitudes towards nursing clinical practice and even towards other nurses. According to Schmalenberg and Kramer (1976), the shock phase is expressed by negative emotions such as “frustration”, “disillusionment” and “anger”. The reality shock phase encapsulates mainly the negative aspects of the NGNs’ experience which is not usually permanent. According to Schmalenberg and Kramer (1976), NGNs recover the reality shock and pass through the “Recovery” phase. Then, NGNs move to the last phase in the transformation process which is the “Resolution” phase where they are able to create a “nursing self-identity”.

Tradewell (1996) explained the transition experience of NGNs based on the socialisation process of the “Rites of Passage” which have been described by Arnold van Gennep in the early years of the twentieth century. According to Tradewell, NGNs need to pass through a process of socialisation to feel accepted as part of the nursing team. Tradewell described the process NGNs need to pass during their transition into three phases. These are “separation from being a student”, “transition to the new role” and a “process of integration into the new role and environment”. According to Tradewell, NGNs start the “Rites of Passage” when they enter the new working environment. At this stage, they start socialising into the organisation structure by wearing the staff nurse uniform and start shift duties. This makes them fit into the working environment and portray the staff nurse image (Tradewell, 1996).

There are also some recent theories and models to explain NGNs’ experience and development during the transition period (Duchscher, 2008; Schoessler and Waldo, 2006; Godinez, et al, 1999). Many of these also emphasise the complexity of the transition period and the fact that NGNs go through phases and development stages of their role

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**Figure 1 Phases of Transition**

- **The Honeymoon Phase**
- **The Reality Shock Phase**
  - Moral Outrage
  - Rejection
  - Fatigue
  - Perceptual Distortion
- **Recovery Phase**
- **Resolution Phase**
and competency. Moreover, they emphasise that the nature of undergraduate preparation affects NGNs’ transition experience.

1.2 The Role of Education in Preparing NGNs.

In the literature, a debate about a gap between nursing education and practice is well documented. This is referred to as the “Theory-practice gap”. According to Greenwood (2000), clinical nurses worldwide complain that NGNs are ill prepared for the “real” role of a staff nurse. They claim that NGNs have a lack of clinical skills. They also claim that nursing curriculum content is not always guided by the real clinical practice (Beecroft, et al, 2004; Watkins, 2000). Nursing academics respond to this by claiming that current nursing education aims to prepare nurses who are critically reflective and have lifelong learning abilities rather than merely competent nurses. They also claim that it is the responsibility of nurses in practice to ease the transition of NGNs and assist them in developing competence and mastering the role of the staff nurse (Greenwood, 2000).

An overview of the development of nursing education will be outlined to provide an understanding of the origins of the theory-practice gap debate.

1.2.1 Development of Nursing Education

It is well recognised that Florence Nightingale played a key role in initiating organised nursing education programmes. In Florence Nightingale’s time, nursing education was based on an apprenticeship model, which means that nurses learnt their job mainly through on-the-job training. Schools of nursing were associated with hospitals rather than academic settings mainly to provide a workforce of nurses to the hospitals (Dingwall, et al, 1988). At that time, this model of nursing education disseminated from the UK to its colonies (Greenwood, 2000).

Until the 1980s, nursing education in the UK was delivered mainly using the apprentice model except for some university-based degree programmes (Roxburgh, et al, 2008; Cowan, et al, 2005; Watkins, 2000). The apprentice model of education was thought to have many limitations. It was believed that nurses trained by this model lacked medical
knowledge and understanding of clinical skills for their roles as qualified nurses (Farrand et al, 2006). It was also believed that this model was producing nurses who were “doers” rather than “thinkers”, fail to respond to changes in healthcare needs and unable to cope with the advances in contemporary healthcare (Greenwood, 2000). In addition, there was growing evidence that some nursing practice was based on rituals rather than research-based evidence (Walsh and Ford, 1989). Therefore, there were increasing calls to move nursing education from the apprentice model to a more academic model. Subsequently, contemporary nursing education went through stages of development and change in order to produce nurses who are able to meet the challenges and demands of the modern healthcare system and able to adopt a more critical and analytical approach in delivering nursing care (Greenwood, 2000; Watkins, 2000). In the UK for example, in 1986, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published “Project 2000: A New Preparation for Practice” guidelines emphasising that student nurses should have a higher education-focused experience (UKCC, 1986). This led to the introduction of “Project 2000” which was a three-year programme. Despite the changes “Project 2000” has brought, there were concerns from NHS managers that the graduates of this programme lacked clinical skills and confidence creating a theory-practice gap (Farrand, et al, 2006; Greenwood, 2000). Consequently, by the late 1990s, a competency-based curriculum was proposed. In this curriculum, there is more emphasis on practical learning in order to bridge the theory-practice gap. At the end of this curriculum, there is a three months of supervised clinical practice to prepare students for the role of a registered staff nurse (UKCC, 1999). The competency-based curriculum is nationally known as “Making a Difference” (Farrand, et al, 2006).

1.3 Issues of Competency

It is argued that defining the competencies of nurses is important to provide guidance to what is reasonable to expect from them. Also, it is argued that nurses’ awareness of their competency is important to protect them and ensure their practice is not detrimental to the safety of patients (Bradshaw, 1998; Bradshaw, 1997). However, changes in nursing education thought to cause confusion in determining the basic competencies expected of registered staff nurses. In addition, in the nursing literature, there is a lack of precise and
concise definition of competency in nursing (Watson, et al, 2002; Bradshaw, 1998; Bradshaw, 1997). Added to that, there are claims that there are variations in how nurses in clinical practice interpret different concepts related to the level of nurses’ competency. For example, some believed the term “expert” is usually given to some nurses without thoughts about its meaning (Thornley and West, 2010). Moreover, some claimed that there are differences in opinions exist between education and work organisation on how to assess competency. Furthermore, many competency assessment tools lack reliability and validity resulting in inconsistencies in competency assessments (Redfern, et al, 2002; Watson, et al, 2002; Bartlett, et al, 2000; Bradshaw, 1998; Bradshaw, 1997).

As discussed earlier, in the UK the issues of NGNs lack of competency led to the introduction of the competency-based curriculum in nursing education (Greenwood, 2000; Watkins, 2000; Bradshaw, 1998; Bradshaw, 1997). Farrand et al (2006) conducted a quantitative study to examine whether the implementation of the competency based curriculum “Making a Difference” improved the confidence of nursing students in performing clinical skills. Questionnaires were mailed to 139 final year adult nursing students who were studying the “Project 2000” or “Making a Difference” curriculum. The results of this study indicated that students studying “Making a Difference” curriculum have higher levels of confidence in all areas of their practice than students studying in the “Project 2000” curriculum. According to Farrand et al (2006), these results highlight important improvements in the confidence of student nurses in their practice following the adoption of “Making a Difference” curriculum. However, increased confidence of students from “Making a Difference” curriculum does not mean that they are more competent compared to students from the “Project 2000”. Moreover, these results do not show if there are differences in the competencies of “Making a Difference” graduates compared to graduates of “Project 2000”.
In this section, some concepts related to nurses’ competency will be outlined. According to Fey and Miltner (2000), competence is defined as “more than possessing the knowledge or psychomotor skills necessary to perform a specific task”. According to them, competent nurses should be able to “integrate knowledge, skills, and personal attributes consistently in daily practice to meet established standards of performance” (Fey and Miltner, 2000). This definition shows that competency in nursing includes integrating both intellectual and behavioural competencies in order to provide safe and effective nursing care. However, the question which remains is when nurses can be considered competent?

In the nursing literature, Benner’s theory of nursing knowledge development is used widely as a framework to explain nurses’ competency development. Benner (2001) adopted Dreyfus’ model to explain the development of nursing knowledge and skills. Dreyfus’ model of skill acquisition was developed by two professors based on a study of chess players and airline pilots (Benner, 2004; Benner, 2001).

According to Benner (2004; 2001), there is a difference between practical and theoretical knowledge. Practical knowledge refers to “know how” while theoretical knowledge refers to “know why”. It is claimed that in a practical profession like nursing, knowledge development consists of practical knowledge based on both theory and clinical experience (Benner, 2004; Benner, 2001; Coffield, 2000). According to Benner’s model, a nurse passes through five levels in their competency development as shown in (Table 1).
Table 1 Benner's Theory of Nursing Knowledge Development

<table>
<thead>
<tr>
<th>Benner’s Levels of Proficiency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>A beginner who has no experience of the situation to base on his/her practice. Work in a new environment or encounter new situations with no previous experience (e.g. student nurse).</td>
</tr>
<tr>
<td>Advanced beginner</td>
<td>The nurse who can demonstrate acceptable performance in a situation based on prior experience. At this stage the nurse starts to develop principles based on his/her experience to guide actions (e.g. NGN). He/she is much aware of the environment and colleagues. Quests for credible sources of information and tends to perceive the knowledge of other co-workers as facts.</td>
</tr>
<tr>
<td>Competent</td>
<td>The nurse who has a constant experience of the same job, encountering the same situations for almost one to two years. At this period, the nurse starts to develop the ability to plan long-term goals for his/her actions and start mastering the nurse role. Yet, the competent nurse might be still slow and lack flexibility.</td>
</tr>
<tr>
<td>Proficiency</td>
<td>The nurse who perceives a situation as a whole and in long-term goals, which enhances his/her decision-making. At this stage the nurse performance is guided by maxims which other junior nurses might not be able to recognize.</td>
</tr>
<tr>
<td>Expert</td>
<td>The nurse who no more relies on analytic principles in order to plan an appropriate action. The expert has a vast experience and his/her work is based on deep understanding of the whole situation.</td>
</tr>
</tbody>
</table>

Benner (2004) claimed that nurses’ development of competency is mainly dependent on practical experience. Based on Benner’s theory, it can be argued that nurses including NGNs who work in completely new environments with no prior experience might be novices or advanced beginners. Thus, they need time to acquire experience and move subsequently to the expert level. Despite Benner’s theory been widely utilised and cited in nursing, it has been criticised for reflecting an ideal learning from experience rather
than being evidence-based. Moreover, it is thought that this theory emphasised on the ideal image of the expert nurse while providing an un-precise criteria of when somebody can be called an “expert” (Eraut et al, 1995 cited in Bradshaw, 1998).

Due to theory-practice gap debate and issues of the competency of NGNs, there are some arguments that, in order to facilitate the transition experience, NGNs must adjust from a university academic setting to the real workplace (Greenwood, 2000). Therefore, there are calls to instil support measures into nursing practice in order to assist NGNs to overcome the difference between academia and practice in order to develop their competency level (Scott, et al, 2008; Greenwood, 2000). There are some formal support measures offered by working organisations to assist the transition of NGNs, which will be discussed in the following section.

1.4 Organisation Support Measures

Currently, formal support programmes offered by healthcare organisations are regarded as an important method in attracting and retaining NGNs (Altier and Krsek, 2006). Preceptorship and mentoring using role modelling are the main methods usually integrated into the nursing support programmes. Preceptorship and mentoring are different terms but sometimes they are used interchangeably. Preceptorship is often the model utilised for orienting NGNs as they begin their staff nurse role in the hospital setting. The NGN whom is usually called the “preceptee” is paired with an experienced staff nurse who is called the “preceptor”. The preceptor is responsible for supporting and “teaching” the preceptee in order to enhance his/her development of clinical competencies and actively engage him/her with the healthcare team (McNiesh, 2007). On the other hand, the mentor is an experienced staff nurse who cares more about establishing a long term relationship with the NGN (mentee) to provide him/her with guidance and support in the clinical area (Kaviani and Stillwell, 2000). According to Kaviani and Stillwell (2000), the preceptor-preceptee relationship is based mainly on the teaching and learning aspects. Conversely, there is a more personal element to the mentor-mentee relationship where the mentee relies on the mentor for continuance support. It seems the profession of nursing continues to use clinical preceptorship as the
main teaching and learning method to support NGNs (Billay and Myrick, 2008; Salt, et al, 2008).

There are many studies and reviews identified in the literature about utilisation of support measures for NGNs. These studies and reviews showed that despite the difference of the support programmes’ structure and length, there is an agreement that these programmes have a positive effect on improving NGNs’ confidence levels and competency (Cubit and Ryan, 2011; Park and Jones, 2010; Winfield, et al, 2009; Salt, et al, 2008; Young, et al, 2008; Santucci, 2004). Halfer (2007) reported the effect of an internship programme implemented in California children's hospital to prepare and retain NGNs. This internship programme included classroom sessions, mentors and individualised preceptor orientation. According to Halfer (2007), implementing the internship programme has increased nurses’ retention, attracted more NGNs to apply to work at the hospital, reduced staff shortages and saved costs. Therefore, it can be argued that support programmes do not only work for the benefit of NGNs but also for the benefit of the health organisations. Studies also showed that NGNs are increasingly seeking to work in organisations, which provide support measures because they believe it is important for their role transition (Heslop, et al, 2001). The benefits of support measures provided by healthcare organisations are now more globally recognised. For example, in November 2009, the Department of Health in the UK published a national framework for one-year preceptorship programme to support NGNs (Department of Health, 2010).

Nevertheless, worldwide there are inconsistencies of the provision of support measures for NGNs during the transition period and their availability depends on the commitment of their work organisations and availability of funds. Furthermore, there is no agreement on the best support measure for NGNs. Most studies on the experience and effects of support measures are limited to a single institution and difficult to generalise. Despite using the same overarching titles for the support measures such as “internship” programme, different organisations utilise different strategies within each programme. Furthermore, there is difference in the time period of support measures offered by different organisations. Some organisations offer programmes for NGNs in their initial weeks only, while others offer programmes which last for one whole year (Clark and
Holmes, 2007; Goh and Watt, 2003; Gerrish, 2000). Furthermore, there are no studies found to investigate the most valuable strategies that NGNs and healthcare organisations can benefit from and what is the appropriate time period NGNs need for successful transition. Identifying the most appropriate support strategies for NGNs and the most appropriate period of support might assist in developing standardised support measures.

On the other hand, there are arguments that despite the availability of formal support programmes still some NGNs leave their work within their first year of practice. Therefore, there are claims that rather than having expensive and time consuming formal support programmes, there is a need for creating and encouraging clinical environments to establish collegial relationship with NGNs and support continues learning (Levett-Jones and FitzGerald, 2005).
1.5 Summary

There is a significant attrition from the nursing profession especially from NGNs. This is mainly attributed to the challenges NGNs face during their transition period. There are some debates that NGNs are not prepared for their new role by their undergraduate nursing education. It is claimed that moving nursing from the apprentice model to the academic setting has created a gap between theory and practice resulting in a failure to prepare competent nurses. However, in the nursing literature, there is no concise and precise definition of the concept of “competency” and also there is no reliable and valid assessment tool. Benner (2001) developed a framework suggesting that NGNs should be allowed time and support to develop their knowledge and skills.

Due to the complexity of the transition period for NGNs and its profound effect on their career, researchers worldwide, mainly in the Western countries, have strived to explore and understand NGNs’ transition experience. This study aims to explore the transition experience of NGNs in one of the developing countries, the Sultanate of Oman; therefore an outline about nursing in the Sultanate of Oman will be given.
Chapter Two- Nursing in the Sultanate of Oman

The Sultanate of Oman is one of the Arab Gulf countries in the Middle East. It is the second largest country in the Arabian Peninsula located on the South-eastern corner. It is bordered to the West by the UAE and the Kingdom of Saudi Arabia and to the South by the Republic of Yemen (Figure 2; Perry-Castaneda Library Map Collection, 2008). The Sultanate of Oman is administratively divided into four governorates, Muscat, Dhofar, Musandam and Al-Buraimi; and five regions, Al-Batinah, Ad-Dhahirah, Ad-Dakhliyah, Ash-Sharqiyyah and Al-Wusta. The governorates and regions are subdivided into cities called Wilayates and there is a total of 61 Wilayates. The capital city of the Sultanate of Oman is Muscat (Ministry of Information, 2002). Muscat and Al-Batinah region are the most populated areas containing almost 55% of the whole population, while 21% of the population live in rural regions and 5% live in the mountains (WHO, 2009).

Figure 2 The Sultanate of Oman Map

The Omani population consists mainly of Arabs, who speak Arabic and are Muslims in religion (Ministry of Information, 2002). Yet, there are still some other Omani nationals from other ethnic groups such as Baluchi, East African and South Asian (U.S. Department of State, 2006). Oman’s total population in 2010 was almost 2.7 million of which about 2 millions are Omani nationals and the rest are expatriates working in Oman.
According to 2003 national census, gender ratio for Omanis is 102 male per 100 female (Oman census, 2010). In 2009, more than 96% of the total Omani nationals were less than 60 years old, of which 11.98% were less than 5 years and 34.52% were less than 15 years (Ministry of Health, 2011b). Some other characteristics of the Omani population are listed in Table 2.

Table 2 Omani Population Characteristics

<table>
<thead>
<tr>
<th>Omani Population Characteristics:</th>
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</thead>
<tbody>
<tr>
<td>Females aged 15 to 49 years (of Omani population)</td>
<td>28.83%</td>
</tr>
<tr>
<td>Crude Birth Rate (per 1000 population)</td>
<td>29.5</td>
</tr>
<tr>
<td>Total Fertility Rate (births per woman 15-49 years)</td>
<td>3.3</td>
</tr>
<tr>
<td>Crude Death Rate (per 1000 population)</td>
<td>3.0</td>
</tr>
<tr>
<td>Life Expectancy at Birth (in years)</td>
<td>Overall 72.7</td>
</tr>
<tr>
<td></td>
<td>Males 70</td>
</tr>
<tr>
<td></td>
<td>Females 75</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000 live births)</td>
<td>9.6</td>
</tr>
<tr>
<td>Under 5 Mortality Rate (per 1000 live-births)</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Before 1970, Oman was a country with no basic signs of modernisation. There were only three primary schools and two hospitals in all of the country. Therefore, there was a high prevalence of poverty, illiteracy and communicable diseases (U.S. Department of State, 2006). After 1970, a period of modernisation occurred brought by political changes when Sultan Qaboos bin Said Al-Said took over the government. At present, the Sultanate of Oman is ruled by a conservative monarchy with the Sultan Qaboos bin Said as the head of the Sultanate (U.S. Department of State, 2006).

In Oman, the period of modernised transformation was supported mainly by oil production discovered in 1964. As a result, the Human Development Index in Oman has increased rapidly for income, education and health (WHO, 2009).

The Omani government led by Sultan Qaboos considered education as a vital factor in economic and social progress and made it one of their top priorities to develop. Education is provided free of charge to encourage the public to seek education (Bahgat, 1999).
The education development efforts by the government were fostered by the construction of Sultan Qaboos University (SQU) in Muscat. SQU is the national Omani university, which opened its doors for the public, free of charge in 1986 with five colleges. The first cohort of students graduated in 1990. Despite the fact that SQU is located in Muscat, it provides education to the whole population from all regions of Oman. Ever since its creation, SQU is expanding and the number of students enrolled had increased from 557 in the years 1986/1987 to 14722 in the years 2007/2008. Currently, the university has nine colleges and offers both undergraduate and postgraduate programmes (Sultan Qaboos University, 2009).

According to 2003 statistics, the total enrolment rate of Omanis in education is almost 98% (U.S. Department of State, 2006), indicating that almost all the Omani new generation are educated to some level including higher education.

2.1 Healthcare Services in the Sultanate of Oman

As mentioned earlier, before 1970, there were only two hospitals in Oman, Al-Rahma and Muscat Hospitals, both located in Muscat. These hospitals were providing basic healthcare services. However, after 1970, the Ministry of Health (MoH) was initiated resulting in improving healthcare services (Ministry of Health, 2011a).

Currently, the MoH is the main healthcare provider for the whole population providing all types of health services in Oman. Primary health services are provided by health centres located in each Wilayate. Some of these health centres provide some specialised outpatient services such as obstetrics and gynaecology; ear, nose and throat, dental care and ophthalmology. Patients requiring specialised care are referred from primary and extended health centres to referral hospitals in each Wilayate, which provide secondary healthcare services. Tertiary healthcare is provided by highly specialised hospitals. There are three major tertiary hospitals in Muscat under the MoH. These are the Royal Hospital, Khoula Hospital and Al Nahdha Hospital (Ministry of Health, 2011a). These hospitals act as referral hospitals for the whole nation. In addition, there is the Ibn-Sina hospital in Muscat, which is a major specialised psychiatric referral hospital providing care for the
whole population (Ramanathan, 2005). There are some other organisations which support
the public health services provided by the MoH such as the Sultan Qaboos University
Hospital (SQUH), Ministry of Defence Hospital (AFH) and Royal Oman Police Hospital.
Also, the private health sector plays an increasing role in providing healthcare services.
This is demonstrated by the increase in number of private healthcare institutions. Based
on MoH 2009 statistics, there are 60 hospitals and 1,034 health centres, dispensaries and
private clinics spread across the country (Ministry of Health, 2011a).

The government covers all expenses of the healthcare services in governmental health
organisations provided for all Omani nationals and for expatriates working in the public
sector. Expatriates who work in the private sector are by law covered by their employer.
The public health services were totally free until 1997, when minimum fees for annual
registration and for each outpatient consultation were introduced. According to the World
Health Organisation (WHO), the fees were introduced to reduce “frivolous” visits rather
than to fund the healthcare services (WHO, 2009).

In the year 2000, the WHO analysis of health systems in 191 member states, reported that
Oman is one of the most successful countries in providing healthcare. The WHO report
commented on the tremendous success which healthcare in Oman has accomplished in a
relatively short time (WHO, 2000). As a result of the improvement of health services,
communicable diseases have been successfully controlled by the measures instilled by
the MoH. For example, Malaria cases dropped significantly from 30,000 cases a year in
1990 to 898 cases a year in 2009 (Ministry of health, 2011b). Moreover, the changes in
child and infant mortality illustrate the successes of healthcare services in Oman. In the
eyear 1970s, almost 1 in 5 children died before their fifth birthday. This has declined
dramatically to 1 in 20 children during the early 1990s and to 12 per 1000 live births
during 2009 (Ministry of Health, 2011b).

Due to increased life expectancy and life style changes in Oman, currently, non-
communicable and chronic diseases cause most deaths in adults. In fact, almost 50% of
the adult population in the urban areas is overweight (WHO, 2009). Moreover, road
traffic accidents are adding an extra burden to all the public and private health services in
Oman. According to MoH statistics (2006), 5217 people of whom more than 85.68% were less than 45 years have been admitted to MoH hospitals with injuries due to road traffic accidents (Ministry of Health, 2011b). The annual cost of road traffic accidents to the Omani health system accounts for 3% of the health budget (WHO, 2009).

On the other hand, long-term geriatric care facilities are not widely available in Oman. This is mainly because families in the Omani and Islamic culture are expected and required to provide care for their elderly with chronic diseases (Moosa and Mazzoni-Maddigan, 2004). Moreover, according to MoH statistics the elderly population accounts for less than 4% of the total population. This indicates that providing geriatric care facilities might not be a priority for MoH.

Despite improvement in healthcare services in Oman, it is faced with ongoing challenges particularly due to its dependence on an international healthcare workforce especially nurses (Alghemini and Denham, 2008; Maben, et al, 2010). In fact, due to worldwide nursing workforce shortages there is now a global labour market in nursing (Ross, et al, 2005). Nurses and midwives were reported to be migrating in vast numbers to countries offering better prospects with more stable and comfortable working conditions and improved quality of life for them and for their families (Kingma, 2001). The global shortage of nurses created a challenge for healthcare provision in Oman when competing with other industrial countries in attracting and retaining international (expatriate) nurses (Maben, et al, 2010; Ross, et al, 2005; Moosa and Mazzoni-Maddigan, 2004).

Having expatriate nurses might indicate that nursing in Oman is a multicultural profession and nurses from different backgrounds have contributed to the development of the nursing profession in Oman. This has an impact on nursing since Omani nurses are interacting with other expatriate nurses who have different experiences which if utilised can contribute positively to nursing development. However, expatriate nurses working in Oman might be novices in respect to Omani society, culture, and healthcare needs and also face communication barriers due to language differences, which might hinder their contribution to nursing development. In the literature, expatriate nurses are found to have difficulties with communication skills. When compared to local nurses, they are found to
have different styles of decision-making, role expectations and behaviours and attitudes (Yi and Jezewski, 2000).

Oman like other Arabian Gulf countries is trying to implement efforts to reduce its dependency on expatriate workers by training its own indigenous/nationals (Maben, et al, 2010). This process is called “Omanisation”. Currently, the Sultan Qaboos University (SQU) and various MoH training institutes plus some private colleges and universities, provide programmes to train Omani healthcare professionals. There has been a marked increase in Omani healthcare professionals in recent years; for example, the number of Omani nurses working in MoH organisations has increased from 49% in 2003 to 59% in 2005 and to 83% in 2010 (Ministry of Health, 2011c). The increase in the number of Omani healthcare professionals is continuous and it covers almost all categories of the multidisciplinary team as shown in Table 3.

Table 3 Proportion of Omani Staff in MoH Workforce

<table>
<thead>
<tr>
<th>Categories</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>27%</td>
<td>46%</td>
</tr>
<tr>
<td>Specialists/Consultants</td>
<td>23%</td>
<td>38%</td>
</tr>
<tr>
<td>Dentists</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>49%</td>
<td>83%</td>
</tr>
<tr>
<td>Nurses</td>
<td>59%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Increasing the number of national healthcare professionals who share the same culture with the Omani population is thought to improve communication with patients and result in providing a more culturally sensitive care (Maben, et al, 2010). However, the WHO have raised a concern that the increase in number of young and less experienced Omanis taking over posts from experienced expatriates may adversely affect healthcare provision (WHO, 2009).

The statistics in Table 3 illustrate the increased progression of the number of Omani healthcare professionals working at MoH organisations only, which might be different to other major hospitals such as Sultan Qaboos University Hospital (SQUH) and Armed Forces Hospital (AFH). For example, according to SQUH recent statistics, Omani nurses
account for less than 20% of the nursing workforce. This indicates that other hospitals might be still heavily dependent on expatriate healthcare professionals.

Despite all the efforts to increase the number of national and expatriate nurses, Oman’s healthcare services had a 30% shortage in the nursing workforce in 2008 (Alghemini and Denham, 2008). There are no recent updated statistics about the shortage of nursing workforce in Oman. Shortages in the nursing workforce might indicate that nursing in Oman is not only faced with its dependency on expatriate nurses; increased number of young inexperienced Omani nurses in direct patient care but also these nurses deal with increased workload which might affect the quality of healthcare provision.

To understand the context of nursing education and practice in Oman, an overview of nursing development will be given.

2.2 Nursing Practice and Nursing Education Development in the Sultanate of Oman

Nursing practice in Oman is influenced by Islamic teachings. In the past, based on Islamic teachings nursing was performed by women who dedicated their life in caring for the needy and wounded (Alghemini and Denham, 2008). Nursing in the Islamic world including Oman was influenced by Rufaidah Al- Asalmiya who is recognised as the first Muslim nurse in the Islamic literature. Rufaidah’s father was a healer (doctor) and she learned nursing by working with him. She had a tent in the battlefield where she nursed the wounded and trained other women to become nurses (Jan, 1996).

Organised nursing practice first introduced in Oman in 1904 by missionary nurses from America, who came to work in a healthcare centre in Muscat. At that time, there was no organised Omani nursing practice. In the 1950s, a small group of American missionary nurses began training Omani nationals and the first batch of Omani nurses consisted of six women and ten men. In 1970, the American Missionary Association established the Al-Rahma School of Nursing. An initial batch of five male nurses graduated from Al-Rahma School of Nursing in 1972 after completing a two-year training programme. This
indicates that nursing education in Oman was initially influenced by the American system of nursing education. In 1972, the Al-Rahma School of Nursing was taken over by the MoH. Then, this training programme was developed to a three-years course and awarded its graduates a Certificate in Nursing. Yet, the course was still mainly based on the apprentice model (Ministry of Health, 2007; Alghemini and Denham, 2008).

In early 1970s, there were few women who joined organised nursing programmes in Oman. This might have been due to cultural constrains and also to the fact that before the 1970s women rarely participated in any activity outside their houses. Subsequently, the number of women involved in nursing education and practice has massively increased resulting in almost 90% of the nursing workforce in Oman being female in the year 2004 (Moosa and Mazzoni-Maddigan, 2004). According to Alghemini and Denham (2008), females are given the greatest encouragement to join nursing. This is due to the fact that Oman is an Islamic country and therefore female nurses can generally work in most areas of the healthcare, whereas male nurses’ practice is restricted from working in some areas including Obstetrics, Gynaecology and Delivery Suites. However, according to MoH statistics, the number of male nurses is increasing. In year 2005, almost 95% of nurses graduated from MoH institutes were females, whereas in 2009 female nurses accounted for only 79.5% of the total nursing graduates (Ministry of Health, 2009).

As a result of the development in health services in Oman after 1970, there was an increased demand for the healthcare workforce including nurses. Consequently, this led to the establishment of the Directorate of Nursing Affairs at MoH. Ms Sally Sedgwick, a British nursing professional, took charge as the first Director of Nursing. Thus, it might be argued that nursing practice and education development in Oman were also influenced by the British system.

Until the 1980s, nursing services dominated by expatriate nurses mainly from India (Ministry of Health, 2007). Omanis have been encouraged to join the nursing profession and contribute to its development. In 1982, Ms Asiya Al-Kharusi became the first Omani to be appointed Director of Nursing at the MoH headquarters. At the same year, a major milestone in nursing education in Oman was achieved when the Institute of Health
Sciences was established in Muscat and included a department of nursing studies. The department of nursing studies was separated from the Institute of Health Sciences in 1994 to become the Muscat Nursing Institute. In the year 2000, another nursing institute called the Oman Nursing Institute was established in Muscat (Ministry of Health, 2007). Currently, there are a total of 12 nursing institutes located in different regions of the country with an annual intake of 540 students. These institutes offer a three year programme and graduates are awarded a Diploma in Nursing which is equivalent to an Associate Degree in Nursing from the USA. All nursing institutes share an identical curriculum developed by the MoH (Ministry of Health, 2007). Each year some of the MoH institutes’ graduates are sponsored by the MoH to do graduate study at Villanova University in Pennsylvania (Alghemini and Denham, 2008; Ministry of Health, 2007; Moosa and Mazzoni-Maddigan, 2004). These students study nursing education and nursing administration (Alghemini and Denham, 2008).

In the year 2000, a Professional Code of Conduct for practicing nurses and midwives was nationally introduced. In 2001, the Oman Nursing and Midwifery Council was established to mainly promote professionalism in the service by enforcing the professional code of conduct for nurses, as well as developing high standards in education and nursing practice to safeguard the public. It licenses nurses and midwives to practice in the Sultanate of Oman (Ministry of Health, 2007). This might mean that nursing in Oman is becoming more recognised as a profession.

In 2001, the Oman Nursing Specialty Institute was established to provide post-basic training in several nursing specialty e.g. critical care (Ministry of Health, 2007). This institute prepares nurses to takeover more advanced roles. In 2002, Sultan Qaboos University (SQU) started a nursing baccalaureate (BSc) programme in the College of Medicine and Health Sciences, which was the first in Oman. In 2008, the College of Nursing became a distinct (9th) college at SQU. The College of Nursing also provides a nursing diploma bridging programme. The first batch of Baccalaureate nurses graduated in 2007. An average of 50 to 60 students is expected to graduate every year from SQU College of Nursing (Sultan Qaboos University, 2011b). The private sector had also launched a four years nursing baccalaureate programme to meet the increasing demand
for nurses in both the governmental and private sectors. Currently there are two private universities in Oman offering four years baccalaureate programme. These are the University of Nizwa in Ad-Dakhliyah region and the University of Buraimi in Al-Buraimi governorate (The University of Nizwa, 2010; The University of Buraimi, 2010).

In the MoH institutes, nursing education is conducted by lecturers from different countries, cultures and backgrounds (Alghemini and Denham, 2008). This can also be observed by looking at the academic lecturers’ lists of SQU College of Nursing which reveals that SQU academic lecturers are mainly expatriates (Sultan Qaboos University, 2011c). Usually expatriate nurse lecturers work under temporary contracts with the educational institutions which frequently result in instability and shortage of staff (Alghemini and Denham, 2008). Nevertheless, there is an increase in Omani nursing educators in most MoH institutions. Nursing educators and clinical instructors in the Oman Nursing Specialty Institute for example are mainly Omani graduates of scholarships awarded by the MoH to study in the UK and Australia (Ministry of Health, 2007).

Nursing graduates from MoH institutes mainly work in MoH primary, secondary and tertiary health organisations located in different regions of Oman. While, SQU baccalaureate graduates work exclusively for Sultan Qaboos University Hospital (SQUH) located in Muscat.

2.3 Sultan Qaboos University Hospital (SQUH)

SQUH is built within SQU campus, on an area of approximately 40,000 square meters with a total bed capacity of 528 beds with 380 currently opened. It is an educational and medical institution, providing teaching and training for medical and health science students as well as providing tertiary medical care to the public and carrying out research. It also provides specialised medical facilities that are limited in Oman such as the Renal Transplant Unit. In 2009, SQUH have increased its bed capacity by opening new wards such as Orthopaedic/Neurosurgery and Cardiothoracic/Cardiology. Table 4 shows the different wards and specialities available at SQUH.
Table 4 Wards at SQUH

<table>
<thead>
<tr>
<th>Colour Code</th>
<th>Wards</th>
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<tbody>
<tr>
<td>4 Red</td>
<td>Male surgical</td>
</tr>
<tr>
<td>4 Yellow</td>
<td>Female surgical</td>
</tr>
<tr>
<td>4 Purple</td>
<td>Special nursing care (private)</td>
</tr>
<tr>
<td>4 Blue</td>
<td>Ophthalmology/ENT ward</td>
</tr>
<tr>
<td>3 Red</td>
<td>Male medical</td>
</tr>
<tr>
<td>3 Yellow</td>
<td>Male medical (Oncology /Haematology)</td>
</tr>
<tr>
<td>3 Blue</td>
<td>Female medical</td>
</tr>
<tr>
<td>3 Purple</td>
<td>Female medical (Oncology/Haematology)</td>
</tr>
<tr>
<td>2 Red</td>
<td>Post natal ward</td>
</tr>
<tr>
<td>2 Yellow</td>
<td>Obstetric and Gynaecology ward</td>
</tr>
<tr>
<td>2 Purple</td>
<td>Cardiothoracic/ cardiology</td>
</tr>
<tr>
<td>2 Blue</td>
<td>Paediatric Haematology</td>
</tr>
<tr>
<td>1 Yellow</td>
<td>Orthopaedic/Neuro-surgery</td>
</tr>
<tr>
<td>1 Purple</td>
<td>Paediatric Oncology</td>
</tr>
<tr>
<td>1 Blue</td>
<td>Paediatric medical</td>
</tr>
<tr>
<td>NNL</td>
<td>Neonatal care</td>
</tr>
<tr>
<td>DCU</td>
<td>Day care</td>
</tr>
<tr>
<td>PDCU</td>
<td>Paediatric day care</td>
</tr>
<tr>
<td>POPD</td>
<td>Paediatric Out patients department</td>
</tr>
<tr>
<td>OPD</td>
<td>General Out patients department</td>
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</table>

SQUH organisational structure is based under SQU management (Figure 3). Currently, the hospital employs 1,780 staff of which the large proportion are nurses (Sultan Qaboos University, 2009). As shown in Figure 3, the nursing staff are managed by the Deputy Hospital Director for Nursing Affairs who comes directly under the SQUH director. The Deputy Nursing Director of Nursing Affairs is responsible for all nursing staff and support services working at different departments in SQUH. It can be noticed that the only support services available at SQUH is the medical orderly services (Figure 4).
Figure 3 SQUH Organisational Chart
Figure 4 SQUH Nursing Directorate Organisational Chart
2.4 Summary

Healthcare services in the Sultanate of Oman went through a period of remarkable development in the past 40 years. The MoH and other governmental organisations such as SQUH, located in Muscat, primarily provide healthcare free of charge. SQUH is an educational hospital attached to SQU, which is the Omani national university.

In Oman, nursing practice and education went through developmental stages since 1970. Currently, there are 12 nursing institutes under the MoH, which award a diploma qualification to NGNs. There is also the baccalaureate degree offered by SQU and some private universities. NGNs graduate from SQU work exclusively for SQUH.

Nursing education and nursing profession in Oman are greatly dependent on expatriate nursing educators and clinical nurses. The attrition of expatriate nurses from Omani hospitals not only reduces the nursing workforce but also leads to an increasing number of inexperienced, young Omani nurses in direct patient care. The context of nursing education and nursing practice in Oman is distinct to other countries. In order to explore Omani NGNs’ transition experience, there is a need to review the existing current nursing literature on (about) the experience of NGNs during their transition period.
Chapter Three- The Literature Review

The aims of the literature review are:

(1) To identify and review the literature in relation to (a) the experiences of NGNs during their transition period and (b) the effect of the undergraduate preparation and the work environment contextual structure on their transition experience.

(2) To assess the methodology of the literature.

Initially, an extensive literature search about NGNs’ transition experience, utilising a variety of methods, was undertaken between October 2008 and December 2011 to reveal relevant literature. The relevant literature was sought from electronic databases, citations, reference lists and the library catalogue. Initially, an electronic search in Medline and CINHAL Plus databases was carried out. The main terms used in the search strategy are listed in Table 5.

Table 5 Search Terms

<table>
<thead>
<tr>
<th>Search Terms</th>
<th>New nurses</th>
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<tbody>
<tr>
<td></td>
<td>New graduates</td>
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<tr>
<td></td>
<td>New graduate nurses</td>
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<td></td>
<td>Graduate nurses</td>
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<tr>
<td></td>
<td>Transition</td>
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<td></td>
<td>Role transition</td>
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<td></td>
<td>Transition period</td>
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<tr>
<td></td>
<td>Transnational</td>
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<td></td>
<td>First year experience</td>
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<td></td>
<td>Residency programme</td>
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<td></td>
<td>Retention</td>
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<td></td>
<td>Internship</td>
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<tr>
<td></td>
<td>Orientation</td>
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<td></td>
<td>Preceptorship</td>
</tr>
<tr>
<td></td>
<td>Mentoring</td>
</tr>
</tbody>
</table>

42
In 2009, the University of Manchester electronic search engine SearchIt@JRUL was used to search multiple information resources simultaneously. The databases searched encompassed literature, published and unpublished, in medicine, nursing, psychology, social science and educational journals. In 2011, the University of Manchester Library Search engine was used to search for any new research using all the search terms.

The search strategy yielded many research papers, journal articles and books. Tables 6 and 7 list the inclusion and exclusion criteria for the papers used in extracting data about the transition experience of NGNs.

**Table 6 Inclusion Criteria**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>English Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 to Date</td>
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<tr>
<td>Studies from different countries</td>
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<tr>
<td>Empirical studies only</td>
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<tr>
<td>Done in Hospital setting</td>
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</tbody>
</table>

**Table 7 Exclusion Criteria**

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>Not published in English language</th>
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<tbody>
<tr>
<td></td>
<td>Editorials</td>
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<td></td>
<td>Letters</td>
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</table>

The search strategy revealed an extensive literature; therefore a decision was made to focus on studies published after 1990. Since 1990, nursing worldwide has gone through a wide range of far reaching changes in both education and clinical practice. Nursing has increasingly moved from the apprentice model to academic settings and degree level courses in nursing have become more prevalent. For example in the UK, the “Project 2000” education reforms were introduced (Greenwood, 2000; Watkins, 2000). Nurses have also increasingly assumed more advanced roles which have increasingly meant a need for higher level education. Therefore, the decision to review studies published after 1990 was made in order to focus on studies which reflect the current situation of new
graduate nurses during their transition period. Nevertheless, there was some reference made in this literature review to NGNs’ transition experience before 1990 (Gerrish, 2000).

3.1 Understanding the Transitional Experience of NGNs: A Review of the Nursing Literature

In order to understand NGNs’ actual transition experience, the literature was searched for studies focused on exploring NGNs’ experiences and perceptions about the transition period. These studies are summarised and organised in a chronological order in Table 8.
<table>
<thead>
<tr>
<th>Author, Year, Country</th>
<th>Method</th>
<th>Design</th>
<th>Sample</th>
<th>Aims</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelly, 1996, UK</td>
<td>Qualitative, retrospective grounded theory</td>
<td>Interviews</td>
<td>10 female nurses interviewed 4 years after graduation, 9 female and 1 male, 25-28 years old</td>
<td>To explore nurses’ experience in their first year of practice in hospital nursing?</td>
<td>“Overwhelming stress related to role anxiety”; “High expectations of themselves”; “pressures of the working environment”; “The pressure to conform to the norms of the team &amp; ward routines”; “Compromising patient care”</td>
</tr>
<tr>
<td>Jasper, 1996, UK</td>
<td>Phenomenology</td>
<td>Focused group interviews</td>
<td>10 nurses</td>
<td>To describes NGNs’ experiences in the first year following qualification.</td>
<td>“Coming out of school &amp; living in the real world”; “Deal with criticism to the course contents by other staff”; “Learning to cope”</td>
</tr>
<tr>
<td>Kapborg &amp; Fischbein, 1998, Sweden</td>
<td>Qualitative</td>
<td>Diary</td>
<td>8 nurses</td>
<td>To investigate nurses' experiences of the transition from student to the nurse professional role.</td>
<td>“Feeling adequately &amp; sufficiently prepared”; “But need more time to feel competent in different situations and more training in communicating with patients and relatives”.</td>
</tr>
<tr>
<td>Kelly, 1998, UK</td>
<td>Qualitative: grounded theory</td>
<td>Open-ended, in depth, audio-taped interviews</td>
<td>13 nurses at the end of the first year. 9 nurses by the middle of the second year.</td>
<td>To describe, explain and interpret how NGNs perceived their adaptation to the “real world” of hospital nursing and what they perceived as major influences on their moral values.</td>
<td>“Preserving moral integrity”; Psychosocial process: vulnerability; getting through the day; coping with moral distress; alienation from self; coping with lost ideals; and integration of new professional self-concept.</td>
</tr>
<tr>
<td>Maben &amp; Macleod Clark, 1998, UK</td>
<td>Qualitative</td>
<td>Interviews</td>
<td>Convenience sample: 10 NGNs from Project 2000</td>
<td>To describe the experience of transition from student to staff nurse and to identify the factors which may facilitate or inhibit transition.</td>
<td>“The emotional highs and lows of the transition period”; “Criticism of the course”; “Assertiveness training and professional values”; “Resistance to change by existing staff”; “Positive emotions”; “Positive Preceptor and ward support”.</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Design</td>
<td>Participants</td>
<td>Purpose</td>
<td>Findings</td>
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<tr>
<td>Charnley, 1999, UK</td>
<td>Qualitative</td>
<td>Semi-structured interviews</td>
<td>Theoretical sample: 18 NGNs</td>
<td>To explore the perceived stress experienced in the current climate by NGNs who have undertaken a Project 2000 course.</td>
<td>“Work overload”; “A deficit in practical and management skills”; “Evidence of a theory practice gap”; “Lack of support”.</td>
</tr>
<tr>
<td>Godinez, et al, 1999, USA</td>
<td>Qualitative study</td>
<td>Daily feedback sheets, content analyses</td>
<td>27 NGNs and preceptors</td>
<td>To describe the initial steps in the role transition of graduate to staff nurse.</td>
<td>“Real Nurse Work”; “Guidance”; “Transitional Processes”; “Institutional Context”; “Interpersonal Dynamics”.</td>
</tr>
<tr>
<td>Holland, 1999, UK</td>
<td>Ethnography</td>
<td>Interviews, observation and open ended questionnaires</td>
<td>Key informants from one English university &amp; sample of 4 groups of Diploma students (no exact number of participants)</td>
<td>To explore the nature of the transition experienced by student nurses in their journey of becoming nurses.</td>
<td>“Reasons for becoming”; “Being a student nurse”; “Giving care”; “Gaining skills”; “Learning to become”; “Performance and manner”; “A stressful experience”; “Learning and experiencing”.</td>
</tr>
<tr>
<td>Gerrish, 2000, UK</td>
<td>Grounded theory</td>
<td>Interviews</td>
<td>-1985: 10 NGNs 3-6 months after qualification. -1998: 25 nurses qualified from Project 2000 adult branch, 4 and 10 months after graduation.</td>
<td>To examine newly qualified nurses’ perceptions of the transition from student to qualified nurse and to compare these perceptions with those of nurses who qualified in 1985.</td>
<td>-There are some similarities between the two cohort groups in the stress experienced. -Yet, the 1998 group had more positive experience due to the assertiveness and the environment support (Preceptorship).</td>
</tr>
<tr>
<td>Duchscher, 2001, Canada</td>
<td>Qualitative: Phenomenology</td>
<td>Semi-structured interviews</td>
<td>5 nurses</td>
<td>To explore how nurses perceived their first 6 months as professional nurses.</td>
<td>“Doing nursing”; “The meaning of nursing &amp; being a nurse”; “Practical lack of skills”; “The Experience of Loss process”: Disillusionment, Disappointment, and Detachment.</td>
</tr>
<tr>
<td>Authors, Year, Location</td>
<td>Design</td>
<td>Methodology</td>
<td>Sample Characteristics</td>
<td>Research Question</td>
<td>Findings</td>
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<tr>
<td>Evans, 2001, UK</td>
<td>Qualitative</td>
<td>Interviews</td>
<td>Convenience sample: 9 child health NGNs, age and gender not mentioned</td>
<td>To examine the concerns and expectations of newly qualified staff at the beginning of their career.</td>
<td>Transition includes “separation, transition and integration”; “Reality shock theme”; “Assertiveness”; “Expectations by others in relation to their abilities and their expectations of themselves as well”; “Feelings of ambiguity surrounding their new role”; “Proud to be qualified”.</td>
</tr>
<tr>
<td>Ramritu &amp; Barnard, 2001, Australia</td>
<td>Qualitative: Phenomenology</td>
<td>Semi-structured interviews and drawings</td>
<td>6 nurses</td>
<td>To understand the experiences of competence of new nurse graduates.</td>
<td>-Competence as “safe practice”, “limited independence”, “utilisation of resources”, “management of time and workload”, “ethical practice”, “performance of clinical skills”, “possessing an adequate knowledge base”.</td>
</tr>
<tr>
<td>Oermann &amp; Garvin, 2002, USA</td>
<td>Quantitative</td>
<td>Survey</td>
<td>46 NGNs in three hospitals in the Midwest region of the USA.</td>
<td>To describe the stresses and challenges new graduates experienced in their initial clinical practice in hospitals.</td>
<td>-Beginning clinical practice on the unit is moderately stressful. -The stressors reported most frequently were: not feeling confident and competent, making mistakes because of increased workload and responsibilities, and encountering new situations, surroundings, and procedures. -The greatest challenges were applying the knowledge into practice.</td>
</tr>
<tr>
<td>Ross &amp; Clifford, 2002, UK</td>
<td>Mixed design</td>
<td>- Pre-qualifying: Questionnaire and interviews 3 months prior to qualifying. -Post-qualifying questionnaire 4 months after qualifying.</td>
<td>Convenience sample: 30 Diploma students</td>
<td>To examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified nurse.</td>
<td>-The transition from student nurse to registered nurse remains very stressful for some NGNs. -Many feel inadequately prepared for their new role.</td>
</tr>
<tr>
<td>Chang &amp; Hancock, 2003, Australia</td>
<td>Quantitative</td>
<td>Questionnaires 2 and 10 months after graduation.</td>
<td>110 NGNs</td>
<td>To examine sources of, and changes in, role stress 2–3 months after employment, and 11–12 months later in NGNs.</td>
<td>-Moderate Levels of stress. -No differences in role overload and role ambiguity over time.</td>
</tr>
<tr>
<td>Delaney, 2003, USA</td>
<td>Qualitative: phenomenology</td>
<td>Interviews</td>
<td>Purposive sample: 10 NGNs</td>
<td>To investigate NGNs’ transition experiences during orientation?</td>
<td>“Mixed Emotions”; “Preceptor Variability”; “Welcome to the Real World”; “Stressed and Overwhelmed”; “Learning the System and Culture Shock”; “Not Ready for Dying and Death”; “Stepping Back to See the View”; “The Power of Nursing; Ready to Fly Solo”</td>
</tr>
<tr>
<td>Ellerton &amp; Gregor, 2003, Canada</td>
<td>Qualitative</td>
<td>Open-ended interviews</td>
<td>Convenience sample: 11 BSN nurses</td>
<td>What do NGNs describe as the content of their nursing practice during their first year of employment as registered nurses? How do NGNs rate their preparedness for their work as registered nurses? How do NGNs describe the maturation of their nursing practice across their first year of work?</td>
<td>“Learning the Job”; “Challenges to Competent”; “Practice and Approaches to the challenges of the Work”.</td>
</tr>
<tr>
<td>Goh &amp; Watt, 2003, Australia</td>
<td>Qualitative</td>
<td>Interviews</td>
<td>Purposive sample: 5 nurses, 4 female and 1 male nurse, 22–28 years old</td>
<td>To explore how NGNs perceived the transition experience.</td>
<td>-Developmental first steps: “Feelings of being unprepared”, “Unrealistic expectations” and “No time to care”. -Developmental stumbling blocks: “Assimilation anxiety”, “Role stress” and “Personal stress”</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Method</td>
<td>Sample Characteristics</td>
<td>Purpose</td>
<td>Findings</td>
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<tr>
<td>Casey, et al, 2004, USA</td>
<td>Mixed design</td>
<td>Survey questionnaire</td>
<td>Convenience: 270 NGNs</td>
<td>To identify the stresses &amp; challenges experienced by cohorts of NGNs at baseline, 3 months, 6 months, 12 months, &amp; an additional continued follow-up of specific groups for a longer employment period.</td>
<td>- Transition from student to professional nurse requires consistent support &amp; professional development during the first year of practice. - Closer partnerships between the academic &amp; practice institutions could facilitate an improved integration in the transition process.</td>
</tr>
<tr>
<td>Kilstroff &amp; Rochester, 2004, Australia</td>
<td>Qualitative</td>
<td>Telephone interviews.</td>
<td>6 nurses: 4 male and 2 female, 23-27 years old</td>
<td>To explore the transitional experiences of NGNs who had previously trained as enrolled nurses.</td>
<td>“Values dissonance” and “Role adjustment”</td>
</tr>
<tr>
<td>McKenna &amp; Green, 2004, Australia</td>
<td>Qualitative</td>
<td>2 focus group, in 2 different points in one-year programme.</td>
<td>Purposive sample: 7 nurses</td>
<td>To provide understanding around the experiences of NGNs in their first year of professional practice</td>
<td>“Focusing on self”; “Facing realities of practice”; “Personal identity”; “Coping mechanisms”; “Focusing on patient care” and “Personal and professional development”.</td>
</tr>
<tr>
<td>Bowles &amp; Candela, 2005, USA</td>
<td>Quantitative</td>
<td>Survey</td>
<td>Questionnaire mailed to 3077 RNs, 11.4% response rate, 88% female, majority 25-45 years old</td>
<td>To determine what NGNs chose for their first nursing position, perceptions of their first nursing position experience, and, if they left the position, why?</td>
<td>-30% of respondents left in 1 year -57% left by 2 years, -Negative: The work is stressful, Staffing level not adequate, No time to spend with patients. -Positive: Evaluations were reflective of their work and Continuing education was encouraged.</td>
</tr>
<tr>
<td>Jackson, 2005, UK</td>
<td>Qualitative: Heideggerian phenomenological methodology</td>
<td>Interviews</td>
<td>Convenience &amp; purposeful sample: 8 nurses</td>
<td>To explain the interpretations of what constituted a good day for a NGNs.</td>
<td>“Doing something well”; “good relationships with patients”; “feeling that you’ve achieved something”; “getting the work done” and “you need team work”.</td>
</tr>
<tr>
<td>Author</td>
<td>Design Type</td>
<td>Methodology</td>
<td>Stage 1 Details</td>
<td>Stage 2 Details</td>
<td>Stage 3 Details</td>
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<tr>
<td>Cowin &amp; Hengstberger-Sims, 2006, Australia</td>
<td>Quantitative</td>
<td>Survey design at 3 different times</td>
<td>1st stage: 187 BSc NGNs 2nd stage: 83 3rd stage: 71 95% female, 50% age 20-22.</td>
<td>To explore the development of multiple dimensions of nursing self-concept and examines their relationship to NGNs retention plans.</td>
<td>-Multiple dimensions of graduate nurse self-concepts rise significantly in the second half of their graduate year. -Nurse general self-concept is a strong predictor of graduate nurse retention.</td>
</tr>
<tr>
<td>Maben, Latter &amp; Macleod Clark, 2006; 2007, UK</td>
<td>Mixed design longitudinal study</td>
<td>Survey and Interviews</td>
<td>1st stage: 72 nursing students from 3 universities filled questionnaire. 2nd stage: interviews with 26 NGNs at two different times after graduation.</td>
<td>To explore the extent to which the ideals and values of the undergraduate nursing education are utilised by NGNs.</td>
<td>There are different sabotages identified by NGNs to affect their implementations of the ideals and values of nursing education (professional and organisational sabotage)</td>
</tr>
<tr>
<td>Schoessler and Waldo, 2006, USA</td>
<td>Qualitative: Phenomenology</td>
<td>Regular meetings: Conversations</td>
<td>Not mentioned</td>
<td>To assess Transition Model for the NGNs.</td>
<td>-“Endings (0-3 months)”; no time to form relationship with patients. Increased responsibility, struggling with how to get organised, learning new skills. -“Neutral Zone (4–9 months)”: Shift organisation is improving as some tasks become more routine; Physician communication seen as problematic; Integrating with the team. -“New Beginning (10-18 Months)”: Family emerges as a new demand; Comfort with procedural care; Organisation has improved; the ward is my home; Physician communication still seen as problematic; Beginning to precept newer nurses.</td>
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<tr>
<td></td>
<td>Methodology</td>
<td>Analysis Type</td>
<td>Sample Details</td>
<td>Research Objectives</td>
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<tr>
<td>Clark &amp; Holmes, 2007, UK</td>
<td>Qualitative</td>
<td>Focus groups</td>
<td>Purposive sample: 105 participants including new and experienced nurses and ward managers.</td>
<td>To identify the perspectives of NGNs and those most closely involved in their development and to gain insight into the way competence continues to develop after qualification. “Ready for practice”; “a question of confidence”; “approaches to staff development”; “core and specialist skills”; “competence versus competencies” and “the role of Preceptorship”.</td>
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<tr>
<td>Mooney, 2007, Ireland</td>
<td>Qualitative: grounded theory</td>
<td>Interviews</td>
<td>Theoretical Sample: 12 NGNs.</td>
<td>To ascertain how NGNs perceived their role transition in an Irish general hospital. “An Unexpected Reality”: “Great Expectations”; “No Time for Nursing” and “Facing the Trepidations”.</td>
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</tr>
<tr>
<td>Newton &amp; McKenna, 2007, Australia</td>
<td>Qualitative</td>
<td>Focus group interviews &amp; anecdotes</td>
<td>Voluntarily: 25 nurses in their graduate programme, 21 females, age 21-45 years old.</td>
<td>Explore how NGNs develop their knowledge and skills during their graduate programmes, as well as identifies factors assisting or hindering knowledge and skill acquisition. “Gliding through”; “Surviving”; “Beginning to understand”; “Sheltering under the umbrella”; “Knowing how to” and “We’ve come a long way”.</td>
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<tr>
<td>O'Shea &amp; Kelly, 2007, Ireland</td>
<td>Qualitative: phenomenology, Heideggerian, hermeneutic</td>
<td>Interviews</td>
<td>10 Diploma nurses</td>
<td>To explore the lived experiences of NGNs on clinical placement, during the first six months following registration, in the Republic of Ireland. “Stressful transition: multi-dimensional responsibilities associated with the new role and to managerial/organisational/clinical skills deficits - Not feeling prepared. -Positive feelings: “Feeling valued”; “making a difference” and “financial reward”.</td>
<td></td>
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<tr>
<td>Duchscher, 2008, Canada</td>
<td>Qualitative</td>
<td>Demographic Survey; Interviews, Focus groups; Questionnaires; Picture drawing; Journals &amp; ongoing e-mail communication.</td>
<td>14 female graduates from a 4-year baccalaureate nursing programme</td>
<td>To build on and mature aspects of the NGNs’ transition experience into acute care. Stages of transition: “Doing”; “Being”; “Knowing”.</td>
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<tr>
<td>Study</td>
<td>Methodology</td>
<td>Design</td>
<td>Sample Description</td>
<td>Research Questions</td>
<td>Findings</td>
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<tr>
<td>McKenna &amp; Newton, 2008, Australia</td>
<td>Qualitative:</td>
<td>Focus group</td>
<td>25 NGNs: 21 female and 4 males, age: 21-45 years.</td>
<td>To examine how nurses developed knowledge and skill in the six months following</td>
<td>“Sense of belonging”; “independence” and “moving on”</td>
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<tr>
<td></td>
<td>phenomenology</td>
<td>interviews</td>
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<td>graduation.</td>
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<tr>
<td>Rydon, et al 2008, New Zealand</td>
<td>Mixed design</td>
<td>Survey</td>
<td>Random sample: 278 registered nurses, 95.5% female, mainly 26-45 years old.</td>
<td>To explore the experiences of graduates as they initially sought employment or their</td>
<td>- 24.5% response rate.</td>
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<td>perceptions of how their ability to successfully gain employment</td>
<td>- The majority felt their nursing education prepared them well for their role as</td>
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<td>a registered nurse.</td>
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<td>Qualitative findings: “a strong need for science throughout the degree”; “longer</td>
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<td>clinical blocks”; “increased hands on experience”; “more practice with skills”</td>
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<td>and “less theory in relation to practical experience”</td>
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<tr>
<td>Scott, et al, 2008, USA</td>
<td>Quantitative</td>
<td>Survey</td>
<td>Random sample: 329 NGNs BSc/AD/Diploma, mainly female, mean age 29 years.</td>
<td>To investigate the influence of anticipatory and organisational socialisation variables</td>
<td>-54.1% were dissatisfied with their current job.</td>
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<td>on the job and career satisfaction, intent to leave their current position, turnover,</td>
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<td>and intent to leave the nursing profession.</td>
<td>-55.0% had already left their first job.</td>
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<td>-70.8% were satisfied with the career of nursing.</td>
</tr>
<tr>
<td>Wangensteen, et al (2008), Norway</td>
<td>Qualitative</td>
<td>Interviews</td>
<td>12 nurses working in hospitals and home care</td>
<td>To illuminate how NGNs’ experience their first year as a nurse.</td>
<td>“Uncertainty and chaos”; “need for induction”; “need for a supportive</td>
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<td>environment”; “need for recognition”; “awareness of responsibility”; “need for</td>
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<td>positive experiences”; “becoming experienced” and “managing challenges”</td>
</tr>
<tr>
<td>Dyess &amp; Sherman, 2009, USA</td>
<td>Qualitative</td>
<td>Pre- and post-</td>
<td>81 NGNs: Associate degree and BSc</td>
<td>To understand the learning needs and transition experiences of NGNs.</td>
<td>“Confidence and Fear”; “Less Than Ideal Communication”; “Experiencing</td>
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<td></td>
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<td>programme focus</td>
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<td>Horizontal Violence”; “Perception of Professional Isolation”; “Complex Units</td>
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<td></td>
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<td>groups</td>
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<td>Require Complex Critical”; “Decision-Making”; “Contradictory Information”</td>
</tr>
</tbody>
</table>
| **Zinsmeister & Schafer, 2009, USA** | Qualitative: phenomenology | Interviews | Purposive: 9 NGNs | To explore the lived experience of NGNs during their first 6 to 12 months of clinical nursing practice. | “Supportive work environment”; “positive preceptor experience”; “comprehensive orientation process”; “sense of professionalism” and “clarity of role expectation”.

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| **Malouf & West, 2011, Australia** | Qualitative | A series of three: in-depth interviews | 9 NGNs | To provide insight into how Australian NGNs experienced their transition to acute care nursing practice. | “Fitting in”: feeling one's self to be part of a social group, success in establishing secure and meaningful social bonds was extremely important for their sense of being. |
As summarised in Table 8, studies were mainly conducted in Western developed countries which might be relatively similar in the context of nursing education and nursing practice in general. These studies included mainly female NGNs aged between 22 to 45 years old from different educational programmes including degree, associate degree and diploma. Despite the assumption that all Western countries might be relatively similar in the context of nursing education and practice, it is acknowledged that there might be differences which might affect NGNs’ transition experience. Added to that, it is thought important to highlight the similarities and differences of NGNs transition experience in different countries. Therefore, in this literature review the setting of each study will be highlighted.

From the literature, three main themes of NGNs’ transition experience have been identified. These are:

- The negativity of the transition period.
- Stress and coping.
- Formal organisational support.
- Positive transition experiences.

These themes will be discussed individually to gain an insight of the actual experience of NGNs during their transition period. Also, studies’ methodology will be evaluated to demonstrate their quality, validity, reliability and implications for practice. Studies’ methodology will either be assessed individually when appropriate or collectively in the strength and limitation section.

### 3.1.1 The Negativity of the Transition Period

Studies emphasised the complexity of the transition experience and its direct effect on NGNs overall perception of their working environment and nursing as a profession. In spite the fact that “reality shock” was first described in the 1970s, studies still echoed the “reality shock” in NGNs experience of the transition period. Some studies referred to “reality shock” using the exact term or other alternative terms, which indicated the shock
such as feeling lost, fear and uncertainty. The unexpected reality provoked negative feelings such as anxiety, stress and frustration.

Generally some studies found that NGNs considered their transition experience to be moderately stressful (Cowin and Hengstberger-Sims, 2006; Casey, et al, 2004; Chang and Hancock, 2003; Oermann and Garvin, 2002), while other studies found that NGNs experience high levels of stress resulting in a large proportion of them leaving their jobs or intending to leave their jobs (Scott, et al, 2008; Bowles and Candela, 2005).

In the UK, many small qualitative studies consistently reported that NGNs working in hospital settings experience overwhelming stress during their transition period (Ross and Clifford, 2002; Evans, 2001; Gerrish, 2000; Holland, 1999; Maben and Macleod Clark, 1998; Kelly, 1996; Jasper, 1996). There are also studies conducted in some European countries to explore and investigate the experience of NGNs in their transition period. Kapborg and Fischbein (1998) carried out a small qualitative study in Sweden which showed that NGNs perceived their initial time at work as “quite a hard time”. Two more recent qualitative studies done in Ireland by O'Shea and Kelly (2007) and Mooney (2007) found that NGNs experienced an unexpected reality in their initial hospital workplace which was anxiety provoking. However, none of these studies provide any descriptive characteristics about the participants’ gender or age. Another qualitative study conducted in Norway by Wangensteen, et al (2008) showed that NGNs experienced uncertainty about their new role as staff nurses. This study included NGNs working in home-care where their experience might be considered different to NGNs working in a hospital setting.

Despite the differences of NGNs’ characteristics, educational curricula and the characteristics of the workplace environment, the experience of NGNs in other Western countries such as Australia, Canada, New Zealand and the USA are also described by NGNs as stressful and shocking (Malouf and West, 2011; Dyess and Sherman, 2009; Zinsmeister and Schafer, 2009; Duchscher, 2008; McKenna and Newton, 2008; Scott, et al, 2008; Schoessler, and Waldo, 2006; Rochester, et al, 2005; Kilstoff and Rochester,
2004; McKenna and Green, 2004; Chang and Hancock, 2003; Delaney, 2003; Ellerton and Gregor, 2003; Goh and Watt, 2003; Oermann and Garvin, 2002; Duchscher, 2001).

In this section, based on the current literature, different aspects related to the negativity of the transition period will be discussed in terms of themes. These themes are:

- Role Transition.
- Theory-Practice Gap.
- Lack of Competency.
- Mismatch of Expectations.
- Heavy Workload and Compromised Patient Care.
- Social Support in the Workplace.
- Social and Financial Aspects.

**Role Transition**

Some studies found that NGNs had known what was expected from them when they were students, but there were ambiguities and uncertainties about their new role as staff nurses which was stress provoking (Evans, 2001; Kelly, 1998; Maben and Macleod Clark, 1998). According to Evans (2001), it seemed for NGNs being a student had provided familiarity and security which NGNs lost by becoming staff nurses. Ambiguities and uncertainties about the role of the staff nurse and also about the working environment was found to affect NGNs’ adaption to their new role (Dyess and Sherman, 2009; Wangensteen, et al, 2008; Ellerton and Gregor, 2003; Kapborg and Fischbein, 1998; Kelly, 1998). Kelly (1998) found that the change in role from student to staff nurse resulted in role conflict which she considered a major cause of stress in NGNs’ transition experience. Some studies found that despite the fact that NGNs found their new role to be stressful, working in familiar environments helped them to adapt and enhanced their performance (Wangensteen, et al, 2008; Kapborg and Fischbein, 1998).

On the other hand, the new role of the staff nurse with its new responsibilities found to be overwhelming for NGNs. Personal accountability and avoidance of mistakes in practice
for instance found to be very worrying to NGNs (Wangensteen, et al, 2008; Mooney, 2007; Schoessler and Waldo, 2006; Kilstoff and Rochester, 2004; Goh and Watt, 2003; Oermann and Garvin, 2002; Duchscher, 2001; Gerrish, 2000; Kelly, 1996). NGNs in Schoessler and Waldo’s (2006) study stated that their sleep was disturbed worrying about what they had forgotten or left uncompleted at work. Moreover, some studies found that becoming responsible for someone’s life; dealing with issues of death and dying and concerns for patients’ safety as major stressors for NGNs (Mooney, 2007; O’Shea and Kelly, 2007; Casey, et al, 2004; Delaney, 2003; Goh and Watt, 2003; Gerrish, 2000; Maben and Macleod Clark, 1998). Some NGNs blamed their undergraduate education for not preparing them for the role of the staff nurse and how to deal with emotional stressful situations and therefore subject them to overwhelming stress, which they could not cope with (Delaney, 2003; Gerrish, 2000).

The role of nursing education in preparing NGNs for the staff nurse role will be discussed in the context of the “theory-practice gap” theme.

**Theory-Practice Gap**

Based on the literature review, there is a consistent idea that theory-practice gap is the major cause for the reality shock or stress experienced by NGNs (Maben, et al, 2006; Kilstoff and Rochester, 2004; Oermann and Garvin, 2002; Ross and Clifford, 2002; Duchscher, 2001; Evans, 2001; Heslop, et al 2001; Charnley, 1999; Kelly, 1998; Kelly, 1996). There are some concerns raised by NGNs about the theoretical material taught at college being different to nurses’ practice in the working environment. Studies showed that NGNs mainly refer to university teachings as “ideals” compared to that found at the real workplace (Maben, et al, 2006; Oermann and Garvin, 2002; Duchscher, 2001; Charnley, 1999; Kelly, 1998). NGNs participated in some studies identified “holistic care”, “quality of care” and “research-based “as ideals which are not practiced in reality (Maben, et al, 2006; Kelly, 1998).

Kelly (1998) found that the difference between ideals and realities distressed NGNs and resulted in them experiencing “lost ideals” which caused role conflict and ambiguity.
According to Kelly (1998), the degree of distress appeared to be linked to the degree of professional responsibility experienced and to the extent participants had “internalised an ideal professional self-concept”. The most persistent attributes of distress described by participants in Kelly’s study were “self-criticism” and “self-blame”.

Duchscher (2001) found in her small qualitative study in Canada, that so much of what NGNs had learnt during their education seemed different to the workplace. This resulted in NGNs trying to rigidly apply what Duchscher called “context-free” concepts to clinical situations and they were confused when they found these concepts not applicable. Those NGNs could not modify or manipulate their knowledge, and thus frequently met with “disappointments” and “disillusionments” about the relationship between their nursing education and real nursing practice.

According to Maben et al (2006), due to many organisational and professional constraints most NGNs in their study were unable to implement their educational ideals in the real working environments. In fact, a study by Ellerton and Gregor (2003) found that after three months of practice, NGNs who participated in their study were more influenced by the needs of the organisation values rather than their education ideals.

Studies discussed in this section highlight the difference between nursing education and practice in terms of theory and the fact that not all theories taught at university are practiced in reality. The theory-practice gap debate also entails a different perception between education and practice about NGN’s level of competency.

**Lack of Competency**

Despite different competency definitions and frameworks discussed in Section 1.3, the question which remains is how NGNs refer to their own competency level during their transition period and how their level of competency affects their transition experience.

Ramritu and Barnard (2001) from a qualitative study found that competence is experienced by NGNs as safe practice. Competence is mainly perceived as “limited independence” where NGNs described their limited ability to provide nursing care.
Moreover, being competent was described by NGNs, as being responsible for ensuring that all care required for their patients was provided and demonstrate the ability to seek assistance from other registered nurses in care provision. Ramritu and Barnard’s (2001) study is limited by the small sample size and there are no descriptive details given about the demographic characteristics of participants such as their gender and age as well as qualifications.

Based on the literature review, most studies showed that NGNs view competency mainly as the practical skills of the nurse, which many of them believe they lack. This lack of skills reduced NGNs confidence level in their working environments. They identified encountering new situations or procedures in their transition periods as the most stress provoking (Clark and Holmes, 2007; Mooney, 2007; O’Shea and Kelly, 2007; McKenna and Green, 2004; Ellerton and Gregor, 2003; Oermann and Garvin, 2002; Evans, 2001; Ramritu and Barnard, 2001; Charnley, 1999; Kelly, 1998; Maben and Macleod Clark, 1998; Kelly, 1996).

Maben and Macleod Clark (1998) found that NGNs in their study experienced initially feeling lost in the clinical environment. According to them, this indicates an initial lack of confidence in NGNs own abilities and skills, which was thought to be the result of unfamiliarity with their workplace. Kelly (1998) found that lack of confidence in NGNs’ clinical skills and fear of error result in a preoccupation with tasks, which provoke guilt feelings. Moreover, NGNs in Charnley’s (1999) study felt that they experienced anxiety about their lack of ability to make decisions and implement care.

O’Shea and Kelly (2007) found that NGNs in their study did not have any difficulties with what they described as the “routine clinical skills”. Yet, some specialised skills such as passing nasogastric tube challenged them. Dyess and Sherman (2009) found that 77% of the 81 nurses participating in their qualitative study in the USA worked in specialised wards. This challenged them to make “high-level critical judgment” which they often felt unprepared to undertake. This has also been found in Schoessler and Waldo (2006) phenomenological study conducted in the USA. On the other hand, Clark and Holmes
(2007) found that NGNs in their study were keen to learn specialised skills as this seemed to help them to be accepted into the team.

Some studies showed that NGNs very often confronted to deal with clinical skills requires theoretical knowledge which needs to be updated frequently and depends on the nature of the case-mix of patients such as drug administration. Despite their limited knowledge and experience, some NGNs were expected to execute these skills alone without no formal supervision or support (Dyess and Sherman, 2009; Clark and Holmes, 2007; Mooney, 2007; O’Shea and Kelly, 2007).

Most studies showed that NGNs attribute their lack of practical skills or competency to their nursing education (Ellerton and Gregor, 2003; Ross and Clifford, 2002; Duchscher, 2001; Heslop, et al, 2001; Charnley, 1999; Maben and Macleod Clark, 1998; Kelly, 1996). Duchscher (2001) found that not being confronted with the full weight of responsibility as students resulted in participants not being able to cope with increased responsibility after graduation.

Some mixed design studies conducted in the UK and Australia showed that nursing students in their final year of study felt inadequately prepared to fulfil the graduate nurse role because their clinical experience was too limited and they had inadequate opportunities to practice skills (Ross and Clifford, 2002; Heslop, et al, 2001). Conversely, NGNs participating in Maben and Macleod Clark’s (1998) and Ellerton and Gregor’s (2003) studies remarked that it was up to the individual to get as much out of the clinical courses as possible to improve their level of competency. NGNs participating in Maben and Macleod Clark’s (1998) also remarked that the theoretical management preparation in their course was good but they felt they initially needed help from clinical nurses to develop their management skills.

There is also an issue of restrictions by healthcare organisations on student nurses’ practice during clinical placements. Some NGNs referred to ethical concerns such as students’ accountability during their clinical placements restricting their learning to what they are allowed to perform under supervision (O’Shea and Kelly, 2007). Some argued
that increasing nursing students’ hands-on-practice under supervision in dealing with a broad range of skills might foster their competency and prepare them for the role of the staff nurse (Rydon, et al, 2008). However, it might be unreasonable to assume that nursing students can be competent in all nursing skills. Therefore, some argued that there is a need to tailor academic nursing programmes to the actual skills nurses practice in the real world (Boxer and Kludge, 2000).

On the other hand, studies showed that NGNs’ level of competency improved by time and there are developmental stages through which NGNs’ progress (McKenna and Newton, 2008; Wangensteen, et al, 2008; Newton and McKenna, 2007; Cowin and Hengstberger-Sims, 2006; Casey, et al, 2004; McKenna and Green, 2004; Ramritu and Barnard, 2001; Charnley, 1999; Holland, 1999). NGNs in Ramritu and Barnard’s (2001) study believed that their clinical competence had increased during the three months after graduation and they expected their competency to continue to increase with experience. Casey et al (2004) found that NGNs’ confidence significantly improved between six months to one year of practice. In Wangensteen et al (2008) study, NGNs found that they needed to work for almost a year to develop confidence in their competencies as nurses. They believed that through their experience they improved their competency when confronted with challenging situations.

Newton and McKenna (2007) in a qualitative study in Australia found that initially, NGNs focused on themselves as individuals and tried to manage their time and get tasks done. In the first six months of their practice, they faced difficulties in learning the organisational culture and establishing themselves within the hierarchy. Despite this, NGNs acknowledged that they had gained significant knowledge and skills during the first six months of their transition period that increased their confidence. McKenna and Newton (2008) followed up the experience of these NGNs after their first year of practice. According to them, after the completion of the internship programme and settlement in one ward, NGNs felt the sense of belonging as part of their practical setting. NGNs started to feel that they have developed independence in their own workplace and able to make their own decisions and carry on procedures. McKenna and Newton (2008) concluded that NGNs go through developing stages and despite difficulties they succeed
in developing independence and working as active team members. However, participants McKenna and Newton’s (2008) study had an internship programme which might have positively affected their experience. This might make their experience different from other NGNs who had not been offered similar programmes.

Studies suggest a variation of the time NGNs take to feel more confident about their competency. Cowin and Hengstberger-Sims (2006) suggested the existence of a relationship between recovering from the reality shock and NGNs’ development of competency and confidence. They found that NGNs start to gain confidence and improve their competency after recovering from reality shock. Added to that, these variations of the competency of NGNs described in different studies might arise from differences in NGNs’ working conditions and also differences in definitions and expectations of NGN’s competency.

Mismatch of Expectations

Studies showed that NGNs come to the working environment with different expectations about themselves and about their working environment. Some of these studies found that NGNs have high expectations about themselves as nurses. This made some of them work hard and feel guilty when failing to meet everyone’s needs (Mooney, 2007; Evans, 2001; Heslop, et al, 2001; Kelly, 1998; Kelly, 1996). Jasper (1996) found that NGNs in her study graduated from school with unrealistically high expectations believed to be instilled by their education curriculum. Those NGNs perceived themselves as being different or even better than other nurses trained in other courses.

Some studies showed that there was a perception held by some NGNs that experienced nurses had high expectations of their competency which resulted in them experiencing stress trying to meet others expectations (Clark and Holmes, 2007; Mooney, 2007; Goh and Watt, 2003; Evans, 2001). Evans (2001) claimed that NGNs in her study indicated that they were worried about staff not knowing they had recently qualified.

Clark and Holmes (2002) found that some ward managers have low expectations of NGNs while NGNs themselves believed that they were expected to be able to fulfil tasks
they feel ill prepared to undertake. Zinsmeister and Schafer (2009) argued that being clear about the role of the staff nurse and matching others’ expectations assists NGNs transition.

The mismatch of expectations of NGNs might be influenced by the context and conditions of the working environment.

**Heavy Workload and Compromised Patient Care**

The literature reviewed also suggests that many NGNs believed that the reality of the healthcare system contributes to the reality shock. Some studies found that many NGNs reported shortage of staff as a work reality, which increased their workload and reduced their job satisfaction (Scott, et al, 2008; Maben and Macleod Clark, 1998). Also, increased workload made NGNs feel isolated and not able to organise their patients’ care and therefore fail to meet the expectations of themselves and others (Dyess and Sherman, 2009; Schoessler and Waldo, 2006; Goh and Watt, 2003; Charnley, 1999; Kelly, 1998).

On the other hand, NGNs in many studies remarked that most of the time they are pressurised with so much routine work. This is not confined to one country as many studies conducted in the UK, USA, Australia and Canada found that NGNs are challenged to complete the routine work (Goh and Watt, 2003; Duchscher, 2001; Gerrish, 2000; Godinez, et al, 1999; Kelly, 1996). Gerrish (2000) found a difference between nurses who graduated in 1985 and those in 1998 in the way they perceived routine work. 1985 nurses felt pressurised to complete the ward routine to the extent that they described themselves as “constantly racing against the clock” to finish the tasks before the next shift, while 1998 nurses preferred to delegate work that they could not complete. Goh and Watt (2003) found that Australian NGNs also felt pressurised to complete routine work and showed reluctance to handover tasks to the next shift for fear of being labelled as incompetent. Canadian NGNs in Duchscher’s (2001) study stated that completing tasks on time allowed them to blend into the culture of the nursing unit. On the other hand, Wangensteen et al (2008) found that NGNs believed that being able to carry out the routine work has positively affected their confidence as nurses.
Some studies showed that NGNs felt that nursing work is predominately about completing routine tasks. This made NGNs’ participating in Kelly’s (1996) study feel that maintaining standards is just about doing ward routines. NGNs in Ellerton and Gregor’s (2003) study described their routine work as “organisational framework” which they needed to learn in order to organise their work.

Many studies showed that NGNs believe that increased workload and routine work restricted their time to provide basic physical care to patients and thus they had no time to communicate with patients and attend to their individual needs (Mooney, 2007; O’Shea and Kelly, 2007; Schoessler and Waldo, 2006; Ellerton and Gregor, 2003; Goh and Watt, 2003; Godinez, et al, 1999; Holland, 1999; Kelly, 1996).

Not being able to spend enough time with patients is identified by NGNs as a major source of dissatisfaction and distress and engendered feelings of guilt (Mooney, 2007; O’Shea and Kelly, 2007; Schoessler and Waldo, 2006; Kilstoff and Rochester, 2004; Ellerton and Gregor, 2003; Goh and Watt, 2003; Charnley, 1999; Godinez, et al, 1999; Holland, 1999; Kelly, 1996). However, some studies showed that some NGNs found communicating with patients and their relatives by itself to be stressful (Schoessler and Waldo, 2006; Ellerton and Gregor, 2003). On the other hand, it seems some NGNs tend to ignore the importance of nurse-patient communication and focus more on completing tasks. For example, NGNs in Ellerton and Gregor’s (2003) study described their patients by their physical signs such as the size of their veins, which indicates that these NGNs mainly focused on practical skills rather than patients’ individual characteristics. However, studies found that NGNs’ relationships with patients to be one of the significant areas which NGNs improve by time (Schoessler and Waldo, 2006; McKenna and Green, 2004).

Studies showed that working in an environment with staff shortage and increased workload and routine work had a profound effect on NGNs’ transition experience, resulting in the working environment being competitive and stressful.
**Social Support in the Workplace**

Studies showed that NGNs are increasingly seeking a supportive work environment to assist their transition (Beecroft, et al, 2008; McKenna and Green, 2004; Ross and Clifford, 2002; Heslop, et al, 2001). The availability of social support in the workplace contributed positively to NGNs’ transition experience and was related to their retention (Zinsmeister and Schafer, 2009; Beecroft, et al, 2008; Rydon, et al 2008; Wangensteen, et al, 2008; Evans, 2001). NGNs participating in Wangensteen’s et al (2008) study identified that the head nurse plays an active role in supporting them by giving positive feedback and facilitating the work.

Some studies found that during the transition period, NGNs sought to form trusting relationships with their nursing colleagues to feel accepted or fit into the work team. NGNs in Malouf and West’s (2011) study described, “Fitting in” to be important for their experience and made them feel part of the ward team. Goh and Watt (2003) found that fitting in the ward team was identified by most of NGNs as an overwhelming need and also as the key for successful transition. Nevertheless, becoming part of the ward culture and fitting in the team was dependent on adopting socially acceptable behaviours. The NGN who did not fit the image expected by others is labelled as a “bad nurse” or a “troublemaker”.

On the other hand, some studies showed that some NGNs experienced working in areas where there was lack of support from ward staff which made NGNs feel isolated and anxious (Dyess and Sherman, 2009; Schoessler and Waldo, 2006; Charnley, 1999; Maben and Macleod Clark, 1998). The lack of support from others was seen by some NGNs as a result of resistance to change by the ward staff resulting in conflict (Maben and Macleod Clark, 1998; Jasper, 1996). Some studies found that some ward nurses tend to criticize NGNs education preparation which reduced NGNs confidence in themselves (Jasper, 1996).

Furthermore, studies found that some NGNs experienced some interpersonal conflict with their colleagues, which is considered by some as a significant issue in the nursing
profession (Dyess and Sherman, 2009; Rydon, et al, 2008; Salt, et al, 2008; McKenna, et al, 2003; Farrell, 1997). McKenna et al (2003) conducted a descriptive study in New Zealand to determine the prevalence of interpersonal conflict or as they termed “Horizontal Violence” experienced by nurses in their first year of practice. They found many aspects of “violence” that NGNs encountered in their first year of practice. Many of these were covert interpersonal conflict. These conflicts had reduced NGNs confidence and self-esteem. However, some participants identified that conflicts enabled them to stand up for themselves and feel stronger (McKenna, et al, 2003).

Also, there is an issue of nurses’ negativity towards nursing which has been reported in Goh and Watt’s (2003) study. Goh and Watt (2003) found that NGNs were shocked to find nurses stating that they did not enjoy working as nurses. This was considered as one of the most negative experiences of these NGNs during their transition period. This has raised some doubts about nursing as a profession affecting NGNs’ job satisfaction.

In addition, studies showed that some NGNs experienced having problems in communicating with doctors or untrained nurses (Dyess and Sherman, 2009; Schoessler and Waldo, 2006; Casey, et al, 2004; Charnley, 1999; Kapborg and Fischbein, 1998; Maben and Macleod Clark, 1998; Jasper, 1996). According to Maben and Macleod Clark (1998), some doctors were unwilling to accept nurses as educated professionals who are entitled to have an opinion, and instead preferred to see them as “handmaidens” as described by some participants. Participants in this study were graduates of “Project 2000” which was a new programme in the UK. However, this is a relatively old study and might not be applicable to the current doctor-nurse relationship. More recent studies showed that NGNs improve their communication with doctors by the time (Schoessler and Waldo, 2006; Casey, et al, 2004).

Studies also showed that many NGNs tend to be assertive when communicating with colleagues and other healthcare professionals to avoid conflicts. This reflects their awareness of the importance of establishing social relationships in the workplace (Malouf and West, 2011; O’Shea and Kelly, 2007; Evans, 2001; Jasper, 1996). Some attributed
this assertiveness to be a result of educational undergraduate preparation (O’Shea and Kelly, 2007; Evans, 2001).

Despite the importance of social support in the workplace for the NGNs’ transition, studies showed that NGNs are sometimes confronted with resistance from other staff or even experience interpersonal conflicts.

**Social and Financial Aspects**

NGNs participating in some studies experienced stress related to personal life, family, relationships and finances (Rydon, et al, 2008; Casey, et al, 2004). Some NGNs’ experienced extreme tiredness, which had an impact on their social life (Maben and Macleod Clark, 1998). In Canada, Duchscher (2008) developed a theory about the transition period that sheds a light on the importance of socio-culture aspect of the transition period. She suggested that NGNs usually go through a process of change not only in their role but also at a socio-cultural level. In this literature review, there are few studies which highlighted the socio-cultural aspect of NGNs’ transition experience. Duchscher (2008) argued that despite its importance, the socio-cultural aspect of NGNs’ transition experience is always ignored in research. Therefore, it can be argued that the socio-cultural aspect of NGNs’ during their transition period should be studied further to determine its direct effect on NGNs’ transition experience.

3.1.2 Stress and Coping

Studies in the literature review showed that NGNs recovered from the reality shock (Cowin and Hengstberger-Sims, 2006), which had been described by Schmalenberg and Kramer (1976) as the recovery phase. However, studies also showed that it cannot be guaranteed that all NGNs will be able to recover the shock. In fact, it is evidenced that excessive stress related to reality shock or negativity of the transition period in general can influence NGNs’ level of job satisfaction and might lead to their attrition (Altier and Krsek, 2006; Bowles and Candela, 2005).
Some studies showed that NGNs tend to develop coping strategies to assist their survival in their workplaces and cope with stress during their transition period (McKenna and Green, 2004; Kelly, 1998; Jasper, 1996). Kelly (1998) found that NGNs in her study developed and adopted what she described as “defence mechanisms”. These are as listed by Kelly (1998) “leaving the unit in search of better conditions”; “decreasing the stress by working fewer hours”; “dropping out of nursing”; “blaming nursing administration”; “blaming the hospital system”; “excusing one’s actions” and “avoiding patient interaction”. These defence mechanisms mainly reflect dissatisfaction and attrition out from the organisation or even from nursing. Chang and Hancock (2003) described four factors that explained the types of strategies employed by NGNs in their study to cope with stress in the transition period. These are “adopting alternative activities to reduce stresses”, “wait and see”, “deal with the problem” and “negative activities”.

It seems not all coping strategies adopted by NGNs in the transition period are constructive and help them to remain in the nursing profession. In fact, the studies discussed above showed that NGNs might adopt maladaptive strategies in coping which ultimately might increase their burnout resulting in attrition. As discussed in Section 1.4, health organisations worldwide realised the importance of providing formal support to NGNs to retain them into their organisations and reduce the cost of nurses’ turnover.

### 3.1.3 Formal Organisational Support

Studies showed that many NGNs regard formal support programmes to have a positive effect on their transition experience. For example, working with preceptors assisted NGNs to cope with learning and adapting to their new role (Zinsmeister and Schafer, 2009; Clark and Holmes, 2007; Goh and Watt, 2003; Ross and Clifford, 2000; Gerrish, 2000). Yet, some studies found that there was inconsistency of preceptors’ provision of support, which was distressing for NGNs and made them feel lost in the workplace (Clark and Holmes, 2007; Gerrish, 2000). Some preceptors were overloaded by supporting both nursing students and NGNs at the same time which allowed them little time to spend with their preceptees (Clark and Holmes, 2007). Also, shortages of staff and increasing high dependency of in-patients affected the time preceptors have to
support preceptees (Charnley, 1999). Moreover, some NGNs failed to develop a supportive relationship with their preceptors. This affected their interaction with their preceptors which consequently increased NGNs stress rather than reduce it (Ross and Clifford, 2002).

Despite the challenges NGNs faced during their transition period and their need for support, there are also some studies, which shone a light on the positive side of the transition period.

3.1.4 Positive Transition Experiences

In most studies discussed in this chapter, some NGNs reported positive experiences during their transition period. Studies showed that there is a sense of pride, excitement and achievement expressed by NGNs about the role of the nurse (Zinsmeister and Schafer, 2009; Oermann and Garvin, 2002; Maben and Macleod Clark, 1998). There were some positive financial and status aspects of getting paid and becoming qualified nurses (O’Shea and Kelly 2007; Goh and Watt, 2003; Evans, 2001; Maben and Macleod Clark, 1998). Moreover, developments in competency, personal growth and positive support from colleagues contributed in making NGNs’ transition experience a positive one (O’Shea and Kelly 2007; Goh and Watt, 2003; Maben and Macleod Clark, 1998). The relationship with patients was regarded by NGNs as an important satisfying aspect of their experience (O’Shea and Kelly, 2007; Jackson, 2005; Goh and Watt, 2003; Maben and Macleod Clark, 1998). In Evans (2001) and Maben and Macleod Clark (1998) studies, NGNs linked their positive experience to their academic education, which they believed prepared them to be more assertive in their way of handling their practice.

While almost all studies discussed in this chapter focused on illustrating the complexity of the transition period, Jackson (2005) carried out a study in the UK to explain what constituted a “good day” for NGNs. Jackson (2005) identified five main themes from the data analysis. These were; “doing something well”; “good relationships with patients”; “feeling that you have achieved something”; “getting the work done” and “you need team work”. According to her, performing highly skilled practice made NGNs experience of
the day a positive one. It seems others’ acknowledgment of NGNs good performance increased their satisfaction about themselves. Participants in this study also identified getting along with everybody and working with “nice” people as important parts of the good day and fostered their sense of belonging to the team.

Jackson (2005) claimed that in her study, NGNs gained a sense of achievement from completing the work and having a sense of control. Also, knowing what needed to be done for their patients and understanding their care played a significant part in how the day was viewed. Jackson (2005) concluded that “wonderful feeling” at the end of the day has a positive impact on nursing satisfaction and therefore their retention into practice. However, in Jackson’s study, participants were all members of an internship programme that aimed to develop clinical confidence and competency which might have positively influenced their experience.

Studies showed a strong relationship between positive experiences and positive feelings towards nursing. Therefore, it can be argued that in order to retain NGNs into the nursing profession, there is a need to increase their positive experiences in their transition period.

3.2 Strength and Limitation of the Nursing Literature

Both qualitative and quantitative studies about the experience of NGNs were reviewed in this chapter. The qualitative studies reviewed utilised mainly descriptive, grounded theory or phenomenology approaches. Qualitative studies are considered important in the early stages of exploring a new field of study to gain knowledge and understanding of the filed (Denzin and Lincolin, 1998).

Despite the descriptive and rich knowledge about NGNs’ transition experience provided by the qualitative studies, most of them have some methodological pitfalls, which affected their rigour. Many of them are limited by the relatively small sample size such as Kelly (1996), Jasper (1996), Kapborg and Fischbein (1998), Kelly (1998), Maben and Macleod Clark (1998), Charnley (1999), Duchscher (2001), Evans (2001), Ramritu and Barnard (2001), Goh and Watt (2003), Kilstoff and Rochester (2004), McKenna and Green (2004), Mooney (2007) and O’Shea and Kelly (2007) studies. On the other hand,
studies like Gerrish (2000), Clark and Holmes (2007) and Newton and McKenna (2007) were exceptions in their sample size. However, small sample size in qualitative study might not affect its rigour if it answers the research question. Moreover, in qualitative studies, the sample size is determined by data saturation where data collection reveals no new data (Marshall, 1996).

On the other hand, the sampling methods of some of the studies posed some questions of how representative are the study participants to the population of NGNs. Qualitative studies discussed in the literature review mainly referred to using convenience and purposive sampling methods in the selection of their participants. Convenience sampling is usually used to select the most accessible participants. It saves researchers’ time and effort (Marshall, 1996). However, convenience sampling might also induce sample bias in getting general ideas about the specific experience of a specific number of NGNs such as in Maben and Macleod Clark’s (1998) study.

Using purposive sampling indicates that the characteristics of individuals are used as the basis of selection of participants and therefore, researchers usually search for contrasting participants to represent the diversity of the sample population (Coyne, 1997). However, a purposive approach might induce sampling bias where researchers might select people who are known by them to have specific experiences. For example, the sampling bias induced in Goh and Watt’s (2003) study by selecting a purposive sampling of five nurses who volunteered to participate. Those five nurses had just finished their residency programme in a private hospital in Australia. Add to the relatively small sample size, those nurses had almost the same qualifications and work experience, which might have affected their transition experience.

Furthermore, there are some studies that were not explicit about their sampling method or even the number of participants such as Schoessler and Waldo’s (2006) study. In addition, some studies did not provide any descriptive account of the characteristics of the participants (Clark and Holmes, 2007; Mooney, 2007; O’Shea and Kelly, 2007; McKenna and Green, 2004; Evans, 2001; Ramritu and Barnard, 2001; Maben and
Macleod Clark, 1998). Providing descriptive details about the sample should help the reader to decide if the study findings are transferable to his/her setting.

In addition, studies have utilised different methods of data collection such as individual face-to-face interviews (Mooney, 2007; O’Shea and Kelly, 2007; Goh and Watt, 2003; Duchscher, 2001; Gerrish, 2000; Charnley, 1999; Kelly, 1998; Maben and Macleod Clark, 1998; Kelly, 1996), telephone interviews (Kilstoff and Rochester, 2004), focus group interviews (Newton and McKenna, 2007; McKenna and Green, 2004; Evans, 2001; Jasper, 1996), diaries (Kapborg and Fischbein, 1998), anecdotes and drawing (Newton and McKenna, 2007; Ramritu and Barnard, 2001), document analysis (Godinez, et al, 1999) and observation (Holland, 1999).

Interviews are regarded as the favourite methodological tool of qualitative studies (Denzin and Lincoln, 1998). There are different types of interviews including individual face-to-face interview, focus group interview and telephone interview. Face-to-face individual interviews have the potential to uncover and represent unobserved feelings and events (Simons, 2009) while focus group interviews are believed to reveal issues not apparent in individual interviews through dynamic interactions between participants with the same experience (Gillham, 2005). However, interviews are not a neutral tool as they are influenced by the personal characteristics of the interviewer and his/her values (Denzin and Lincoln, 1998; Morgan, 1997). In focus group interviews some participants can dominate the discussion and therefore, one person’s experience can affect the interaction of other members. Some studies such as in Kilstoff and Rochester’s (2004) used telephone interviews which is an option when face-to-face interview is not possible. However, telephone interviews might hinder many aspects of non-verbal communication cues and affect the level of interaction and exploration of the topic under study. Furthermore, in general individual and focus group interviews are frequently criticised as self-reported data (Morgan, 1997).

On the other hand, some studies utilised diaries, information sheets and anecdotes for data collection which has the strength of providing frequent reports on the events and experiences of people’s daily lives (Newton and McKenna, 2007; Godinez, et al, 1999;
Kapborg and Fischbein, 1998). Diaries are thought to be beneficial in studying changing processes (Bolger, et al, 2003). The diary studies must achieve a level of participants’ commitment in order to obtain reliable and valid data which might be difficult to achieve (Bolger, et al, 2003). Not all participants in Kapborg and Fischbein’s (1998) study for example were able to maintain consistency in their diaries. Furthermore, participants might be selective in what they want to write in their diaries which might also induce bias.

Some studies used a retrospective approach in data collection, such as Kelly (1996) who interviewed nurses four years after graduation. This might had influenced their recalling of their experience about the transition period and caused retrospective bias.

There are some quantitative studies which provided data that concur with the findings of qualitative studies (Scott, et al, 2008; Cowin and Hengstberger-Sims, 2006; Bowles and Candela, 2005; Chang and Hancock, 2003; Oermann and Garvin, 2002). There are also some studies that used a mixed design approach that strengthen their methods of data collection and therefore their generalizability of findings (Rydon, et al 2008; Casey, et al, 2004; Ross and Clifford, 2002). However, there are also some methodological pitfalls identified in these studies. Some of them have small sample size, which made them statistically un-representative of the whole population under study (Rochester, et al., 2005; Oermann and Garvin, 2002; Ross and Clifford, 2002). Some studies included participants who are from the same organisation or university which might have influenced participants’ responses and therefore, affected the validity of findings. In addition, some studies relied on self-reported data that only reflects participants’ perceptions but does not always reflect reality. Moreover, some studies’ findings were limited by a decreased response rate and attrition with time, resulting in fewer participants at some stages of the study (Rydon, et al, 2008; Bowles and Candela, 2005; Casey, et al, 2004). For example, there was only 11.4% response rate to Bowles and Candela’s (2005) study. This means that the sample studied is not representative for the whole population, which potentially affected the external validity of the results.
On the other hand, Boxer and Kludge’s (2000) and Rochester et al (2005) studies used existing questionnaires, which their validity and reliability were already assessed. Yet, in both studies there were minimal changes made to the questionnaires, which were not tested. It was assumed by the researchers that since only minor amendments were made to the questionnaires, neither their validity nor reliability was compromised. Also, the instrument for data collection used in Casey et al (2004) was under development, which might have affected its reliability and validity.

Despite the limitations of the studies discussed in this chapter, they provided collective and consistent evidence of the complexity of NGNs’ transition experience.
3.3 Summary

Findings from both qualitative and quantitative studies carried out in different Western countries are consistent on the complexity of the transition period. There is a general theme of reality shock experienced by NGNs in the transition period caused by different reasons. Some of these reasons identified are “role transition”; “theory-practice gap”; “lack of competency”; “mismatch of expectations”; “working conditions and compromised patient care”; “social support” and “social and financial aspects”.

NGNs’ academic preparation and expectations of the workplace affected their adaptation to the practical environment. NGNs are expected to socialise into the context of nursing practice, to become accountable for patient care and ward activities and develop their own clinical expertise. This might also have an impact on their adaptation to the new environment as well as to their professional and practical development.

Nursing education is blamed by NGNs for not preparing them for the reality of the workplace. Moreover, there are some issues about NGNs’ lack of competency and clinical skills, which concur with the theory-practice gap debate. Lack of skills and the reality of the challenging and stressful workplace resulted in NGNs having limited time to care for their patients.

Some NGNs adopted coping strategies to survive in the workplace but these were not always constructive. All studies agreed on the importance of formal organisational support offered in the transition period as a positive aspect. However, there is inconsistency in the provision of this support, which adversely affected NGNs’ experience.

It is evident from the literature that the challenges of the transition period are usually short lived and many NGNs pass the shock period. The transition period is not merely about negative experiences as NGNs also experienced some positive aspect during their transition period.
Studies’ findings suggest that the educational curriculum and the clinical and organisational environment mainly influenced the transition experience of NGNs. Therefore, both education and practice share the responsibility of easing the transition period, overcoming its negative aspects and assisting in the professional development of NGNs.

The literature review gives an overview about the experience of NGNs in their transition period in Western countries. Exploring the experience of NGNs in the transition period may assist in tackling its negativity and identifying NGNs’ needs. This may ultimately improve the provision of support for NGNs and reduce their burnout and therefore increase their retention into the nursing profession. However, all the literature available about the transition experience of NGNs is from Western countries and there is no data available about the transition experience of the NGNs in any developing country. Thus, this research aims to study the transition experience of NGNs in one of the developing countries, the Sultanate of Oman.
Chapter Four- Study Design and Methods

In the view of the fact that most studies to date have taken place in Western countries, the literature review findings discussed in Chapter three might not reflect the experience of NGNs in developing countries such as the Sultanate of Oman. As discussed in Chapter two, the context and the development of the nursing profession and the nursing education in the Sultanate of Oman are different to those in the Western countries. Therefore, Omani NGNs might have a different experience compared to their counterparts in the Western countries.

The main question posed by this research study is:

“How do Omani newly graduated baccalaureate nurses experience their first year of work -the transition period- in the Sultanate of Oman?”

This study will focus on exploring newly graduated baccalaureate nurses from Sultan Qaboos University (SQU) College of Nursing who are working at one health organisation, Sultan Qaboos University Hospital (SQUH). The reasons for choosing this group of participants will be explained later.

Two major over-arching aims guided the study enquiry. There are also some specific objectives identified for each aim. These are:

1- Explore the experience of SQU New Graduate Nurses (NGNs) during their transition period in the contextual setting of SQUH.

- Identify SQU NGNs’ expectations and perceptions about their new role as staff nurses.
- Explore the experience of SQU NGNs role transformation.
- Explore the effect of SQUH working environment on SQU NGNs’ transition experience.
- Explore SQU NGNs’ experience dealing with different healthcare professionals and its effect on their transition.
- Identify the support provided for SQU NGNs during their transition period and its effect on their experience.
- Explore the facilitators and/or challenges faced by SQU NGNs during their transition experience at SQUH.
- Follow up SQU NGNs in their first year of work at two different points of time to identify any changes in their experience.
- Explore the effect of the transition experience on NGNs’ commitment to the organisation and the profession.
- Explore the expectations and perceptions of head nurses, preceptors, and nursing managers about SQU NGNs.

2- Explore the effect of the nursing education on the transition experience of SQU NGNs and how studying and working at the same organisation affected their transition.

- Elicit SQU NGNs and student nurses’ (SNs) motives to study nursing at SQU.
- Explore the attitudes and perceptions of SQU NGNs and SNs about their undergraduate preparation for the role of the nurse.
- Explore perceptions, attitudes and expectations of SQU SNs about the role of the staff nurse.
- Explore the expectations and perceptions of academics about the preparedness and readiness of SQU SNs for the role of the staff nurse.

4.1 The Research Methodology or Design

Research methodology or design is the backbone of the study that links research questions to data collection methods and ultimately to a conclusion (Yin, 2003). A qualitative design is used to explore SQU NGNs’ transition experience.

4.1.1 The Qualitative Design

The qualitative design was used because it is appropriate to explore SQU NGNs transition experience into the contextual setting of SQUH. It enabled the researcher to
make sense of reality and assists in exploring and describing SQU NGNs’ experience. Furthermore, this is a new topic which relatively little is known about and using the qualitative design helped the researcher to “get under the skin” (Gillham, 2000, P.11) of SQU NGNs’ real transition experience.

The qualitative study design has other characteristics which made it an appropriate design to meet the study aims and objectives (Box 1).

**Box 1 Characteristics of the Qualitative Design**

<table>
<thead>
<tr>
<th>Characteristics of qualitative studies (Creswell, 2003; Munhall, 2001; Gillham, 2000; Hall and Hall, 1996; Morse and Field, 1996; Stake, 1995):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A holistic approach recognising that human realities are complex.</td>
</tr>
<tr>
<td>• Focus on human experience within their context.</td>
</tr>
<tr>
<td>• Provide in-depth understanding of how people make sense of their experiences.</td>
</tr>
<tr>
<td>• Utilise interactive data collection methods that involve active participation and discussion.</td>
</tr>
<tr>
<td>• It is flexible and allows new findings to emerge during the study.</td>
</tr>
</tbody>
</table>

4.1.2 The Case Study Research

An organisational qualitative case study research was adopted to meet the study aims and objectives. In this section, the rationale for selecting the case study research for the purpose of this study will be explained by given an overview of the case study research including its characteristics, definitions, and types. Its strength and limitations will also be outlined.

**An Overview of the Case Study Research**

The case study research is increasingly used in nursing. In the literature, the term “case study” has been used to denote a research design, a research method, a research strategy, a data collection method as well as a teaching technique (Anthony and Jack, 2009). The term “case study” shares many similarities with other research methodologies and designs, which makes it confusing for many (Appleton, 2002). Some researchers argued that case study research does not fit the criteria to be described as a research method, a
strategy or a design (VanWynsberghe and Khan, 2007). Nevertheless, many authors believed case study research has specific characteristics, which differentiate it from other research designs or methods and make it valuable (Yin, 2009; Baxter and Jack, 2008; Gillham, 2000; Stake, 1995). Case study research specific characteristics will be highlighted.

**Defining Case Study Research**

There is no clear and concise definition for the case study research in the literature. Gillham (2000) made an attempt to define what a case study is. He defines it as the “one which investigates:

- A unit of human activity embedded in the real world;
- Which can only be studied or understood in context;
- Which exists in the here and now;
- That emerges in with its context so that precise boundaries are difficult to draw;

to answer specific research questions and which seeks a range of different kinds of evidence, evidence which is there in the case setting, and which has to be abstracted and collected to get the best possible answers to the research questions” (Gillham, 2000, P.1-2).

On the other hand, Yin (2003; 2009) provided a “technical definition” of case studies divided into two parts. According to Yin (2009, P. 18): “

1- A case study is an empirical inquiry that:

- Investigates a contemporary phenomenon within its real-life context, especially when
- The boundaries between phenomenon and context are not clearly evident.
2- The case study enquiry:

- Copes with the technically distinctive situation in which there will be many more variables of interest that data points, and as one result
- Relies on multiple sources of evident, with data needing to converge in a triangulating fashion, and as another result
- Benefits from the prior development of theoretical propositions to guide data collection and analysis”.

This definition is merely technical and the importance of in-depth inquiry of the case study is not emphasised. In addition, the definition concentrates more on the deductive quantitative approach of enquiry, about testing propositions or hypothesis more than the inductive qualitative method.

Simons (2009) in her practical guide t conducting case study defined case as “an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institutions, programme or system in ‘real life’ context. It is research-based, inclusive of different methods and evidence. The primary purpose is to generate in-depth understanding of a specific topic, programme, policy, institution or system to generate knowledge and/or inform policy development, professional practice and civil or community action” (Simons, 2009, P. 21). However, Simons’ (2009) definition narrowed the utilisation of case study to specific settings only.

VanWynsberghe and Khan (2007) also made an attempt to create a precise and concise definition of the case study research. According to them, a case study is “a transparadigmatic\(^1\) and transdisciplinary\(^2\) heuristic that involves the careful delineation of the phenomena for which evidence is being collected (event, concept, program, process, etc.)”. VanWynsberghe and Khan attempted in their definition to include all the main characteristics of case study and at the same time clarify the myths about case study research.

\(^1\) Case study is relevant regardless of one’s research paradigm.
\(^2\) Case study has no particular disciplinary orientation.
As identified from different definitions, the case study research is used to explore and understand the particularity, complexity and uniqueness of individuals or organisations in their real context. It focuses only on studying contemporary events and utilise a multi-method approach (triangulation). Triangulation means that different methods are used in collecting data to ensure the issue is explored through a variety of lenses. This is believed to allow for multiple aspects of the phenomenon to be discovered and understood (Baxter and Jack, 2008; Yin, 2003; Gillham, 2000). Triangulation might not be specific to case studies, but in case studies it is used to provide more in-depth and specific relevant information about the case (Walshe, et al, 2008). Therefore, using case study research in studying SQU NGNs’ experience working at SQUH required relevant data to be collected from different resources utilising different methods to understand the setting and the culture of the organisation and how this affected SQU NGNs’ transition experience.

**Types of Case Study Research**

There are different terms used to describe a variety of case study research and there are many types of case study research identified by many authors. It is thought that understanding the difference between the types of case study research helps identify the methods to be used in collecting data (Simons, 2009; Stake, 1995). For the purpose of this study, the different types of case study described by Yin and Stake will be outlined. Yin (2003) has identified three specific types of case studies (Table 9).

**Table 9 Yin’s Types of Case Study**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanatory</td>
<td>To answer a question that requires explanation of a complex real-life intervention.</td>
</tr>
<tr>
<td>Exploratory</td>
<td>To explore situations in which an intervention under evaluation has no clear or specific outcomes.</td>
</tr>
<tr>
<td>Descriptive</td>
<td>To describe an intervention and its own context.</td>
</tr>
</tbody>
</table>
Yin (2003) further divided case study research into different designs (Table 10).

**Table 10 Yin’s Different Types of Case Study Designs**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic single case designs</td>
<td>Single case with single unit of analysis.</td>
</tr>
<tr>
<td>Embedded single case designs</td>
<td>Single case with embedded (multiple) unit of analysis.</td>
</tr>
<tr>
<td>Holistic multiple case designs</td>
<td>Multiple cases with single unit of analysis.</td>
</tr>
<tr>
<td>Embedded multiple case designs</td>
<td>Multiple cases with embedded (multiple) unit of analysis.</td>
</tr>
</tbody>
</table>

The unit of analysis refers to the actual source of information for the case studied (Yin, 2003). Yin (2003) considered defining the unit of analysis as a major step in the process of designing and conducting case study.

On the other hand, Stake (1995) focused more on qualitative case study designs. He identified case study types directed by the purpose of the case study as shown in Table 11.

**Table 11 Stake Types of Case Studies**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic</td>
<td>Used when the researcher has intrinsic interest to learn about a particular case.</td>
</tr>
<tr>
<td>Instrumental</td>
<td>Used to understand more than what is apparent and provide an insight into an issue.</td>
</tr>
<tr>
<td>Collective</td>
<td>Multiple case study</td>
</tr>
</tbody>
</table>

**Defining the Case**

As shown above, the types of case study research proposed by Yin and Stake depended mainly on the purpose of studying particular cases and the number of cases included in one’s research. According to Stake (1995), the case is chosen based on what one can learn from that specific case. Some considered defining the case as the most important step in conducting qualitative case study research (McKee, 2006). Defining the case involves defining boundaries that separate some aspects of the case to make it distinct.
Moreover, it is argued that binding the case to one organisation for example will ensure that the study remains within a reasonable scope and data can be managed (Baxter and Jake, 2008).

**Limitations of Case Study**

Despite the merits of using the case study research to explore the experience of SQU NGNs’ transition, there are some doubts about the quality of the evidence provided by case studies (Yin, 2009; Simon, 2009; VanWynsberghe and Khan 2007). Case studies are heavily criticised for their lack of rigour as previously case study researchers failed to report the findings in a systematic manner, which was believed to induce bias (Yin, 2009). However, Yin (2009) argued that bias and lack of rigour can also exist in other research types and it is not confined to case study research. Furthermore, case studies have been criticised for their lack of generalizability. Yin (2009) remarked that case studies are not generalizable to population instead they are generalizable to “theoretical propositions”. He furthers argued that the case study research case is not different to experiment for example because usually it is difficult to generalize from a single experiment results.

**The Rationale for Selecting Qualitative Case Study Research**

Most of the qualitative studies discussed in Chapter three focused on exploring the transition experience of NGNs who graduated from the same nursing curriculum and worked at the same organisation. Most of these studies reported the experience of NGNs from one perspective only using one method of data collection. These studies did not fully explore the effect of the actual contextual setting of the working environment or the nursing education on NGNs’ transition experience. It can be argued that applying the same study strategies might not add much as the study might explore the transition experience of NGNs in general from one aspect and fail to draw a clear picture about the role of education and working environment context on NGNs’ transition experience. For the purpose of this study, the qualitative case study research offered the opportunity to
understand the complexity of SQU NGNs’ transition experience and allowed holistic exploration of individualised and specific characteristics.

As mentioned earlier, Yin and Stake are the two main writers on case study methodology. This case study mainly utilised Yin’s approach to case study when defining the case and its context. This is mainly because Yin’s provision of a technical definition of the case makes it easier for the novice case study researcher to understand what the case is and be able to define it. Yin gives a clear distinction between different types of case study and shows how different sources of data and methods of data collection can be integrated in order to fully explore the case under study. On the other hand, Stake’s definition and descriptions of types of case study are more general accounts which do not provide clear guidance for novice researchers as to how to undertake case study research.

The case and its context

The case identified for this study is “SQU NGNs’ transition experience working at SQUH” (Figure 5; 6). SQU NGNs are a distinct group compared to other Omani NGNs because they are graduates of the first baccalaureate programme in nursing in Oman. SQU is unique in that it trains students from different regions in Oman, which means that a proportion of SQU NGNs are originally from outside Muscat. Therefore, exploring the experience of SQU NGNs means that this study will include NGNs from different areas in Oman. At the time of this study, NGNs graduating from SQU work exclusively at SQUH. SQUH is a governmental university teaching hospital and is considered an important and prestigious hospital in Oman. It is distinct from other governmental hospitals in Oman in that it comes under the organisational control of a university. Thus, it has a different budget scheme to the MoH hospitals.

Figure 5 The Case

SQU NGNs’ Transition Experience working at SQUH
Using the embedded design entails utilizing “units of analysis” which are the data sources to explore SQU NGN’s transition experience at SQUH. These were determined by the aims and objectives of the study. To achieve the first aim of the study of exploring SQU NGN’s transition experience in the contextual setting of SQUH, the main source of data used to explore the case are SQU NGNs from the June 2009 and January 2010 cohorts during their transition period working at SQUH. After graduation, SQU NGNs usually join a six months internship programme at SQUH. Other key data sources included NGNs who have just joined their internship programme and those who have just finished their internship programme but still within their first year of experience. In order to explore SQU NGNs’ transition period, from a variety of perspectives those who worked and interacted with SQU NGNs during their transition period were also included. In addition, key informants who were part of SQUH organisational context and working environments were included. Key informants identified for this study included preceptors, head nurses and managers.
To meet the 2nd aim of the study, the influence of education on NGNs’ transition experience was investigated by including students, clinical instructors and a manager from the College of Nursing in the units of analysis. Relevant documents and events related to the internship programme of SQU NGNs during their transition period were considered as important sources of information to enrich the case. Policies and regulations relevant to SQU NGNs during their transition period were also considered as having an effect on SQU NGNs transition experience working at SQUH.

Studying SQU NGNs’ transition experience working at SQUH only as a single case was a pragmatic decision given limited resources and time. Furthermore, focusing on SQU NGNs’ experience at SQUH as a single case served the longitudinal purpose of studying their experience at different time points during their transition period (Creswell, 2003).

4.2 Conducting the Case Study

In case study research, it is argued that the methodology, which answers the research question and directs the data method collection, should be determined “pragmatically rather than paradigmatically” (Rosenberg and Yates, 2007).

In this section, the actual methods of conducting the study will be outlined. This includes; the ethical concerns, gaining access, sampling and recruitment, data collection and analysis (Figure 7).
Figure 7 Stages of the Case Study

Organisational Qualitative Case Study: Embedded Single Case

Single Case: SQUH  
Sub-units: NGNs, HN, P, M, CI & SNs

Obtaining Ethical Approval

Gaining Access to Site & Participants

Recruitment (Purposive Sampling)

Presentations  
Sending Invitation Letters  
Distributing PIS

1st stage of Data Collection (Triangulation)

Interviews: NGNs, M, HNs, P & CI  
Focus group: students  
Observation notes  
Relevant document analysis

2nd Stage of Data Collection

2nd Interview with NGNs  
Observation notes  
Relevant document analysis

Analysis

Transcribing: Verbatim  
Analyse: Microsoft Access  
Comparing and Contrasting  
Writing up analysis report
4.2.1 Ethics

Ethical approval for the study was obtained from the Committee on the Ethics of Research on Human Beings at the University of Manchester, 2010. The key ethical principles highlighted by the committee were informed consent, confidentiality and minimisation of harm.

**Autonomy and Informed Consent**

Respecting the autonomy of participants by requiring informed consent is a basic ethical requirement for conducting this case study. Potential participants who showed interest to the study were given invitation letters and a Participant Information Sheet (PIS) which outlined relevant information about the researcher, their role as participants and how their data would be handled (Appendix 8 & 10). The right of autonomy of participants to agree or refuse to participate or even withdraw from the research at any stage was outlined in the PIS. It was made clear to all participants that participation is entirely voluntary. After given them the PIS, participants were given one to two weeks’ time to make an informed decision about their participation. Then, potential participants who agreed to participate were given consent forms to sign before been interviewed (Appendix 9). There are different PIS and consent forms designed for each group of participants. Participants from the NGN group were informed about the 2nd phase of the study where if they agreed another interview would be conducted with them.

**Confidentiality**

Confidentiality is another key ethical issue for the study. In exploring individualised data, confidentiality can be maintained by maintaining privacy and anonymity (Simons, 2009). Efforts and measures were undertaken to maintain participants’ confidentiality through the process of recruitment, data collection, analysis and reporting of findings.

For the purpose of maintaining confidentiality, all participants’ records (both audio and transcripts) were kept anonymous by removing names and other identifiers. Codes were given for each group of participants such as “NGN” for the NGNs group. Furthermore,
each participant within the group was given a number. For example, NGNs were coded as NGN1, NGN2 and so on. Also, only the researcher transcribed all interviews. In addition, strict anonymity was applied by avoiding the use of quotes which have a direct connection to a person or the use of personal information and/or traits. Although, this study included participants from the same organisation, it is thought that selecting participants from different groups and from different wards at SQUH should assist in maintaining confidentiality. In fact, the participants did not know who participated in the study from their wards or from their colleagues.

After finishing data collection, audio records were kept anonymous by using codes while transferred from Oman to the UK. Data will be kept for five years once the study is completed in line with the University of Manchester guidelines.

**Minimisation of Harm**

The ethics committee had shown a concern about the distress policy, which might be available for referral for the study participants and the researcher during carrying out the study. It was made clear to the ethics committee that there are no counselling services available for healthcare professional working at SQUH. There is also no GP referring system in place in Oman, but there is student-counselling service at SQU. Referring distressed participants to student counselling services was considered because they were recent graduates. Yet, there was no incident of major distress expressed by any participant during the process of data collection.

On the other hand, harm of embarrassment or distress to participants was minimised by ensuring that privacy and confidentiality is maintained. All interviews were conducted in a private office, which is located at SQUH outpatient department to ensure privacy and maintain confidentiality. In addition, participants were given the freedom to choose the time of the interview based on their convenience time. Participants were also given the freedom whether to inform their seniors of their participation.
Furthermore, the ethics committee insisted on considering participants’ complaints in the distress policy. The complaints procedure was made explicit and described in detail in the PIS for each group of participants.

4.2.2 Gaining Access to SQUH

Gaining access into the research site is considered a crucial step in carrying out a research (Creswell, 2003). Prior to the conduction of this study, the researcher was a staff working at SQUH. She was familiar with the context of SQUH, which helped her in gaining access and planning data collection. To gain access to SQUH, the University of Manchester ethical approval with a summary of the study proposal was submitted to the Office of the Advisor for Academic Affairs, at SQU. The Advisor issued an approval letter to conduct the study at SQUH. This letter was also used to gain access to participants at SQU College of Nursing.

4.2.3 Sampling

Sample selection in qualitative studies is important and has a profound effect on the ultimate quality of research (Coyne, 1997). Purposive sampling is normally the best option for case studies to gain an in-depth understanding of the case. Purposive sampling is a form of non-probability sampling where resources of data are selected by the researcher on the basis of emerging theoretical concerns (Simons, 2009). Using purposive sampling demands the researcher to select specific resources including selecting participants or documents in order to meet the study aims and objectives. This requires the researcher to use critical thinking in identifying potential participants and data that might enhance the findings of the study (Silverman, 2005; Russell and Gregory, 2003).

As discussed earlier, studying the experience of SQU NGNs in the contextual setting of SQUH serves the purpose of exploring the experience of a distinct group of NGNs. To draw a comprehensive picture and gain an in-depth understanding of SQU NGNs’ experience in the contextual setting of SQUH, a purposive sample from SQU NGNs and others directly interacting with them was selected. Table 1 illustrates the different groups of participants and the rationale for including them.
<table>
<thead>
<tr>
<th>Group</th>
<th>Inclusion criteria</th>
<th>Rationale</th>
<th>Time line</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGNs</td>
<td>NGNs working in adult female, male and paediatric Haematology/Oncology, ICU and general (medical and surgical) wards.</td>
<td>To capture the different experiences of NGNs working under different working conditions and in different wards.</td>
<td>January-May 2010</td>
<td>15 NGNs: 10 NGNs who had just completed their internship programme. 5 NGNs who had just finished their nursing curriculum and join the internship programme.</td>
</tr>
<tr>
<td></td>
<td>Include both male and female NGNs</td>
<td>To explore similarities and differences of the experience of both, female and male NGNs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two cohorts of NGNs; January and September cohorts.</td>
<td>To compare and contrast the experience of the two cohorts of NGNs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NGNs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same group of NGNs followed up at another set of time.</td>
<td>To capture NGNs transition experience at two points of time.</td>
<td>September and October, 2010</td>
<td>9 NGNs: 6 NGNs who had just finished their first year of practice. 3 NGNs who have just finished their internship programme.</td>
</tr>
<tr>
<td>Student nurses (SNs)</td>
<td>SQU nursing students during their “advanced clinical course”.</td>
<td>To explore student nurses’ expectations and perceptions of the role of the staff nurse and the working environment.</td>
<td>January-May, 2010</td>
<td>8 Student nurses.</td>
</tr>
</tbody>
</table>
To explore the readiness of student nurses for the role of staff nurse. To explore their experience during their clinical placements.

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
<th>Goal</th>
<th>Time Period</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptors (P)</td>
<td>Preceptors who had experience supervising SQU students and NGNs.</td>
<td>To understand preceptors’ role and its effect on SQU NGNs’ transition experience.</td>
<td>January- May, 2010</td>
<td>6 Preceptors</td>
</tr>
<tr>
<td>Clinical Instructors (CI)</td>
<td>Clinical instructors who supervise SQU students during their clinical placements, advanced clinical course in particular.</td>
<td>To explore clinical instructors’ expectations and perceptions of their students’ preparation for the role of the staff nurse.</td>
<td>January- May, 2010</td>
<td>5 Clinical instructors</td>
</tr>
<tr>
<td>Head Nurses (HN)</td>
<td>Head nurses from the same wards where NGNs participated.</td>
<td>To explore the expectations and perceptions of head nurses about SQU NGNs.</td>
<td>January- May, 2010</td>
<td>5 Head nurses</td>
</tr>
<tr>
<td>Managers (M)</td>
<td>Managers from different levels. Directly interacting with NGNs. Responsible for decision making</td>
<td>To explore the expectations and perceptions of managers about SQU NGNs.</td>
<td>January- May, 2010</td>
<td>4 Managers: 2 managers from the nursing management 1 manager from the hospital management 1 manager from the college of nursing</td>
</tr>
</tbody>
</table>
Due to confidentiality and anonymity issues, it was difficult to identify and include participants from unit of analysis groups who have direct contact with NGNs who participated in the study. Therefore, an effort was made to identify and include key informants whom have a general experience dealing and interacting with SQU NGNs such as head nurses, preceptors and managers. This helped in maintaining confidentiality and anonymity of SQU NGNs and also other participants from the units of analysis and did not affect the depth of data extracted.

There are no formulae to apply in determining sample size in qualitative studies (Munhall, 2001) and usually the adequacy of the sample size in qualitative studies is assessed based on its ability to answer the questions of the study (Russell and Gregory, 2003). The sample size shown in Table 12 has been determined by (a) the number of interviews that the researcher was able realistically to conduct during the data collection period (around 6-9 months) and transcribe and analyse during the PhD course balanced against (b) obtaining sufficient in-depth understanding of SQU NGNs’ experience from a number of different perspectives.

4.2.4 Recruitment

Recruitment of potential participants working at SQUH was done through two separate meetings arranged in coordination with the nursing administration at the hospital. The 1st meeting was with nursing managers and head nurses. The 2nd meeting was with SQU NGNs. During the meetings, short presentations about the rationale of the study and the aims were given. At these presentations, invitation letters and PIS were distributed to all potential participants who showed interest in the study. Direct contact with potential participants assisted the researcher to build a trusting relationship with them. It also served as an interaction point where participants were given the opportunity to discuss the study rationale, aims and its direct implications for them. In addition, these meetings enabled the researcher to identify potential participants who met the purposive inclusion criteria of the study. Potential participants who met the criteria and showed interest in participation were followed up for arrangement of interviews.

Potential participants from the College of Nursing were recruited through a meeting arranged in coordination with the college administration. The meeting was held at the College of Nursing with student nurses and clinical instructors. At this meeting, a short presentation about the study was given and invitation letters and PIS were distributed to potential
participants. Almost all those attended the presentation met the inclusion criteria of the study. Therefore, those who were interested in participation were encouraged to contact the researcher through the email address provided.

4.3 Methods of Data Collection

In this study, interviews as well as observation and document analysis were used to collect data.

4.3.1 Interviews

There were two types of interviews used in this study; semi-structured face-to-face individual interviews and focus group interviews (Table 13). Topic guides were designed for each group of participants. They included open-ended questions that allowed for a degree of discussion and exploration. The topic guides were reviewed by the supervisors and piloted by reviewing them with a potential participant from each group of participants. Topic guides were updated frequently based on the findings of the study (Appendix 1; 2; 3; 4; 5; 6 & 7).

Table 13 Method of Data Collection

<table>
<thead>
<tr>
<th>Group</th>
<th>Method of data collection</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGNs</td>
<td>1st set of interview: 35 minutes-1 hour &amp; ½</td>
<td>A quiet room at the hospital</td>
</tr>
<tr>
<td>NGNs</td>
<td>2nd set of interviews: 10-20 minutes</td>
<td>A quiet room at the hospital</td>
</tr>
<tr>
<td>Student nurses</td>
<td>1 hour &amp; 44 minutes</td>
<td>Seminar room at the College of Nursing</td>
</tr>
<tr>
<td>Preceptors</td>
<td>27-56 minutes</td>
<td>Seminar room</td>
</tr>
<tr>
<td>Clinical Instructors</td>
<td>1 hour-1 &amp; ½ hour</td>
<td>Clinical instructor office</td>
</tr>
<tr>
<td>Head nurses</td>
<td>40 minutes - 1 hour</td>
<td>Head nurse office or seminar room</td>
</tr>
<tr>
<td>Managers</td>
<td>28 minutes - 1 hour</td>
<td>Manager office</td>
</tr>
</tbody>
</table>
**Individual Interviews**

In this study, face-to-face in-depth individual interviews were used at two different points of time. At the first stage of the study, individual interviews were used to collect data from NGNs, preceptors, academic instructors, head nurses and managers. Then, the second sets of interviews were conducted again with some SQU NGNs who agreed to have a second interview. Interviews allowed for a degree of adjustment, clarification and exploration of the experience of NGNs in their transition period (Box 2). They also allowed more understanding of the topic by exploring the different experience of individual participants (Simons, 2009). Individual interviews were thought to be appropriate to maintain confidentiality and encourage participants to freely share information away from any influence or pressure applied by others.

**Box 2 Main Features of Interviews**

<table>
<thead>
<tr>
<th>Features of interview (Simons, 2009; Gillham, 2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The answer to the interview topic or question is open.</td>
</tr>
<tr>
<td>• The relationship between interviewer and interviewee is responsive and/or interactive.</td>
</tr>
<tr>
<td>• Has a natural or naturalistic structure.</td>
</tr>
<tr>
<td>• Allows using prompts or questions to achieve full coverage of the topic.</td>
</tr>
</tbody>
</table>

Despite the benefits of interviews, there were some practical constrains in conducting them. One of the major constrains was arranging time for the interviews. Due to the fact that the main group of participants are NGNs, who are considered staff, this made it difficult for them to arrange a time for an interview. Most of them preferred to be interviewed during their working hours. This is due to the difficulty in arranging transport. Yet, most of the times, NGNs were not able to attend the interview at the arranged time due to work situation in the wards. Some participants came for the interviews during their break times or after finishing their shifts. Others were not able to find time for the interview or were constrained by other arrangements. Sometimes work or transport arrangements pressurised NGNs and limited the time available for them to be interviewed.

In the first set of interviews, 15 NGNs were interviewed. In the second set (follow up), only 9 NGNs were interviewed. This is again because of time limitations and the difficulty in finding a convenient time for interviews.
On the other hand, head nurses and preceptors found it difficult to leave the wards for the interview. Therefore, for these groups of participants, interviews were held in a quiet room in the ward such as the head nurse’s office or the ward seminar room. This was not always practical and it was difficult prevent people from interrupting the interviews and therefore maintain privacy. Moreover, some participants from these groups did not feel committed to the research and they failed either to attend or even apologise for not attending.

Individual interviews were also used with managers. This type of interview is usually called “élite interview”.

**The Élite Interview**

Élite interviews involve interviewing people who are knowledgeable about a particular area of research or context. They are considered useful in understanding cases in depth from a perspective of empowered people (Gillham, 2005). Interviewing managers from SQUH administration and nursing management and SQU College of Nursing helped in exploring their perceptions and expectations of SQU NGNs, which provided a rich source of information about their transition experience.

Élite interviews on the other hand have their own problems. In regards to this case study, some potential managers refused to participate despite showing their support. Other managers were always busy which made it difficult for them to set a specific time for the interview. Managers were interviewed in their offices however; it was not always a quiet venue. It is has been noticed that managers tended to be selective with the information they shared during the interviews and only willing to articulate an “official” view of the topic.

**Focus Group Interview**

Focus group interview is a widely used method for data collection. The basis for using focus groups is the assumption that attitudes and perceptions do not develop in isolation but through interaction with other people. Focus groups allow the researcher to access the attitudes and values of participants who share the same experience (homogenous group) through dynamic interactions (Gillham, 2005; Morse and Field, 1996).

The focus group interview method was used to explore the experience of student nurses who were in their final semester before graduation. This focus group revealed important aspects of
their experience, including perception and expectations about their preparation for the role of the nurse. The student nurses focus group consisted of 8 participants, which is considered appropriate for a focus group interaction (Gillham, 2005). The group consisted of four male students and four female students.

There were some practical challenges faced during the arrangement and conduction of the focus group. The first challenge was arranging a convenient time for all participants. Having both female and male participants was also challenging, as due to cultural barriers it was difficult to convince them to sit closer. Initially female and male participants were not interacting and therefore there was constant attempts made to encourage them to interact. In addition, female participants were talking in a very low tone, which made it difficult to find a good place for the audio recorder. This has affected the quality of the audio file and made transcription difficult and time consuming.

For facilitating the focus group, a staff nurse who had experience in running focus groups helped in moderating. Having two facilitators helped to ensure an even spread of participation, to be alert to those who are hesitant about making contribution and manage those whom might try to dominate the discussion (Gillham, 2005).

Due to the difficulty in ensuring confidentiality in the focus group interaction, there was enforcement made to all participants about the importance of maintaining confidentiality and not disclosing any information discussed in the focus group with others.

**Conduct of Interviews**

Interviews were audio-recorded and conducted in English only. This is because of two main reasons. Firstly, as mentioned in Chapter two, despite the fact that Arabic is the main language in Oman, Omani nationals are a mixture of ethnic groups, which means that Arabic might not be the participants’ native language. Secondly, the nursing programme is taught in English and it is the language of communication at SQUH. Yet, participants were from different countries and their level of English proficiency was different. The researcher herself is not an English native speaker. To overcome this, she piloted the different topic guidelines to ensure the language was clear and understandable. During the interview, she tried to give each participant enough time to think, express and clarify. However, the researcher did not encounter any difficulties in using English in communicating and interacting with the
participants during the interviews. None of the participants object to being interviewed in English or stated that they would prefer to have the interview in Arabic. There were no concerns raised by participants that using English is difficult for them.

4.3.2 Observation

Observation is a widely used method of data collection. It can be formal or informal. Observation is used when the researcher observes things around him/her in the research setting including participants. Observation is usually combined with interviews in case studies and helps in capturing the experience of those who articulate less in interviews. Using observation is believed to increase the understanding of the structure of the organisation and helps in gaining a comprehensive understanding of the organisation by learning its culture (Simons, 2009; Stake, 1995).

During this case study, field notes were taken to document data collected through observations during the conduct of interviews. In addition, some events, meetings and courses related to NGNs were attended and observation field notes were taken (Table 14).

Table 14 Events, Meetings and Courses Attended

<table>
<thead>
<tr>
<th>The event</th>
<th>The Venue</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital and nursing administration meeting with interns</td>
<td>SQUH Board-room</td>
<td>This is an introductory meeting with NGNs before they start their internship programme.</td>
</tr>
<tr>
<td>Preceptor course</td>
<td>3 days course, SQUH Training Department</td>
<td>A course given to staff nurses working at SQUH to prepare them to become preceptors. Meeting different preceptors and exploring how preceptors are prepared.</td>
</tr>
<tr>
<td>SQUH staff nurses workshop</td>
<td>Conference hall</td>
<td>A workshop where current nursing issues at the hospital are discussed, including issues related to NGNs.</td>
</tr>
</tbody>
</table>

4.3.3 Document Analysis

Documents of anything written or produced about the context can be used and analysed in case study to portray and enrich the context and contribute to analysis of issues (Simons, 2009; O’Leary, 2004; Stake, 1995). Document analysis is believed to have the advantage to suggest issues which may be useful to explore. It also may provide a context for interpretation of data collected by other methods (Simons, 2009).
For the purpose of this case study, documents relevant to SQU NGNs transition experience in the contextual setting of SQUH were collected and analysed. These documents were identified through interviews (where participants made reference to them), the preceptor course or through searching the internet and SQUH intranet. Initially a large amount of documents were collected. These documents were then screened for direct relevance to NGNs’ experience and decisions were made of which to include. Documents, which participants referred to, were mainly included in the data analysis (Table 15).

Table 15 Documents Analysed

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Source</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>SQUH resignation analysis for the years 2010, 2009 and 2008</td>
<td>SQUH nursing administration</td>
<td>To measure the extent of attrition of nurses from SQUH</td>
</tr>
<tr>
<td>Log book (A competency check-list NGNs need to complete during their internship)</td>
<td>SQU College of Nursing</td>
<td>To analyse the competency required for NGNs during their internship programme</td>
</tr>
<tr>
<td>SQU College of Nursing Curriculum plan</td>
<td>The College of Nursing website</td>
<td>To explore the contents of the nursing curriculum</td>
</tr>
<tr>
<td>Internship programme policy</td>
<td>The College of Nursing website</td>
<td>To explore the structure of the internship programme and its aims and objectives</td>
</tr>
<tr>
<td>Preceptorship programme policy</td>
<td>SQUH intranet and SQUH Training Department</td>
<td>To explore the relevant contents to SQU NGNs’ transition experience</td>
</tr>
<tr>
<td>Relevant Job descriptions</td>
<td>SQUH intranet</td>
<td>To explore and understand the values and expectations of the organisation</td>
</tr>
<tr>
<td>SQUH vision and mission</td>
<td>SQUH intranet</td>
<td>To assess the effect of the hospital vision and mission on SQU NGNs experience</td>
</tr>
</tbody>
</table>

4.4 Data Analysis

Data analysis is a crucial step in the study where data should be pulled together in order to understand the case (Baxter and Jack, 2009). In this research, data analysis started simultaneously with the process of data collection where topic guides were updated according to new findings. One of the limitations of case study research is that it reveals a huge amount of data, which are difficult to manage and analyse. In this study, data were managed and analysed using Microsoft Access Software. This method is mainly adopted from Hahn’s book of “doing qualitative research using your computer” (Box 3).
Box 3 Steps of Data Analysis

- Each interview is transcribed verbatim. Transcripts were typed and saved in Microsoft word document format.
- Each transcript was formatted with row counters and a column for code descriptions (table format, appendix 10 & 11).
- Create codes: a phrase that captures the meaning of the text.
- Create level one Code: this is done through thorough reading, thinking and identifying important and relevant text. This helped in meeting the study aims and objectives. The relevant texts identified are then highlighted with a different font to the actual text to be recognized easily.
- Analysed documents and observational field notes were coded in the same way.
- Then an Access database was created (a pre-existing database downloaded from the internet: http://qrtips.com/chapter7/).
- All level one codes and the “text” that reflect them were copied to the access database.
- After transferring all the data to the access database: data were compared and contrasted to identify relevant level one codes. These codes then grouped into more general codes “level two codes”.
- Then again data were compared and contrasted to develop “level three codes” which incorporated relevant level two codes.
- Data were also compared and contrasted to group relevant level three codes into more major “Theoretical concepts” (Appendix 12).
- Different theoretical concepts were compared and contrasted to draw a comprehensive picture of SQU NGNs’ transition experience into the contextual setting of SQUH from different perspectives.
- Then the “filter” icon was used to aggregate all codes and quotes, which pull the same thematic category together to write the results and analysis report.

Using Access database in data analysis is similar to the “framework analysis” adopted in some studies, which utilised case study research (Walshe, et al, 2008). This includes “familiarisation”, “creating a thematic framework”, “indexing”, “charting” and “mapping and interpretation” (Ritchie, et al, 2003; Ritchie and Spencer, 1994).

Using Access computerised database has its pros and cons, which are listed in Table (16).
VanWynsberghe and Khan (2007) claim that “case study research” might be biased by the researcher’s interest and motive of conducting the research in a particular case. Furthermore, in qualitative studies the researcher’s views and beliefs is thought to influence the study conduction, analysis and reporting of findings. This is called researcher’s bias (Kuper, et al, 2007).
Despite the benefits of the researcher being a staff working at SQUH in assisting gaining access and data collection, SQUH was not chosen based on a personal interest. The selection of SQUH as the case of study was based on the fact that SQU NGNs work exclusively at this hospital.

Nevertheless, being a staff member at the hospital had made it difficult for the researcher to define her position to clinical preceptors, head nurses and managers who knew her as a staff rather than as a researcher. Therefore, to exclude researcher’s bias in this study, reflexivity was adopted through every stage of the study. This was done by being explicit about the study aims and objectives to gatekeepers and participants from different groups throughout the process of the study. A statement was also included in the participant information sheets that this study is part of a PhD degree. Furthermore, the researcher dressed casually and presented herself as a University of Manchester student and always wore the University of Manchester identification card.

4.6 Methodological Rigour

The issue of assessing qualitative research quality is controversial. There are different positions to the argument of assessing qualitative studies’ quality. Some argued that qualitative studies should be assessed using the same measures used in assessing quantitative studies (Morse, et al, 2002), while others argued that qualitative studies are completely different to quantitative ones and therefore distinct quality measures should be used in assessing the quality of qualitative studies (Mays and Pope, 2000). Instead of using validity and reliability, trustworthiness is suggested as an alternative. For qualitative research, trustworthiness has been broken down into; credibility/internal validity; dependability/reliability; transferability/external validity; and conformability/presentation.

To ensure trustworthiness during the process of conducting this study, the supervisors, who are experienced researchers, were involved in all stages of the research. Prior to data collection, supervisors assessed topic guides to ensure that questions are direct and open ended. After transcribing all the interviews, each interview was analysed by the researcher. Then, samples of the transcripts were counter analysed by the supervisors. The analysis done by each supervisor was compared and contrasted with the researcher’s analysis to come to a consensus. This was done for most of the transcripts. Observational field notes were sent to supervisors during the process of data collection and they gave their feedback on how to link
those with the interviews’ findings. In addition, codes were discussed with supervisors, who with their level of English proficiency, advised on how English might be used to describe the main themes identified.

Poland (1999) stressed that transcriptions are the basis of data analysis. Thus, ensuring its quality and trustworthiness is very important in ensuring the rigour of the study. For this case study, all interviews were recorded in a digital voice recorder with high quality audio detector and the researcher who has conducted the interviews transcribed all of them.

Furthermore, to ensure trustworthiness, clear detailed description of the different methods of data collection and analysis are described in detail (Mays and Pope, 1995). There is also an explicit description given for each code. It is argued that using systematic processes of data analysis and explicitly reporting that, is important to ensure rigour (Barbour, 2001).

In this study, respondents’ validation was not considered as a method of maintaining trustworthiness. This is mainly because the benefit and credibility of study participants to assess the general account of data analysis of the research, which includes the accounts of many different types of participants, might not be relevant (Mays and Pope, 2000) and it can add an additional burden on participants who have already freely given their time.
4.7 Summary

Qualitative embedded single case is the design used to explore and understand the experience of SQU NGNs in their transition period in the contextual setting of SQUH. The qualitative approach provided a rich description of SQU NGNs’ experience. Exploring SQU NGNs’ experience from different point of views (units of analysis) of people who interact directly with them provided a more detailed picture and included different aspects of their experience.

Relevant data were collected through individual, focus group and elite interviews. Data were also collected through observations and document analysis. To make sense of the data collected, transcripts, field notes and documents were analysed thematically using Microsoft Access database. To ensure trustworthiness, supervisors who are expert researchers were consulted and they provided guidance at the different stages of the study.
Chapter Five- Results and Analysis

5. 1 Demographic Data Analysis for Different Groups of Participants

Descriptive demographic data collected about SQU NGNs and other groups of participants are listed in Box 4; 5 & 6.

**Box 4 Demographic Data of SQU NGNs**

<table>
<thead>
<tr>
<th>Characteristics of NGNs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st set of interviews</strong></td>
</tr>
<tr>
<td>Type of Participants</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Origin</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2nd set of interviews (follow-up)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Participants</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Origin</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Box 5 Demographic Data of SNs

<table>
<thead>
<tr>
<th>Characteristics of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Origin</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total number</td>
</tr>
</tbody>
</table>

### Box 6 Demographic Data of Key Informants

<table>
<thead>
<tr>
<th>Characteristics of Key Informants (units of analysis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Nationality</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Type of Participants</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The number of male NGNs and student nurses from their cohorts is further analysed. Furthermore, the number of male participants in the NGNs and SNs groups is compared with the number of female participants (Box 7; 8).
Box 7 Proportion of Male NGNs and SNs

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male NGNs</td>
<td>17 out of 48 NGNs (June Cohort 2009)</td>
<td>35.4%</td>
</tr>
<tr>
<td>Male interns</td>
<td>5 out of 17 interns (January Cohort 2010)</td>
<td>29.4%</td>
</tr>
<tr>
<td>Male NGNs</td>
<td>22 out of 65 NGNs (June 2009 &amp; January 2010 Cohorts)</td>
<td>34%</td>
</tr>
<tr>
<td>Male students</td>
<td>8 out of 25 students (June Cohort 2010)</td>
<td>32%</td>
</tr>
</tbody>
</table>

Box 8 Male and Female Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male participants (NGNs and Interns)</td>
<td>6 out of 22 male NGNs</td>
<td>27%</td>
</tr>
<tr>
<td>Female participants (NGNs and Interns)</td>
<td>9 out of 43 female NGNs</td>
<td>21%</td>
</tr>
<tr>
<td>Male participants (Students)</td>
<td>4 out of 8 male students</td>
<td>50%</td>
</tr>
<tr>
<td>Female participants (Students)</td>
<td>4 out of 17 female students</td>
<td>23%</td>
</tr>
</tbody>
</table>

As shown in Box 8, male NGNs and SNs are slightly over represented in this study. This was not done intentionally but as a result of trying to select a purposive sample of different participants who have different experiences working in different wards.
5.2 SQU NGNs’ Transition Experience

SQU NGNs’ transition experience is extracted mainly from the two sets of individual interviews with NGNs done at two different stages during their first year of work. Also, data extracted from the focus group interview done with student nurses (SNs) is incorporated in the results. To draw a more clear and concise picture of SQU NGNs’ transition experience, data from the interviews with SQU NGNs was constantly compared and contrasted with the data extracted from individual interviews with preceptors, clinical instructors, head nurses and managers. In addition, data from observation notes and relevant documentary analysis is analysed accordingly.

In this chapter, each aspect of NGNs’ transition experience is conceptualised in terms of overarching themes utilising all types of data collected. Each theme will be divided further into main key themes and subthemes. There are four overarching themes identified from SQU NGNs’ transition experience. These are NGNs’ “study experience”; “role transition”; dealing with the realities and context of the “working conditions” at SQUH and “the status of nursing” (Figure 8).
Figure 8 Theoretical Concepts

SQU NGNs' Transition Experience

The Studying Experience
- Choosing Nursing as a Future Career
- The Experience of Studying Nursing

Role Transition
- Becoming A Staff Nurse
- Support in the Transition Period

The Working Conditions
- The Realities of Practice
- The Context of the Working Environment

The Status of the Nursing Profession
- Basic Nursing Care
- Doctors versus Nurses
- The Context of the Nursing Profession in Oman
5.2 The Studying Experience

At the time of the first set of interviews, SQU NGNs were still in their first year of practice after finishing their degree. Five of them had just finished their nursing course, not officially graduated from the College of Nursing and just started their internship programme at SQUH. As mentioned in Section 3.1.1, many studies suggested a strong link between education and NGNs’ transition experience. Therefore, it is thought important to take a retrospective account of SQU NGNs about their student experience to explore the influence of the nursing curriculum on their transition experience. The study experience of NGNs is compared and contrasted with that of SNs. There are two main key themes of “the Student Experience” identified from the data analysis. These are:

- Choosing Nursing as a Future Career.
- The Experience of Studying Nursing.

5.2.1 Choosing Nursing as a Future Career

Different aspects of choosing nursing as a future career will be discussed in terms of subthemes.

A Tactical Choice

The majority of NGNs and SNs stated that they did not choose nursing as their first choice of study. Many of them wanted to study medicine but they chose nursing as an alternative to medicine or as their second or even the last choice. Many of them stated that they randomly chose nursing because they mainly wanted to get accepted at SQU regardless of the subject. In Oman, as mentioned in Chapter two, SQU is the only national university in Oman which seems to make it a prestigious organisation to SQU NGNs and SNs and their families. Therefore, for most of NGNs and SNs the choice of university was more important than the choice of the subject. There is huge demand on SQU from secondary school qualifiers\(^3\) resulting in students with high grades accepted only to study at SQU different colleges. Consequently, the students admitted to the College of Nursing have high grades almost close to the grades of students admitted to the College of Medicine. Many NGNs and SNs thought

\(^3\) It is the last year of school before college. Recently the name of the certificate has been changed to General Diploma Certificate.
that since nursing at SQU is offered at a degree level; they would be different to other nurses who graduate from the MoH institutes with diploma certificate in term of roles and status.

“SQU is the dream of every student. I did not know even there is nursing at SQU but they told me in the registration [SQU registrations/admission office], they said ‘you have good grades you have to try it’, then I choose it as the 2\textsuperscript{nd} choice” NGN9

One male NGN and one male SN stated that they have chosen to study nursing because of the guaranteed vacancies in nursing. All SQU graduate nurses are guaranteed a job at SQUH which seemed to encourage some of them to study nursing, male nurses in particular. Some clinical instructors and preceptors believed that having a guaranteed job has a negative effect on the profession because it tends to attract and retain uninterested students into nursing. On the other hand, there were a few NGNs and SNs who chose nursing as their first choice and stated clearly that they applied to study nursing because they wanted to become nurses. Their main reason for choosing nursing was because of its caring nature.

“The first reason that for securing a job, that first which made me choose nursing, I did not know a lot about nursing, but I know that who is entering the nursing profession will have a job for sure” SN1

“There are the once you do not know why they become nurses in the first place, they are totally not interested in whatever they are doing, it is sad to say it is maybe just for the salary” P2

\textit{Family Influence}

Family advice influenced many NGNs and a few SNs decision in studying and choosing nursing as a future career. Some of them were advised by their families to study nursing because they thought that studying nursing at SQU is better to other diploma qualifications. There is also a cultural issue where some families influenced their female members (daughters) to study nursing because they thought it is more suitable for girls as a future career than other occupations. However, one male SN insisted that he chose nursing against his family’s wish that wanted him to become an engineer and they were all surprised when he chose nursing. Also, families played a role in encouraging some NGNs to accept nursing and stay at the College of Nursing.
“Actually before I choose nursing profession, I had another chance to be an engineer, to be a teacher, to be even in another medical field, even to do medicine in private [college], my secondary school grade was ‘A’4. I had chances, but my family, they were telling and insisting on nursing. this affected my thinking about my future, [then] I decided to go for nursing” NGN5

Ambivalence about Studying Nursing

Due to the fact that only a few NGNs and SNs applied for nursing as their first choice and they were happy to get accepted at the College of Nursing, many of them were ambivalent; indeed, some of them were even disappointed when they got accepted at the College of Nursing. Many of them stressed that they preferred to study other professions such as medicine or engineering and tried to transfer to a different college at the university. However, it seems this was not possible due to the university regulations. Eventually many of them stated that they had to accept studying nursing in order to stay at SQU. Moreover, many of them stressed that after they accepted to study nursing they started to enjoy it. Many clinical instructors referred to students, especially males, trying to move out from the College of Nursing and go to the College of Medicine in particular. They all agreed with NGNs and SNs that it is difficult to transfer to another college within the university and students have to accept nursing if they want to stay at SQU. They believed the lack of knowledge about nursing and the low status of nursing in the Omani society are the main reasons for students feeling ambivalent towards studying nursing. Nonetheless, they remarked that once students know about nursing they tend to accept staying in the College of Nursing. Yet, some of them raised concerns about the benefits of restricting and retaining uninterested students in the Nursing College.

“When they start their nursing profession, the first year students, 50% of them if not more want to transfer to another college, they want to go to the College of Medicine, there is a gender difference, majority of the men want to change but they are not able to change” CI5

4 More than 90%.
5.2.2 The Experience of Studying Nursing

Study experience at the College of Nursing affected NGNs’ and SNs’ views and perceptions about the nursing profession. The experience of studying nursing will be discussed in terms of subthemes.

Trying to Cope

The curriculum of the College of Nursing at SQU was initially prepared by medical doctors from the College of Medicine and clinical Master holder nurses from the MoH. Then, a nurse consultant from San Francisco, USA, reviewed the proposed curriculum. Since then the curriculum was reviewed several times by a curriculum committee. To understand the effect of the nursing curriculum on SQU NGNs’ study experience, the nursing curriculum of SQU nursing college is compared and contrasted with nursing curricula in the UK in general as shown in Table 17.

Table 17 SQU Nursing Curriculum versus Nursing Curricula in the UK

<table>
<thead>
<tr>
<th>SQU Nursing Curriculum</th>
<th>Nursing Curricula in the UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>A general programme includes courses for adults, child health and mental health.</td>
<td>There are three distinct courses for adult, child health and mental health specialities.</td>
</tr>
<tr>
<td>Consist of 11 semesters including three semesters in the summer.</td>
<td>Three years, 38 weeks a year.</td>
</tr>
<tr>
<td>There are 38 theoretical courses, nine clinical courses and a graduation project.</td>
<td>Theory and clinical placements account for 50% each of the total course hours.</td>
</tr>
<tr>
<td>Start clinical practice in semester four.</td>
<td>Start clinical practice early in the course.</td>
</tr>
<tr>
<td>Initially, two clinical courses to be taken in each semester plus other theoretical courses. In the 2010 updated curriculum, one clinical course in each semester except in the last two semesters where there are two clinical courses concurrently.</td>
<td>One clinical placement in each semester.</td>
</tr>
<tr>
<td>In the initial eight clinical courses, students are divided into groups and work under the supervision of their clinical instructors except in “the advanced clinical course” where students start to do shift duties and work with clinical nurses.</td>
<td>Student nurses are expected to do full shift duties and work under the supervision of clinical nurses early in the course.</td>
</tr>
</tbody>
</table>

The latest curriculum was revised in 2010.
Many NGNs and SNs regarded the nursing curriculum as a new subject, which they initially found difficult to understand. Many of them did not know what degree nursing is. A few NGNs believed they were not introduced to the nursing profession and not prepared by the college to understand the expectations of being a degree student nurse. They believed they needed as students to be oriented more to the nursing profession for them to decide if they want to become nurses.

Many managers, head nurses, preceptors and clinical instructors referred to SQU students as the cream of the Omani students because they have got high grades in their secondary school certificate. Due to the fact that NGNs and SNs in this study got an “A” grade in their Secondary School Certificate, most of them expected studying nursing to be easy which was not what they experienced. In fact, many of them found studying nursing difficult and challenging resulting in getting lower grades especially in their initial years. A few NGNs found it difficult to improve their grades later because of the Curve Grading Scale used at SQU. Many clinical instructors described SQU nursing students as “grade oriented”. By this they meant that students cared more about getting grades rather than learning.

“It is tough, we finished our secondary school with ‘A’ grades, we thought that nursing is something easily we can do, but [we] found that the schedule and the curriculum is very tough, even comparing to other colleges in the university, and not anyone can get grades in nursing, so there is a lot of students who are getting very low grades and they are trying to survive in the nursing college” NGN5

“They are grade oriented, they somehow want to get grades even if they really deserve it or not, they come barging for grades, they want to do well, they want to impress” CI1

In addition, many NGNs stated that the nursing curriculum was congested and there were many things to learn at the same time. Many of them believed there is some repetition of some education material such as doing sociology and psychology courses and then psychosocial course which they believed overlap with the former courses. Moreover, there are concurrent practical and theory courses which many NGNs and SNs believed made them feel pressurised. In addition, some NGNs remarked that having congested curriculum not only created psychological stress but also made them feel tired and some of them got sick.

\[\text{Curve grading scale is a statistical method of assigning grades designed to yield a pre-determined distribution of grades among the students.}\]
The manager from the College of Nursing insisted that the college administration tried to distribute the clinical courses more to reduce the pressure on students. However, as described in Table 17, the new curriculum is more intense in terms of using up all the summer holidays for both theoretical and clinical courses.

“We are doing the practice and theory at the same time, even with the exams in the same day and sometimes we are going directly from practice to theory and it is continually and I noticed that most of us in the class are getting ill, tired and sick. Some students got anaemic and gastritis” NGN9

Some clinical instructors highlighted that initially students face some language difficulty in dealing with the curriculum. This is mainly because students have their pre-college learning in Arabic and then have to deal with a new curriculum in a foreign language (English). However, some clinical instructors and preceptors believed that subsequently students improve their English language. Indeed, some preceptors commented on the high level of English proficiency of SQU SNs and NGNs compared to others.

On the other hand, as shown in Boxes 4 and 5 in Section 5.1, a high proportion of NGNs and SNs are originally from outside Muscat. Oman is a conservative country with strong family relationships where usually both boys and girls stay in their family houses unless they get married7. Studying at SQU means the majority of NGNs and SNs had to leave their families’ houses and stay in Muscat. For many of them this was their first experience away from their families. Some NGNs believed being away from families limited the positive reinforcement they received as students which made them feel lonely and increased their stress although none of the SNs participating in the study referred to any stress related to living away from their families.

**Limited Practice**

This group of NGNs and SNs started their clinical practice in their 3rd year. They had to do two different clinical courses in each semester concurrent with other theoretical courses. Student nurses usually spend two days a week in each clinical area alternately, from 7am to 2pm except in “the advanced clinical course”. They usually undertake these clinical courses

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7 There are also some people who stay in their family house even after marriage.
at different hospitals in Muscat. They are usually divided into groups and supervised by clinical instructors.

Many NGNs believed there was no balance between theory and practice during their study. They believed the college focused more on teaching them knowledge and theory rather than teaching them practical skills. In addition, a few SNs believed that the college focused on teaching them scientific knowledge they thought irrelevant to the nursing practice. Some clinical instructors and preceptors also believed there is no balance between theory and practice in the SQU nursing curriculum.

Many NGNs believed not doing full working shifts decreased their exposure to different situations in the working environment. Furthermore, many NGNs and SNs remarked that there were some limitations put on their practice as students due to ethical concerns of patients' safety. They stated this has restricted their clinical practice as students and limited their exposure to different cases and experiences. A few managers agreed that there are many restrictions put by the hospital rules and regulations on students’ practice in the working environments which affected their learning such as not allowing them to do some procedures. Nevertheless, a few NGNs believed that they had sufficient practical experience as students and they were given a chance to work in different wards which they thought was beneficial. Yet, they believed the experience varies among students because it mainly depends on the wards they were posted in and individual students’ initiative.

“We need more practice; some procedures when we were students we were not allowed to do or we are used to have our preceptors, our teachers around us. We were having limited [practice]; we were missing a lot of important things, other procedures. Now in the clinical area there are procedures I did not see before in my student period” NGN8

Working Under the Supervision of Clinical Instructors

As mentioned earlier, during most the clinical courses, SQU student nurses have to work under the supervision of the academic clinical instructors. Many NGNs and SNs stated that they were always following their clinical instructor in groups and she/he is the one who supervised them and arranged their practice which controlled their learning. Most of the NGNs believed that clinical instructors were always “on their back” during the clinical courses, which made them feel uncomfortable. Furthermore, a few NGNs stated that some
clinical instructors treat them as “babies” and shout at them. This affected their confidence as students and made some of them doubtful of the quality of the nursing profession. On the other hand, some NGNs highlighted that following their clinical instructors was not always negative and in fact sometimes made them feel supported as students. Supportive clinical instructors gave students more freedom and made them feel more comfortable in the clinical area. Some clinical instructors and preceptors believed that nursing students need more time and more freedom in the clinical area in order to prepare them to be competent staff nurses.

“Depends on the clinical instructor, some of them will be on your back, ‘did you do this?’ And because they are on your back, you will not feel comfortable. But some of them will tell us ‘you have this patient, do the usual care and then I will come to check what you have done’, so this was better, we were more comfortable” NGN1

“They are dealing with us as we are little small babies, [as] we cannot do anything without them” NGN9

Many clinical instructors described their role as guiding and evaluating students and facilitating clinical teaching. A few clinical instructors believed that students behave like children and depend mainly on the clinical instructors to prepare everything for them. In fact, many clinical instructors stated that SQU nursing curriculum encouraged “spoon feeding” students and that self-directed study is not enhanced.

“They are spoon fed, majority times if we push them to do, they will do, many times they do not even find procedures, if I ask ‘why did you not do IM injection’, because it is my [clinical instructor] responsibility to find IM injection and make them do” CI1

All clinical instructors who were interviewed are expatriate nurses who had no previous experience working in any Omani hospital and most of them are non-Arabic speaking. Many NGNs and SNs felt that many international clinical instructors were not aware of the Omani culture. Some of them mentioned that they would feel more comfortable to work with Omani or Arabic-speaking clinical instructors or those who are more aware of the Omani culture. The cultural difference created some misunderstandings between students’ especially female students and their clinical instructors. According to some female NGNs, clinical instructors asked them to carry some procedures which they believed are against their culture and religion beliefs such as bathing a male patient. A few of them stressed that clinical instructors...
did not accept their culture limitations and insisted on them doing these procedures. In fact, one female NGN and one clinical instructor interviewed had both described a conflict where a student (the NGN) had refused to fold up her sleeves. The NGN believed that it was her right to refuse to fold up her sleeve because this is not an acceptable act in the Omani culture especially in front of males. Conversely, the clinical instructor insisted that the student should have folded up her sleeves because she was doing a sterile procedure.

“We are not that much comfortable because most of our instructors if not all are expatriates, actually they did not understand our culture. I remember when we are working at AFH, they asked us to do many things which we cannot do as Omanis and as Muslims. For example bath a male patient, catheterisation [for male], to fold up our sleeves, many things, and we always discuss with them but no benefit, that will be in our evaluation” NGN15

“I have a student who was really fighting with me. She did not fold up her sleeves to do dressing. She had long sleeves. She had to wear the gloves and we were at AFH’ CI4

NGNs suggested some measures in order to increase students’ clinical experience. Some of them suggested that to gain more from practice they needed to focus on one clinical course at a time and to be given more freedom to work with nurses in the wards rather than following clinical instructors. In addition, many NGNs believed that clinical instructors’ teaching styles needed to change to understand students more. Some NGNs suggested that more collaboration is needed between the college and the hospital to facilitate students learning and clinical instructors need to build good relationship and work closely with ward staff.

“Our college should ask for help from the ward, because when the group of 6 students with one teacher, and they will stay for 4 hours, this teacher cannot satisfy the needs of every student, so he needs to ask for help from staff nurses, he needs to have good communication with the staff so they will help him” NGN1

**The First Taste of Real Nursing**

The advanced clinical course is the last clinical course in the SQU nursing curriculum. All students do 30 shifts of clinical practice in a ward at SQUH. They work under the direct supervision of clinical nurses who are called “preceptors” and also under the supervision of

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8 Fold up sleeves and expose arms is considered against the Islamic religion where women are expected to cover their bodies from strange men.
academic clinical instructors. Despite doing many clinical courses during their study, many NGNs and SNs regarded the advanced clinical course as their first real practice in the clinical environment because it is the only clinical course where they work full shifts with clinical nurses. Many of them stated that being detached from clinical instructors and solely working with clinical staff nurses made them feel part of the healthcare team. It also helped them focus more on practice what they have learned and learn new skills. All Key informants from the College of Nursing viewed the advanced clinical course as the most important course in the nursing curriculum because it allows students intensive clinical exposure, improves their confidence, develops critical thinking, an opportunity for students to integrate knowledge into practice and it helps them to familiarise with SQUH setting.

“That course [advanced clinical course] was very beneficial because we were doing 30 shifts in the hospital, we are learning many procedures, some of these procedures we did not expose to them previously” NGN12

However, the advanced clinical course was stressful to many NGNs and SNs because they did it with other college requirements and examinations plus the graduation project. Most NGNs and SNs remarked that during the advanced clinical course they were mainly preparing and worrying about the “exit exam” rather than focusing on learning practical skills. This made a few of them choose clinical areas for their advanced clinical course which they thought would be easy for them to learn and therefore, able to pass the examination. Most clinical instructors agreed that the advanced clinical course is stressful for students. According to many of them, students tried to balance between theoretical courses and shift duties which made them work night shifts or weekends resulting in students working alone without any formal supervision. Many of them believed that students mainly focused on finishing their working hours to meet the course requirements and they were only anxious about the “exit exam” because they were “grade oriented”. Some of them experienced working with students who have chosen wards only for the purpose of passing the “exit exam” which is consistent with NGNs and SNs accounts. Also, a few head nurses highlighted that students experienced stress because of the “exit exam”. However, they believed the examination had a positive effect because it motivated students to learn.

“In the advanced course you need to review all what you have learned, so it is like stress environment for you to retrieve all the information. Also some students do other courses. Other exams, projects” SN1
“To achieve the objectives within 30 shifts, this means the students really will be focusing on the exam. The students try to choose a safe area for their practice, in the sense that they get limited number of questions and one of the students he told me secretly ‘Miss actually I do not want to work in this area but for the exam point of view I am choosing this area’” CI4

A few NGNs and SNs felt that 30 shifts is an appropriate time given that students have to complete many other requirements and sit many examinations in the same period. However, the majority of NGNs felt that having many courses with the advanced clinical course means 30 shifts is a very little time to learn and there is a need to increase the number of shifts. Also, clinical instructors and head nurses believed the period of advanced clinical course is limited and should be increased. However, a few managers insisted that the number of shifts is reduced in order to reduce the study pressure on students. However, there is an agreement from different participants that to reduce pressures and maximise learning, the advanced clinical course should be done alone without other courses.

“For me it is not enough because really even you will fit in as a staff but sometime maybe the study load will make it [difficult], because during advanced you will study for the exit exam” NGN13

Added to that, NGNs and SNs had different experiences which affected their learning during the advanced clinical course. During the advanced clinical course, some NGNs and many SNs remarked that some nurses practise skills different to what they were taught at university. Some of them worked with nurses or preceptors who sometimes compromise standards in the working environment or cut corners, which they regarded as “wrong practice”. NGNs and SNs referred mainly to the infection control, sterile technique procedures and not following the standardised procedure of administering medications. In regard to the sterile techniques, some SNs as well as many clinical instructors referred to clinical nurses claiming to use “no touch technique”, which means that while preparing the sterile trolley, clinical nurses do not use sterile gloves but instead they place the sterile equipment directly from their packs into the sterile trolley without touching them. Clinical instructors regarded this as “cutting corners” rather than “wrong practice”.

Many clinical instructors stated that they expect a difference between theory and practice in terms of standards because they teach ideal practice in an ideal environment which might be different to the real clinical area resources and settings. However, they insisted that nurses
should avoid using cutting corners in front of students because sometimes their students get confused and tend to “copy-paste” other nurses’ practice without critically analysing it or referring to their theoretical background. They also insisted that preceptors should rationalise to students when they cut corners or when they modify procedures due to limited resources to help students to learn critical thinking. A few head nurses and preceptors highlighted that due to work pressures some nurses tend to cut corners or even compromise standards, which they also believed should not happen. Some preceptors insisted that they advise students not to copy their compromised practice or cut corners and instead follow the procedures taught to them at the college.

“While we are students because they know that we are here to learn so they do their best in their practice, they will do everything correctly, even sometimes when they are teaching us, they will do something wrong and she [the preceptor] will say ‘no this is not the right way you should do it, you have to do it this way but because I used to do it this way every day so it is ok that I do it’” NGN1

Some SNs believed that clinical nurses, preceptors in particular, have working experience but they lack scientific knowledge or evidence-based practice. Moreover, many SNs and clinical instructors remarked that preceptors and nurses in the wards are “task-oriented” and tend to care only for the physical needs of the patients. They used the phrase “functional” work to denote clinical nurses “task-oriented” work. Many of them believed increased workload on nurses played an important role in making them task-oriented. However, some SNs did not rule out the possibility that some nurses were task oriented because they lack interest to provide other aspects of patients care.

Some SNs and clinical instructors stated that the main focus of the degree training is to prepare nurses to provide holistic care. However, they highlighted the difficulty of students meeting their learning objectives in providing holistic care because nurses are mainly task-oriented. A few clinical instructors questioned if SNs will provide holistic or individualised care after graduation or start to become task-oriented as other nurses in the wards. Some SNs anticipated that it will be difficult for them to attend to different aspects of patient care when they qualify as independent staff nurses because of time pressures.

“They will take practice as physiological need, medication, positioning, feeding, suctioning. But for example because we are baccalaureates we are different to diploma we are caring...
from holistic care [aspect]. For example for my objectives, if I need to meet holistic care for the patient, emotion, social, all other aspects. He [preceptors] is not aware of that. He is only aware of meeting the physiological needs of the patients” SN1

Many NGNs and SNs referred to some nurses using them as “extra hands” to do the basic nursing care such as checking vital signs or doing medical orderlies’ work during the advanced clinical course. Some head nurses stated that due to the pressures of the workload, students were used as extra hand in their wards. However, a few of them insisted that they never used students as extra hands and in fact they focused more on achieving the course objectives.

Many NGNs and SNs felt angry that they were spending most of their student time carrying out basic and routine work and not focusing on their learning objectives. According to them, many times nurses asked them to do the basic care and did not involve them in carrying out more technical and scientific procedures. Some NGNs referred to academic clinical instructors expecting nursing students to focus more on “higher” nursing skills rather than doing the basic nursing which conflicted with what they were asked by nurses to do. Some SNs in particular, stated that they refused sometimes to help nurses in carrying out basic care or routine work because they wanted to achieve their learning objectives. According to them, clinical nurses did not accept that and reported it to the nurse in charge.

“During the study time, we come morning to do the bed making, the teacher will come and she will say ‘what have you done for your patient?’ So she does not like to hear the word that I did only bed making and vital signs checking, she feels that we are for something higher” NGN6

Clinical instructors considered using their students as extra hands one of the major constrain to students’ learning from practice. They believed this did not only restricted students learning but it also limited the time available for them to supervise students’ learning. However, a few of them blamed students for being passive and not objecting when used as extra hand. They believed that some students preferred to only do the basic care because this means that they are only focusing on physical care and not integrating knowledge or using critical thinking. Some clinical instructors insisted that basic care is important but it should not consume all the student time. A few of them highlighted that they sometimes need to
compromise in order to have a partnership with the hospital. They encourage students to be involved with other staff in doing basic care to make them feel as part of the ward staff.

On the other hand, some preceptors commented that other nurses regarded students as extra hand that can help the preceptor in completing the work. They argued that sometimes students were “extra burden” rather than “extra hands” because they added to the preceptors’ responsibilities. Some academics insisted that students should be regarded neither as “extra hands” nor as “extra burden”. However, they believed students could still help nurses to complete their work rather than holding them back especially in completing patients’ assessments and evaluations.

“One evening I went for supervision, I saw a student nurse who is working in a busy medical ward, and I asked her ‘did you look after a patient’ and she said ‘no’, and I asked her ‘what did you do since you came in?’ ‘I checked 20 patients vital signs, I checked 14 patients blood sugar, I checked urine output for 10 patients’ you know like that she was given me the numbers, so when the staff nurses are busy they do not want to teach anything, they do not want to give the students specific patients assignment, they do functional kind of work, they consider the student nurse like one more hand” CI5

Many SNs felt that due to huge workloads there was no time for the preceptors to teach them. Many preceptors and head nurses agreed that due to increased workloads there was no time for teaching students. Therefore, they suggested that clinical instructors should be involved more in teaching students and supervise them to maximise students’ learning and achieve their learning objectives. However, all clinical instructors insisted that their role in the advanced clinical course is about “indirect supervision” and it is the time for the preceptors to take over their role in teaching students. They believed this should assist students to move away from academic supervision and prepare them for the staff nurse role. However, many of them highlighted an increasing pressure put on them to play a more active role in supervising students which they believed reduce students’ independency and support “spoon feeding”.

“Actually this course [the advanced clinical course] is built to make the students independent, to feel that he/she is at least partially away from the academic environment and the direct supervision of the clinical instructor, and he/she is working with other people, taking part of the responsibility for hi/hers study, to read more, to discuss with the people more but unfortunately I feel that still the coordinators here in the college want us to follow
the students more, supervise them more, spoon feed them more, we are not given them that much independence” CI2

A few NGNs and SNs experienced working with preceptors who did not teach them or tried to ignore or avoid them. Also, a few NGNs and SNs had conflicts or disagreements with their preceptors during the advanced clinical course. On such occasions, some NGNs stated that they sought advice and support from their clinical instructors. Yet, this did not help in resolving the issue or reducing preceptors’ negative feelings toward the student.

All SNs and many academic key informants believed the college should contribute in selecting preceptors who can act as role models for students to assist their learning and help them meet the objectives of the advanced clinical course. They believed preceptors should be oriented more to their role or given some monetary incentives such as bonus to motivate them to teach. However, academic key informants remarked that their recommendations of some preceptors were not always considered and the hospital nursing management are the once selecting preceptors and assigning them to students.

Many academics made a reference to a “preceptor training course “offered by the College of Nursing for SQUH clinical nurses to prepare them to supervise students during the advanced clinical course. Nevertheless, some SNs believed that many preceptors were not aware of their role and students’ level of competency or their learning objectives during the advanced clinical course. Many clinical instructors and a few managers also believed that preceptors were not fully aware of students’ learning objectives and sometimes they were not committed to teaching. This study showed a lack of clarity about the role of the preceptor and that of the student during the advanced clinical course. From the college side, a few academic key informants insisted that during the advanced clinical course, students are ready to take their responsibilities alone and should not follow preceptors but preceptors should be available only for advice. While, some clinical instructors and head nurses insisted that students should always work under the supervision of the preceptor except while doing basic skills such as checking the vital signs.

“I have noticed that the preceptors do not know exactly their role. When they are confused about their role they will get confused with our roles. This makes us under stress. We do not know what we have to do and how we can do our roles. So it is better to educate them what...

9 This includes one manager and five clinical instructors
exactly are their roles and what are the expectations from us? What we can do? Because sometimes they do not allow us to do some procedures and also they give us sometimes criticisms on that. They criticise us ‘you are in the fifth year why you do not know how to do this? Why sometimes you do not know that procedure’ and they have over expectations sometimes in our skills. So it is better for them to be oriented to their role” SN8

**Studying Nursing as a Positive Experience**

Despite all the criticism of the nursing curriculum, some NGNs believed studying at SQU College of Nursing was a positive experience. The nursing curriculum was described by many of them as comprehensive including theory and practice. Some NGNs felt the College of Nursing used different resources to give them a wide knowledge base which they can utilise as staff nurses. A few of them underpinned that it depends on the student’s initiative in benefiting the most from the nursing curriculum. Also, many NGNs believed the College of Nursing prepared them well to introduce change to the working environment. However, they highlighted that there is a problem at the practice area, which affected their learning from practice.

“In terms of knowledge, really, they prepared us very, very well, sometimes I find myself having good knowledge which make me manage situations of the patients with the doctors. As a whole programme it is a good programme, it taught us a lot of things that we really need and made us able to face this reality” NGN8

Many SNs and NGNs expressed some positive feelings toward the support they received from the College of Nursing. Many NGNs regarded the university staff as being supportive. They believed that teachers are different in their provision of support but still many of them provided satisfactory support. Also, many NGNs viewed the college provision of free books for example as a kind of a positive support. Furthermore, some NGNs believed that studying at SQU and having most of their practice at SQUH, made them feel fully oriented to SQUH and actually think of it as a home. On the other hand, there is a sense of achievement expressed by almost all SNs and NGNs of being SQU graduate nurses. This made them feel different to other Omani nurses who are diploma graduates. Moreover, many NGNs proudly referred to the external examiners’ comments about them as excellent in terms of both, theory and practical skills. According to them, international clinical examiners commented on their preparation as of international standard. Many managers, head nurses, preceptors and clinical
instructors believed the nursing curriculum to be at international standards and meet the demands of the workplace. Many of them also highlighted the positive comments given by external examiners about SQU nursing students as outstanding and meeting the international standards.

“I feel that they really prepared us, even the external examiners who came from the UK, US, Canada, Egypt and Jordan, [they said] ‘you are knowledgeable, even you can work abroad’, one of the professors told us that ‘even directly you can go and work in the UK and USA’, he told ‘you are really, really, really ready to work there’” NGN5

“The academic perpetration is very comprehensive, I mean of high standard and their learning objectives also you know equivalent to very recognized universities” M1
5.2.3 Summary: The Studying Experience

This study showed that not many NGNs and SNs intended to study nursing in the first place and randomly choose nursing because they wanted to study at SQU. In addition, families played a role in encouraging their members (daughters or sons) to study nursing because it is at a degree level or due to cultural considerations. Many students were ambivalent to study nursing and a large proportion of them stayed in nursing because of their limited options to transfer to other colleges within the university or also due to family advice.

Nursing was seen as a new topic which was difficult to understand. Also, the nursing curriculum is congested with many theory and practical courses to learn. Moreover, SQU College of Nursing takes students from different regions of Oman. This resulted in many of them living away from their families which reduced the positive support and reinforcement they received and increased their stress.

There is a concern raised in this study about the balance between theory and practical courses in the nursing curriculum. The nursing curriculum is believed to focus on theory. Also, there is a reference made to how exhausting and distracting it is to have concurrent practical and theory sessions on the same days with other university activities or examinations. Moreover, students had limited practical experience because they were mainly working half days in groups under their academic clinical instructors’ supervision. There were also many constrains put on their practice which limited their experience.

The “advanced clinical course” is regarded as the most important course in the nursing curriculum. It allowed students the opportunity to work shift duties with the ward nurses for the first time. Yet, the advanced clinical course was stressful for students because it was concurrent with other theoretical courses and examinations. Also, there were some concerns that clinical nurses are “task-oriented” and focus on teaching students’ ritualistic practice rather than evidence-based practice. Furthermore, there were some concerns that ward staff nurses used students to complete the basic and routine work of the wards. There were also concerns that not all preceptors were aware of their roles. Due to work demands, some preceptors had no time to teach students or sometimes tend to teach students compromised practice. This is believed to make it difficult for students to meet their learning objectives of providing holistic individualised care and using critical thinking.
Despite all difficulties and negativities of the student experience, there was a sense of achievement expressed by NGNs being SQU degree graduate nurses. NGNs emphasised that the College of Nursing prepared them well with good background knowledge. In fact, some of them believed that the deficit in their practical experience is not because of the nursing curriculum but it is due to limitations in the working environment.

After completing their study, NGNs had to go through role transition to transform from being students to become staff nurses.
5.3 Role Transition

The 2nd overarching theme identified from the data is “Role Transition”. NGNs in this study have passed through three distinct experiences in their role transition. First, during the internship programme, NGNs perceived themselves as “interns” working under the supervision of preceptors with no responsibilities for patients’ care. Then, they also worked under the preceptor supervision for one-month orientation in the ward they were posted in. Still they were not fully confronted with the full weight of responsibility. After finishing the orientation period, they started perceiving themselves as fully independent staff nurses responsible for a caseload of patients’ care. The “Role Transition” theme will mainly focus on describing NGNs experience during the internship period, after finishing the internship period and after completing the first year of experience. In this section, an analysis of NGNs experience of role transition will be discussed in terms of key themes. These are:

- Becoming a Staff Nurse.
- Support in the Transition Period.

5.3.1 Becoming a Staff Nurse

For this group of NGNs, the experience of becoming staff nurses had brought some uncertainties and challenges with it. This experience will be analysed more in terms of subthemes.

_Lack of Clarity of the Staff Nurse Role_

Initially some NGNs experienced confusion about their new role as staff nurses. Many of them believed this confusion resulted from differences between what they were taught at college and the reality of the workplace. They believed the college have taught them “ideal” nursing as it is written in textbooks which they found difficult to apply in a real dynamic work environment. A few of them believed that the theories taught at college are adopted from Western organisations and literatures thus, do not reflect the Omani culture. Many NGNs found the culture and priorities of their working environment to be new and different to that of the nursing curriculum. A few NGNs stated that they were explicitly told by clinical nurses to disregard what they have learned from college as it is not relevant to the real working environment.
“One of the in-charges here, in one of the wards, he said ‘forget what you have learned in 5 years, here in the hospital this is a changing environment, you will not get in your books, so you have to learn from here’” NGN11

Furthermore, the majority of NGNs believed there is a difference in focus between theory and practice in the nursing curriculum and the working environment. This contributed significantly to their initial role confusion. Many NGNs believed theory is very important in order for them to understand the nature of nursing work. Yet, in the working environment, they observed nurses rarely using or relating to theories. This made many of them feel unprepared for their expected role as staff nurses. Therefore, many of them argued that there should be a more balanced account between theory and practice in the nursing curriculum and also in the nursing practice. As mentioned earlier in Section 5.2.2, many clinical instructors agreed that they mainly teach students ideals, which might be different to the real working environment. Some managers, head nurses and preceptors also believed there is a difference between what is taught at college and what nurses’ practice. They believed that SQU NGNs have a wide base of theoretical knowledge, which they did not know how to apply in real practice, or they were not able to apply because of the work demands in the workplace. Nevertheless, some academic key informants insisted that the nursing curriculum prepares NGNs for the reality of the workplace and their graduates do not usually suffer from the reality shock.

“No more theory, noooooooooo more, I am telling the truth, no more theory, ask any staff here, no theory, only cleaning, bathing” NGN7

Subsequently, at the 2nd stage of the study, many NGNs reported that they became more oriented and familiar with the staff nurse role which made other nurses respect them and treat them as peers. Also at this stage, many NGNs felt they could draw a balance between theory and practice and are able more to use more critical thinking.

“I am concentrating in what I need in the clinical area, yes I am going back to what I have studied before but not the whole things, now I am specific, so I try to read topics related to my experience now” NGN14 (2nd interview)
Moving from Dependence to Independence

As mentioned earlier, during the study period, internship period and the orientation period, NGNs were always working under supervision. Therefore, by becoming independent staff nurses, many of them started feeling the increased pressure of the workload. Initially some of them found themselves having difficulty in managing their time and carrying out all patients’ care within one shift duty. Moreover, many of them, especially those who were working in new wards with no previous experience, found it difficult and challenging to have a responsibility for a caseload of patients’ care. They expressed the feeling of lack of confidence and worried they might make mistakes or omissions of care, which might harm their patients due to their limited knowledge and experience.

“The first 2 months I always hold my heart, you know sometimes, at home, I just remember did I do that one, did I check that for that patient, did I forget something for that patient, like I am putting a list and just tick, not done, done, not done, like that, really even in my dreams, sometimes I dream about calculating urine output or maybe checking reflow for patient, so it is really the idea itself to become responsible for these patients after you were supported by your instructor and your preceptor” NGN13

Many NGNs believed that becoming independent does not mean that they were fully competent and despite finishing the internship programme, they perceived themselves as still learning and needing support and guidance. Some NGNs especially those working in specialised areas such as Oncology/ Haematology and ICU expressed feelings of fear of working independently because of their lack of knowledge and experience. Some head nurses and preceptors believed that NGNs should always counter check before they carry new procedures to prevent making mistakes, while some managers and preceptors believed that SQU NGNs learned fast when they were given the opportunity and trust to work independently. On the other hand, increased responsibility and accountability made some NGNs want to work harder to ensure that they have done everything for their patients. Furthermore, some of them felt that working independently allowed them freedom at work as they were not following or taking orders from others. They believed this gave them more room to practice what they have learned at college which some of them regarded as the “correct” thing. A few NGNs felt working independently increased their confidence in their skills and made them gain more respect from their colleagues, while restricting their practice reduced their confidence and made them scared of being held responsible and accountable of
patients’ care. For the majority of NGNs, by time they were able more to learn to manage their time and organise their patients’ care which increased their confidence level. They also became more aware of their working environment and their new role.

“I do not know anything about chemotherapy, that’s the problem; I do not even [know] one knowledge about chemotherapy. We are supposed to give chemotherapy. Because this is your patient you have to give it, I do not know any side effect, even about blood transfusion, what if anything happens to the patient, who will be responsible? I will be responsible. Sometimes I feel I do not want to come to work because I am responsible and accountable” NGN2

**Lack of Experience**

Initially, all NGNs believed they lack practical experience as staff nurses. Many of them attributed this to the “limited practice” during their study referred to earlier in Section 5.2.2. NGNs that were still in their internship programme realised they lack experience and they need to work under supervision to feel prepared to take full responsibility as staff nurses. Many NGNs insisted that having a previous experience during their advanced clinical course and/or internship programme in the same wards where they work as staff nurses assisted their transition. They believed this helped them to be more familiar with the ward settings and routines and made them more confident to practise skills. Having limited experience in some areas such as specialised wards affected NGNs experience as staff nurses. This made some of them feel unprepared and lack confidence to deal with new situations, which triggered stress, made them feel depressed resulting in increased absence. This is also supported by some head nurses who noticed that NGNs who had their advanced clinical course or a rotation of their internship programme in the wards they work at as staff nurses; had less stress and took a shorter time to familiarise to the setting and assume their responsibilities as independent staff nurses compared to other NGNs. Some head nurses and preceptors stated that NGNs are beginners and lack experience. They mainly blamed the nursing curriculum in limiting NGNs’ clinical experience and creating a theory-practice gap. They regarded clinical skills as important and NGNs should be allowed more time in clinical placements during their study.

“We had enough placements but not with all specialities, like me I am now in Haematology/Oncology, from first year until my fifth year in nursing, I have not gone for one week in Haematology/Oncology ward, I feel depressed, really how I will work in a ward that I do not have much knowledge about” NGN2
Many NGNs felt that they are learning more from their working environment as staff nurses compared to the time when they were students or interns. They believed this gave them the opportunity to learn in the real ward context from different nurses with different experiences. This helped in making them aware of the policies and procedures of the hospital. Many NGNs also believed that experience reduces their dependence on others. Many NGNs believed that learning skills is easy and not a real challenge. A few of them felt that after a few months of practice, the differences between them and experienced nurses have been minimised to only NGNs taking slightly longer in executing certain procedures. Subsequently, many NGNs who finished their first year of practice felt that they became more experienced. In fact, they believed that they were almost at the same level of other nurses in terms of skills. This experience assisted them in dealing with their working environment and also with their colleagues. Throughout the study process, many NGNs valued the experience of others and believed that they need to learn from other experienced nurses to improve their competencies. During the different stages of NGNs’ experience, almost all NGNs highlighted a linear relationship between experience and confidence levels. Moreover, having more experience increased many NGNs’ satisfaction and engendered feelings of happiness that they were able to control their work. In addition, many NGNs highlighted that despite the first year being exhausting with many things to learn, they were able to learn different experiences and asked more for help and guidance.

“I feel I need the experience. Sometimes I need supervision to work. I am still new. I am BSc yes, but I am still new. I have to know the routine. I have to learn skills which cannot be gained just by knowledge but with experience. Lots of practice we have to do under supervision” NGN5

“After one year experience in the ward now I can say I have got good experience and I am working with confidence and good skills of communication with others, and also my experience was improved so much by interacting with others, and communicating and asking our senior staff” NGN14 (2nd interview)

**Mismatch of Expectations**

Initially, many NGNs experienced a mismatch of expectations about their role as staff nurses and what they are expected to do in the working environment, which fuelled their role confusion. All NGNs expected their role as staff nurses to be different to diploma-qualified
nurses, which was also mentioned earlier in Section 5.2.1. The majority of NGNs remarked that they expected that after studying five years or so at college, their work would entail mainly practicing specific or “high” nursing skills such as giving medications. Yet, in the real working environment, many of them found they were fully occupied with basic nursing care and also doing some other extra work which made many of them feel disappointed and angry.

On the other hand, a few NGNs have expressed the fact that they had high expectations of the posts would be given to them as degree graduates. Many of them expected that they would get senior nurse posts as head nurses or work as doctors’ assistants. Some of them highlighted that their families and the public made them believe that they are different to other Omani nurses and should work in higher posts. However, NGNs found themselves given a junior staff nurse post and working as other nurses with lower qualifications which disappointed them. A few academic key informants and head nurses highlighted that they expect SQU NGNs to lead the nursing profession in Oman, which might have influenced NGNs high expectations about themselves. On the other hand, some managers, head nurses, preceptors and clinical instructors experienced working with some SNs and NGNs who had high expectations of themselves as SQU graduates. Those NGNs and SNs wanted to assume administrative duties such as becoming specialists or link nurses or taking on in-charge duties or work as senior nurses or even head nurses. However, those key informants believed NGNs are still juniors and lack experience to assume such responsibilities. Some of them highlighted that SQU NGNs are moving away from nursing and wanting to be involved more in administration issues.

“I thought that I will be something else not like diploma, yanee I will do something else, I will be in another position, also my family, not only me, they thought I will be the head of the nursing, I will not be only bed nurse” NGN4

There was a mismatch of expectation about how prepared NGNs were for the role of a staff nurse. A few NGNs stated that initially they thought that they are fully prepared to take over their staff nurse responsibility. However, when they came to the real working environment they found themselves unprepared to work as staff nurses. On the other hand, many NGNs believed that some nurses have high expectations of their preparation because they are mainly trained at SQUH. It seems some nurses expected NGNs to be able to work independently

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10 I mean.
from the first day. Also, some clinical instructors believed that NGNs are competent to work in any ward in the hospital and they are ready to assume their responsibilities as staff nurses. However, many NGNs believed that despite having their training mainly at SQUH, the staff nurse role is new to them and there is a difference between being a staff and being a student or intern. Many NGNs believed that they should be allowed time to adapt to the environment and learn the staff nurse role. In contrast, a few NGNs stated that some clinical nurses underestimated their knowledge and competence. In fact, some managers, head nurses and also clinical instructors stated that they believe NGNs should only work as first level nurses who need to gain experience.

“Some of the staff they will not let you participate with them, they think that you will not know, they think that you are slow, you will take time, so they prefer to do it by their self, and some of the nurses they will let you do all the job and they will go” NGN4

“You know nursing is like a small bud, if the small bud comes out of the egg will not fly because it is small still, it has to grow the wings, and when it tries to fly it will fly short distance and fall. So it is the same thing with graduates because they cannot say I am completely independent, but in their mind, they can tell themselves that they want to be future leaders, they want to be educators, they want to be clinical nurse specialist but all that is based on the experience” HN5

Social Life and Work Life Balance

Initially, most NGNs found it difficult to cope with working full shift duties. Many of them described it as stressful, affecting their sleeping and eating patterns and therefore, affecting their health. Some managers remarked that many male NGNs in particular approached the administration asking to be moved to other wards where they work day shifts only. On the other hand, the majority of NGNs believed that as staff nurses they were spending most of their time in the hospital and had no time to spend with their families. Moreover, working long hours and starting shift duties made it difficult for many of them to balance between their professional and personal life. A few female NGNs anticipated that working shift duties might affect their life more when they get married and start their families. NGNs that are originally from outside Muscat in particular felt working shifts is detrimental to their social life. On the other hand, only one NGN favoured working shifts. This female NGN is originally from Muscat and still lives with her parents.
“Changes in the shifts and working late and then next day we are having night and then another night and then off and then evening, we feel that even we will not get that much sleep. Sleeping hours is not regulated and sometimes we cannot eat and feel fatigue, tired all the time” NGN12

Most NGNs felt that their health, personal and social circumstances were not always taken into account in the roster allocation of the shift duties, which made them feel unsupported and distressed. NGNs that are originally from outside Muscat believed that head nurses did not always allowed them enough time off to enjoy a good quality time with their families which made some of them feel lonely and depressed. All head nurses realised that some NGNs are stressed because they are not able to cope with shift duties or long hours of work. They also believed that some NGNs faced difficulty balancing their personal life and work. Many of them insisted that they are trying to consider NGNs personal and social circumstances but it is not always in their capacity to grant them adequate time off to visit families. Moreover, a few head nurses believed that NGNs are not students anymore and they should accept being treated like other nurses in terms of the duty roster.

Some male and female SNs and NGNs stated that they might consider leaving SQUH due to social circumstances to move closer to their families. Nonetheless, a few NGNs believed that they got used to coping with being away from their families since they were students at SQU. A few other NGNs and SNs believed that the case of nurses is not different to others who are working in Muscat and they have families outside Muscat. For some, being a nurse is very important and worth the hassle but they still need time to adjust between their professional and personal life. One manager believed that living away from families should not be a problem for NGNs, as professional success requires sacrifices.

“We are staying here for maybe two weeks, three weeks without even seeing one member of our family, so you will feel some time that you are depressed of being alone, no one is with you, it is difficult” NGN2

“Now I am pregnant and I asked her [head nurse] to reduce the night shifts for me. I am doing here six or seven nights a month. So I asked her to at least [reduce] one day for me but no benefit, she totally refused” NGN15
Female NGNs who lived away from their family houses usually stay in groups in private accommodations close to SQUH. As mentioned in Section 5.2.2, Oman is a conservative country where it is still not widely acceptable for women to live away from their families. Some female NGNs felt unsafe living in private accommodation and found many services such as shops inaccessible. Also, initially due to financial constraints, the majority of female NGNs had to rent a private vehicle with a driver to go or come back from work. Thus, some of them considered working night and evening shifts as unsafe. Some female NGNs preferred to work in hospitals close to their families’ hometown. According to some female NGNs, they as well as their families expected that after they finish their study at SQU they will be employed in their hometown close to their families. Subsequently, in the follow up interviews, most female and male NGNs who finished their first year of experience found themselves able more to balance between their professional and personal life.

“But I feel some of them especially like the father of one of my friends is saying ‘her family is in Sohar\(^{11}\) and she is living here’ he was asking ‘why she is living here? Why she doesn’t go back to her place?’ So they are looking negatively to this” NGN1

“I am living now with my friends, khalas\(^{12}\) I use to the environment of living with them, I just try to blend myself in this situation, they [family] know this is my life, and they adapt too” NGN8 (2\(^{nd}\) interview)

**Job Security**

Initially, all NGNs who finished their internship period were still working under temporary contracts. Working under temporary contracts means NGNs are treated like temporary employees and not entitled to any annual leave and there is no regular payment period. Many NGNs complained that not getting their salaries at fixed times led to many of them facing financial difficulties. Initially when this study started, ten of the NGNs interviewed worked for almost nine months without being able to take annual leave. Delays in getting permanent work contracts at SQUH made all NGNs feel insecure and scared that they would not be employed by SQUH. Moreover, some of them remarked that their thoughts were fully occupied with the issue of employment and they were not able to focus on their work. A few head nurses also commented on how stressed the NGNs working in their wards were because

\(^{11}\) A town about 200KM away from Muscat

\(^{12}\) That’s it
of job insecurity. However, during the process of data collection, some NGNs who completed their internship programme got permanent working contracts at SQUH, which made them feel happy and safe. Consequently, according to some NGNs, the sense of job security relieved their stress and made them feel more satisfied with work.

“We are not supported really, now we are working for nine months in the hospital but we are still not officially employed, now nine months we are working without leave. At the end we are not in our homes, here we need to pay for rent, for transportation, so if I do not get my salary at exact time, I will be delaying some other things that I have to pay [for]” NGN1
5.3.2 Support and Adjustment

Officially, SQU NGNs are provided with two distinct periods of supervised support; the internship programme and the orientation period. The internship programme is a period where NGNs work under the supervision of preceptors and rotate to different wards, while the orientation is a period that NGNs spend after the completion of the internship programme in the wards they are assigned to work in as staff nurses. In this section the experience of NGNs with different aspects of support will be discussed in terms of subthemes.

The Importance of the Internship Programme

The College of Nursing issued a document about the internship programme. According to this document, the internship programme provided by SQUH is a six months programme, of which interns spend four-months at SQUH and the other two-months are spent abroad. During the internship programme, interns rotate to general medical/surgical wards at SQUH under the supervision and support of preceptors. In this document, the internship is described as an “academic” programme. Yet, there are no structured academic courses or credits assigned to it. In fact, the programme only includes the preceptorship or role modelling method of learning.

All SQU NGNs interviewed in this study agreed that the internship programme was very important and assisted their role transition. They believed that despite been trained at SQUH as students, they still lack experience and need to learn the staff nurse role. Most of them believed the internship programme allowed them the opportunity to learn from clinical nurses in the context of the working environment. This helped them to increase their confidence in assuming their responsibilities as staff nurses. All SNs believed that they are not fully prepared to work as independent staff nurses and insisted that they need the internship period to assist their role transition. Many key informants considered the internship programme as a good step taken by SQUH management to support NGNs’ transition. They believed the internship period is a necessity for SQU NGNs because they “lack experience” and therefore they need to work under supervision to gain that experience. However, a few managers and clinical instructors believed the internship programme is not important and SQU NGNs are fully prepared and can assume their responsibilities as staff nurses straight after graduation. They believed that if there is a need to increase NGNs’ clinical exposure, then instead of having six months of internship programme, “the advanced clinical” course could be
extended. They also believed that since most of NGNs training was at SQUH, then, a short orientation period would be enough to orient them to their working environments. They insisted that the internship period limits NGNs’ practice and development while what they need is guidance and support.

“If we did not have internship and we work in one ward, we work directly independent, this will be difficult, in advanced course we did not take responsibility for the patients independently even if we were doing full shifts but still, we were only under our college, but here we are not under the college [any more], we will be under the supervision of the staff, we will learn at least from them, it is different” NGN15

“The internship in this country actually device as a copy from other countries, where they have less trust to their institutions, and we just copy it. The meaning of the intern in the language is ‘in-prison’ so someone you put in the prison, that means you put limitation, the word itself implies that they are limited and we do not want them to be limited” M2

Many NGNs considered the internship period as a happy phase and stress free period. They believed they felt relaxed as interns with no worry about responsibilities for patients’ care. Moreover, they believed being interns made other staff nurses treat them as juniors and did not put many expectations on them which reduced their stress. Almost all NGNs felt satisfied with the period and rotation of the internship programme. Many of them regarded the rotation as a good experience because they were exposed to different settings. Yet, a few of them felt they had limited exposure to some wards, which they believed they needed more experience in, such as medical wards. They suggested that the rotation could be modified to expose them to more wards and settings so they can gain different experiences. In comparison, the majority of key informants believed that six months period of the internship programme is adequate. They also believed the rotation to main wards at the hospital is a good opportunity for NGNs to expose them to different environments and skills and should help NGNs decide where they want to work as staff nurses.

“I was relaxing, nothing to bother about when I was intern, if I will do a mistake; everybody will expect that because I am still an intern” NGN8

The internship abroad is usually sponsored by private sources and coordinated and organised by the College of Nursing. Based on the availability of funding and cooperation of hospitals
abroad, different interns were offered different opportunities. The main countries NGNs went to included India, Jordan, Canada and America. The internship abroad has no fixed times within the internship period because it mainly depends on the time agreed with the hospital abroad. Therefore, interns expect to go for their internship abroad at any time during their six months internship programme. This sometimes affected the time available for NGNs rotations in some wards.

According to SQU internship programme document, the internship abroad is a valuable opportunity for SQU graduates to broaden their prospect by learning in different cultures. Yet, it was not clear how this evidence was gathered and how representative is to all NGNs. All academic key informants and SNs also considered the internship abroad as a valuable opportunity offered to SQU NGNs. Many NGNs participating in this study believed that the internship abroad is a good opportunity offered to them to learn and interact with different cultures and settings. Some of them believed going abroad made them see a different perspective of the nursing profession, which changed their views for better. Yet, a few of them doubted the benefits of the internship abroad and believed they did not learn anything useful to use when they came back to SQUH. This is because the culture and setting of the hospitals they had their internship abroad in, was different to SQUH. They believed spending two months abroad affected the time available for them to learn the environment of SQUH and rotate to different wards. Moreover, according to a few NGNs, hospitals abroad were not fully aware of their competency level and treated them as students rather than graduates restricting their practice and limiting their learning.

“The experience gained by the students who completed internship abroad was really valuable. Students acknowledged that the exposure to a different healthcare setting contributed to their professional development. They were able to appreciate the technological advancements, cultural aspects, health needs, professional nursing and other unique aspects of the country they visited during internship. Moreover they could explore the opportunities for higher studies abroad. In addition such opportunity helps them to practice nursing across boundaries” (SQU College of Nursing, Internship Programme Document, 2009)

“I went abroad to do my internship in Jordan, then 180 degree my views about nursing changed. I noticed that a lot of good things about nursing. I learned a lot of new things” NGN5 (2nd interview)
There is a logbook given by the College of Nursing to all NGNs during their internship programme. The logbook consists of core competencies that NGNs are expected to complete in their different rotations. Preceptors stated that they treated the “logbook” as a framework and guidance for their teaching. After completing the internship programme, NGNs are expected to complete the logbook and countersign it by their preceptors and their head nurse. Then, they need to send it to the College of Nursing where the Dean signs it. The College of Nursing then issues a certificate to prove that the NGN has completed the internship programme successfully. SQU NGNs should complete the logbook and get it signed for them to be allowed to practice. However, a few NGNs stated that they did not complete and signed the logbook and this did not affect them getting a job at SQUH.

The role the College of Nursing play in the internship programme made many NGNs confused about the relationship between the College of Nursing and the internship programme. In fact, the majority of them thought the internship programme was provided by the College of Nursing, while, managers and clinical instructors insisted that the internship programme is provided by the hospital under the umbrella of the college as a partnership programme. A few managers agreed that this partnership in the internship programme is confusing to NGNs and also to academic and clinical staff. However, they claimed that sheltering the internship programme under the college umbrella is mainly to increase interns’ commitment to work by subjecting it to certification. Furthermore, treating interns as staff working at the hospital was mainly to provide them with financial support.

“It is not part of the curriculum, they can be licensed, but this internship we kept it academically supervised, we are putting the college umbrella on this internship with the hospital, now we are sharing the responsibility, we are not throwing them away completely to the hospital, if we do not do this the students will not take it seriously, so in the beginning we told them let it be all the hospital then they [interns] were not taking it serious, then we said no let us put it under the college umbrella, and the college is the one who is given them the certificate” M3

After completing the internship programme, SQUH provided all NGNs with one-month orientation in the ward they were posted in. During the orientation period, based on the hospital policy, NGNs were assigned preceptors whom they followed to learn the ward

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13 NGNs are treated as paid employees during their internship programme.
setting and routine. Many managers, head nurses and preceptors referred to this as a chance for NGNs to familiarise themselves with the ward setting and routines. Some head nurses suggested that NGNs who work in more specialised areas should be given more orientation time.

Learning from Preceptors

In the College of Nursing internship programme document, there is no mention about the need for interns to work under the supervision of preceptors during their rotations at SQUH. However, it is mentioned that SQU NGNs need to work under preceptors’ supervision during their internship abroad. According to this document, the preceptor should hold a minimum qualification of a Master degree in Nursing. On the other hand, many head nurses and preceptors referred to another policy, which is the “SQUH preceptorship programme”. They insisted that based on this policy interns should always work under preceptors’ supervision. SQUH preceptorship programme stated that preceptors should be senior nurses who “must attend the Nursing Preceptor Course”. The nursing preceptor course is a three days course conducted by the hospital training department. During these three days potential candidates are given lectures about communication skills, reflective diary, evaluation, the nursing process, the preceptors’ teaching role, professionalism and reflections. Candidates are given a handbook that included SQUH preceptorship programme policy and some relevant reading material.

Many head nurses and preceptors believed that preceptors are usually held responsible and accountable for their interns’ actions. Therefore, some head nurses insisted that they do not allow interns to do many procedures unless supervised. They also referred to the policies of SQUH requiring fully registered nurses only to execute certain procedures such as drug administration policies (oral and intravenous) or check and administer blood components. However, one intern stated that she started administering intravenous chemotherapy without any preceptor supervision from the 2nd week of her internship programme. She stated that she only has a general idea about the side effects of chemotherapy and not aware of the extravasations or spillage policy at the hospital. Conversely, a few preceptors and head nurses believed strict complete supervision policies delay interns transitioning and learning because it limits their hands on practice. They believed this made it difficult for NGNs to work independently and made some of them develop dependency on preceptors where they continued seeking preceptors’ support even after completion of the internship programme.
They believed interns should be encouraged to work independently under supervision but they should not be overwhelmed with many high acuity patients.

Interns experience working with preceptors is largely similar to students experience working with preceptors during their advanced clinical course described in Section 5.2.2. Many NGNs in this study believed that preceptors played a critical role in teaching them competencies that they may carry for life long. Many of them viewed their preceptors as supportive who were role models that put an effort in teaching and encouraging their learning. They also believed that preceptors guided them closely and helped them in building their confidence and developing their independence as staff nurses.

“Really my preceptors were cooperative and they made me feel that I can do everything, and I can work independent. They give me something to do. After that they will give me positive reinforcements ‘you can do it, you can’. Every staff get 5 to 6 patients, she [preceptor] will say ‘ok then you take today all of the patients and see if you can manage’ because after that I have to do it” NGN1

On the other hand, some NGNs believed that their preceptors were not prepared to act as role models. They believed their preceptors cared only about completing the paper work rather than teaching. Moreover, a few of them believed their preceptors were teaching them wrong practices or practices different to what they have learned at college. Some also felt that they are even better than their preceptors in terms of some skills. Some preceptors also commented that some nurses practice differently to how NGNs were taught at college, which they believed confused NGNs. Some preceptors remarked that sometimes they are forced to compromise standards or cut corners due to increased workload and time pressures. However, many of them highlighted that they usually accept NGNs criticism of their practice and insisted that becoming preceptors made them improve their practice. In fact, some head nurses and preceptors remarked that nurses and the ward benefit from having SQU NGNs and students. This is mainly because SQU NGNs are equipped with strong theoretical background and they always ask question which creates a challenge for experienced senior staff nurses and encourage them to read and update their knowledge in order to be able to teach. Some preceptors also referred to some interns not only challenging nurses and making them change but also challenging doctors.
Some NGNs believed that some nurses especially preceptors did not treat them with respect as interns. A few of them stated that as preceptees they only followed the preceptor without any real teaching which made them feel humiliated and increased their anxiety. In addition, some NGNs experienced some verbal abuse from their preceptors such as shouting at them. On the other hand, many preceptors emphasised that they had good relationship with their interns and treated them as brothers and sisters. However, a few of them highlighted that they had some clashes with some interns due to the fact that some of them “do not like to be told”, “do not accept criticism” or “they do not feel committed to work”. In fact, some expatriate nurses who participated in the preceptor course commented that sometimes they could not criticise Omani interns or students because they do not accept criticism. Some head nurses believed language and culture differences between expatriate preceptors and interns sometimes caused misunderstandings. Head nurses stated that they try to be culturally sensitive by assigning male preceptors to male interns and female preceptors to female interns. Male preceptors highlighted that they prefer to supervise male interns because of culture barriers. However, none of the female preceptors identified female gender as a preference or identified any difficulties related to gender.

“Actually no preceptorship, ask others here, maybe one or two preceptors are ok, but others no, here they just want to finish their work, no communication, just follow them without any benefit. Really, really embarrassed about it at that time. But at the same time I followed him, but no teaching just followed him, just like an animal following the human” NGN7

“I face this week my preceptor was shouting at me, she wants to teach me but not in that way, shouting at me in front of the patient, in front of attendant14, I felt very upset how she is doing like that, everyone make mistakes but not to correct it in that way” NGN12

As mentioned earlier in Section 5.2.2 about SNs experience of being used as “extra hands”, many NGNs also described being used as “extra hands” by the ward nurses during their internship programme. Some of them stated that nurses feel happy when they see an intern coming to the ward because it means an extra hand to help them to finish their basic nursing care. Some of them believed that some preceptors focused on making them do the routine of the ward rather than teaching them individualised patient care or high-level skills. This made many of them feel that nurses are abusing and misusing them rather than teaching them. The

14 In Oman, family member or a carer usually stay with the patient if he/she is physically dependent.
main basic skills NGNs were asked to do by their preceptors and/or other nurses are taking vital signs, positioning patients and giving bed baths. Moreover, some NGNs experienced being given extra work to do which was more than their capacity and in fact made some of them move away from these wards. It is worth noting that some NGNs believed senior nurses compared to more junior nurses tended to treat them more as extra hands.

Many head nurses and preceptors believed interns were not used as “extra hand”. Many of them referred to interns as extra work and it is not possible to treat them as extra hands because they usually slow down or delay the work and need teaching and guidance. They claimed that NGNs come to the workplace with pre-conceived idea about practice that conflict with the reality of nursing practice which is mainly about dealing with basic nursing care. Some of them also stated that initially they allow interns only to do basic care because of legal issues and lack of awareness about their competency level. Conversely, some head nurses highlighted that sometimes due to workload they use interns to help them complete the work of the ward and also to communicate with patients. Moreover, some head nurses and preceptors referred to sometimes counting interns in the staff list and allotted them responsibilities or sometimes increase preceptors’ workload because they have interns who can help them complete the work.

“I feel if they are so senior, not all seniors, but some seniors, they are using us to do their simple work and they are not teaching, they are teaching some little only, but mostly they want us to finish their simple work, but if they are junior, it is ok, we have good relationship with them, everything, also spending time to teach and also they are listening to us when we are asking” NGN3

Almost all NGNs believed that very often there is no time for teaching due to the increased workload in the working environment, which is also consistent with SNs experience described in Section 5.2.2. They believed that increasing preceptors’ workload reduces the time available for teaching and also affects their interest to teach. Some NGNs believed that preceptors or even other nurses tend to become aggressive when the working environment becomes stressful. In fact, many NGNs felt that preceptors tend to be more cooperative and spend more time teaching them when the workload is less. In comparison, all preceptors referred to how busy they are in completing and carrying their patients’ care and having limited time to teach and guide interns. They believed this reduced the benefits interns gain from preceptorship. Sometimes preceptors were expected to have more than one preceptee
because of the shortage of preceptors and the increased number of NGNs and students, which also increased the pressure on them. Managers and head nurses remarked that sometimes it is difficult for preceptors to accommodate the teaching role with the increased workload they have. Some nursing managers, head nurses and preceptors referred to the preceptorship policy of SQUH of assigning preceptors a smaller patient caseload. However, managers and head nurses referred to the difficulty in implementing this policy with the current working conditions of increased workloads, time pressures and staff shortage. In fact, some head nurses and managers believed that interns need to learn different experiences under different conditions and therefore they believed reducing the workload of preceptors would reduce interns’ exposure to different experiences. Nonetheless, there is nothing in the SQUH nursing preceptorship document about giving preceptors a smaller patient caseload.

“They [preceptors] do not have time, and I mention this point to the head nurse, she said ‘yes it is like that’, she did not give me any solution” NGN12 (2nd interview)

“No time for them to teach, no time, six patients and they say ‘they give us a new graduate nurse to teach, how we can teach?’ that’s what they say” NGN7

Some NGNs believed that not all preceptors were aware of their roles. They believed the hospital administration should be selective in choosing preceptors due to the importance of their role in teaching. Some NGNs suggested that their feedback should be taken to evaluate preceptors while some head nurses stated that they consider NGNs and SNs feedback when evaluating preceptors.

“Some preceptors even they are not aware that they have preceptee and some of them they do not know even they are supposed to do the same shifts [with the intern] and work together” NGN12 (2nd interview)

All key informants agreed that NGNs needed to work with role models who they can follow. According to the preceptorship programme document, head nurses are the one responsible in selecting candidates who can attend the “preceptor course” and become preceptors. Many managers, head nurses as well as preceptors stated that according to this policy, preceptor should have at least two years of experience. However, the policy stated that preceptor should be a senior nurse and did not quantify the number of years the preceptor should have. This
might mean that those key informants refer to a senior nurse to the one who have at least two years of clinical experience.

Some managers, head nurses and clinical instructors believed that not all experienced nurses could work as role models. Many clinical instructors believed that beside experience, preceptors also needed to hold either a BSc or Master degree to be able to supervise SQU NGNs. Some head nurses highlighted that SQU NGNs usually prefer to work with degree or master qualified nurses to diploma nurses. They attributed this to their preference to work with knowledgeable nurses who are able to answer their questions and base their practice on theory. A few managers insisted that instead of having preceptors who mainly focus on teaching practice, there is a need for the hospital to carefully select mentors who can act as role models.

“Mentors are actually role models where preceptor is just a function on the job, and especially at the beginning when you are a new person coming to a new working environment, you want to have that sense of feelings that I am doing the right thing and I am following this because this is the right thing, so having a role model will work much better than having a preceptor who just went to a course and depends mainly on their experiences and experiences could be valid or could be wrong. But mentors always are the people who market themselves and interns or other nurses want to be like them, we want to have that effect in the future” M2

Many head nurses insisted that they carefully select preceptors who are hardworking, committed, knowledgeable, role models and able to teach (a good teacher). However, head nurses identified “interest and commitment to teach” as one of the major problems they faced when selecting preceptors. Some head nurses and clinical instructors believed the hospital should invest more in motivating preceptors and making them feel committed to their teaching role. They suggested preceptors to be paid monetary incentives. Some head nurses referred to motivating preceptors by sending them to the preceptor course or giving them “word of thanks”. Many preceptors stated that they feel motivated when their students and other senior nurses such as head nurses appreciate their contribution to teaching and development of junior nurses. Many clinical informants including preceptors believed that teaching is inherent in nursing and the job description of the nurse at SQUH specifies teaching as one of their main roles.
Many managers and head nurses insisted that according to the preceptorship policy, nurses could not attend the preceptor course or work as preceptors unless they have at least two years of experience. Moreover, they insisted that nurses cannot act as preceptors unless they have attended the preceptor course which is the training requirement stated in the policy. However, many participants who attended the preceptor course have been involved in supervising students and acting as preceptors before attending this course. Moreover, one of the participants had less than two years of experience. Many preceptors believed the preceptor course oriented them to their role as preceptors. While some other preceptors and a few managers believed the preceptor course is congested with so much theory and it is not focused on how preceptors can update their knowledge and implement different teaching techniques.

**Collegiality and Team Work**

Added to the support of preceptors during the internship programme and orientation period, many NGNs believed that working with supportive staff assisted their transition and helped them to overcome the difficulties of the transition period. Supportive staff offered help and guidance and gave NGNs the feeling that they can manage patients’ care. It also helped in reducing the anxieties brought by the staff nurse role and made many NGNs enjoyed working. Many NGNs felt that most nurses in the wards are supportive and willing to provide them with help and guidance. Some NGNs and many managers, head nurses, preceptors and clinical instructors referred to SQUH as a teaching hospital and nurses being expected to contribute and participate in teaching and supporting junior nurses. Many preceptors and head nurses insisted that many nurses are committed to teaching and willing to care for NGNs and provide them with support.

“You know with the help of the nurses, we are junior, really we find that support from them, sometimes they will come to say ‘anything to do, anything to help you’ they really provide this support. I enjoy working, when I know that when I need help there is somebody will help me” NGN13

Moreover, many NGNs experienced working in environments where they felt there is teamwork. They believed that teamwork helped them to cope with the shortage of staff and the increased workload because nurses tried to help each other even if they were busy. Yet, this experience was not consistent with all NGNs because a few of them stated that workload
itself made it sometimes impossible to have teamwork because every member of the staff will be busy. Some NGNs experienced working in wards where there was multidisciplinary teamwork. They believed having teamwork with other professionals reduced their occupational stress and helped them to cope. Some head nurses and preceptors believed teamwork have a positive effect on NGNs learning and socialisation in the working environment. However, some of them highlighted that NGNs needs to work hard to feel part of the team.

“I feel that at SQUH you have the abilities because first of all the team that I am working with, our nurses are very nice, they are cooperative, the in-charge is cooperative and she is trying to help us to get in the right communication channels with other departments, like with the doctors, with the physiotherapist, dietician, so whenever we need something we know who to communicate with” NGN6

However, a few NGNs found that some ward staff nurses were not always supportive which contributed to their initial negative feelings about their new role. Some NGNs reported that some clinical nurses did not consider that they are new and tended to criticise their practice in front of others. Not getting positive support from other staff made NGNs struggle in managing patients’ care and provoked anxiety and stress. Moreover, many NGNs felt that lack of experience and knowledge and lack of support made it difficult for them to manage and finish their work and they had to leave uncompleted work for the next shift. This made staff criticise NGNs and complain about them not working efficiently. Some NGNs experienced working with nurses who wanted them to learn fast and did not consider that they were still new. A few head nurses and preceptors believed that some NGNs tended to act as students expecting someone to guide them and supervise them at all times. Nevertheless, many NGNs stated that as staff nurses they should be assertive in dealing with their nursing colleagues or other health professionals to maintain their relationship and should not create conflicts. Also, they believed they should not say “no” if they are asked to do something which might not be related to nursing because they are still new. A few NGNs expressed a preference to seek support from their Omani colleagues rather than from expatriate staff. This is mainly because they felt that Omani nurses are at the same level and grades as them. They also felt that they enjoyed working with Omani nurses more because they tend to work as a team.
“Sometimes you will not have the time to complete your work, because you do not know what to do, so at the end, your work will be postponed to others, so they will complain about you, you are not working correctly. Sometimes you are working and working and working but others do not look [at] that, they are telling at the end ‘you are doing nothing’” NGN2

“They made us feel sometimes that we are stupid. Because when we are doing something like I am scrubbing a case for the first time so definitely I will not know most of the things, but the doctors will not know that I am new here, the nurses know that we are new but they will not consider that we do not know, so they will tell in front of doctors ‘see she cannot do this thing, she cannot do it correctly’” NGN1

Many NGNs believed head nurses and ward managers played a major role in supporting them and creating supportive environments. They highlighted how working with supportive head nurses improved their experience and helped them to adjust. In fact, some NGNs who initially felt stressed and overwhelmed with their new environment referred mainly to the support role of the head nurse in retaining them into the wards. Many head nurses stated that they are trying to create a supportive environment for NGNs. They also referred to how important it is to make NGNs feel part of the team and comfortable in working in the wards by considering their personal and social circumstances. Yet, a few NGNs found that some head nurses were not supportive which is also mentioned in Section 5.3.1. Some NGNs also remarked that a few head nurses tended to “throw blame” on nurses and support doctors rather than nurses.

“The thing that have not changed is the support from the team, especially the head nurse, I do not feel like she is in our side, if any problem happen between us and the doctors, she would not be in our side even if we were right, I feel like she is always on their side, she is really the only problem that I see until now” NGN1 (2nd interview)

Initially, some NGNs stated that being unfamiliar with the staff working in the ward made them hesitant to ask for help and guidance. In the follow up interviews, NGNs who believed that they worked in supportive environments felt that support was carried out even after they finished their first year of work. Moreover, some NGNs believed that their relationship with their colleagues and seniors improved by time and became one of trust and mutual respect. Moreover, many of them after finishing their first year of practice referred to working as a team with their colleagues to help them to cope with increased workload. This indicated that
getting familiar with the ward setting made them improve their communication and collegiality with the staff. Moreover, NGNs who moved to new wards as staff nurses, found their new environments to be supportive and friendly. NGNs who finished their first year felt more settled and even started to provide support for some junior nurses. It is noted that NGNs referred more to clinical support compared to social or emotional support they received from their colleagues.

“Day by day we are improving, at the beginning maybe we feel shy to ask, also maybe we are worried to ask more questions, we feel our preceptor will not get time to answer, but day by day we are improving our skills in communication with staff, so we are now [feel] freely to ask them, [feel] freely to communicate with them” NGN14

**Administrative Support**

Many NGNs and SNs believed that SQUH as an organisation is trying to provide them with positive support to assist their learning and professional development. Many NGNs stated that they are satisfied with their salaries working at SQUH. In the internship introduction meeting, many NGNs (interns) were happy when the assigned hospital administrator told them about their salaries, which it seems more than what they expected. Furthermore, a few managers and head nurses remarked that SQUH offer better payment compared to other hospitals, which they believed attracted some NGNs to work at SQUH. Many managers, head nurses and preceptors believed that working at SQUH itself is a motivation for NGNs. This is because SQUH has its own prestigious status compared to other hospitals in Oman.

Almost all key informants believed that SQU NGNs have many opportunities for professional development working at SQUH. Moreover, due to the limited number of Omani nurses compared to expatriate nurses at the hospital some expatriate head nurses believed that Omani nurses have a bright future working at SQUH. However, some NGNs were concerned that having so many NGNs made SQUH a competitive environment where they need to work hard to convince nursing managers of their abilities. As a result of administration support for professional development, the majority of NGNs and SNs have already thought of their future professional development. Most of them saw their future as pursuing higher studies or becoming specialist nurses. In fact, in the 2nd stage of the study, many NGNs started to think about their area of interest such as cardiology or ICU. Moreover, some NGNs and SNs saw themselves as senior staff nurses or in charges or head nurses. They believed that they would
stay in clinical setting and try to change the standards of practice. It is worth to note that more male NGNs and SNs wanted to become specialists or pursue higher education compared to those who wanted to stay in clinical practice.

“We are given them special treatment, we are given them a lot of special treatments and nobody will question you, why? Because you are looking at the future you know the chance of training it should be for nationals mostly, the non-Omanis are sometimes getting the chances for training, education, but we are focusing on the future, we do at times you know receive requests which we feel that we could entertain and you know grant them whatever they are requesting, and that is not actually a special treatment but people might perceive it that way”

M2

Some NGNs believed positive support from the nursing and the hospital management is critical in motivating them to improve their work. However, initially, many NGNs mentioned not having much contact with the nursing management preferring to deal and discuss their issues with their senior nurses or head nurses who usually approach the management when required. Yet, they felt that there are people in the nursing management who listen to them. Nursing managers insisted that they provide an “open door policy” for all staff nurses including NGNs. The main support services the nursing managers referred to are taking complaints, counselling and providing motivation. Some managers claimed that NGNs only approached them with social problems, negative attitudes towards the nature of the nursing work or requesting not to work shift duties. By time, some NGNs started to believe that they are not getting as much support as they expected from the nursing management which disappointed them. One NGN used the term “fight” to describe his approach in convincing the nursing management to keep him in the ward which he wanted to work in. Some NGNs believed there was a distrustful relationship between the administration and nurses. One NGN brought the example of the hospital administration sending only nurses for a documentation workshop. She questioned why only nurses needed their documentations to be evaluated and monitored. Nevertheless, some managers and one lecturer from the preceptor course believed that the documentation course was a positive innovation of the nursing management to improve the quality of nurses’ work.

“It is really, really difficult because I did not get any support from them [nursing management], at all, I have asked for another place, even my situation was not that much
good, they directly shifted me from there to here, even without informing me that we want to shift you there, directly it was ‘go to this ward’” NGN2 (2nd interview)

“They are trying to improve the documentation which is a good thing, but they are not looking at the documentation of other departments except the nursing department, so we are the only one who have to go to the documentation workshop and we are the one who have to be observed by administration and we get corrections for our documentation but what about doctors’ documentation, nobody is looking at them, the physiotherapists, the dieticians” NGN6

Adjustment and Coping

Moreover, it is apparent that NGNs participating in this study went through a process of transformation which was stress provoking. Therefore, they had to adopt different strategies to overcome the stress and cope with the new role. Some of these are adaptive such as talking to others or spending time with friends or family members. Yet, some other coping strategies are maladaptive such as over sleeping, crying or taking sick leave. In addition, one NGN experienced nurses using laughter to cope with stress. Another one believed that he could cope with stress if he is positive in his thinking and approach. He believed trying to be positive made him able to manage patients’ care and reduced his stress.

“I found in ICU they are using laughter, some of the staff, to stress manage situation they will say to you ‘just relax, be happy’” NGN11

In the 2nd stage of the study, many NGNs found their adjustment and adaptation to the working environment helped them to cope with the challenges they faced as staff nurses. They became more able to deal with their environment. This reduced their occupational stress and increased their job satisfaction. Moreover, many NGNs believed working in an environment that they like made them feel settled and comfortable which increased their self-confidence. Some NGNs found changing their stressful work environments by moving to other wards, which they believed is less stressful, helped them to adapt to the staff nurse role. In fact, by moving away from the stressful environments, some of them started to enjoy working as staff nurses. Moreover, many NGNs believed at this stage of their career development, they were working in their preferred working environments, which indicated their adjustment and adaptation. Some head nurses and preceptors believed that NGNs should
be given the option to work in the wards they are interested in and they should not be forced to work in a specific ward otherwise they will lose interest. However, a few managers and head nurses highlighted the fact that the options of the wards for NGNs depend mainly on the organisation needs and the increasing number of NGNs is limiting their options.

“Really for me now I feel very different compared to before, because now I came to a period of adjustment from that period, because in the beginning I was really very stressful and because of the environment and all the responsibility came at the same time, so I was very stressful at that time” NGN11 (2nd interview)
5.3.3 Summary: Role Transition

The staff nurse role was ambiguous and stressful for many SQU NGNs. The “theory-practice gap” theme identified in the literature was identified as one of the main reasons for SQU NGNs confusion and lack of clarity about the staff nurse role. Working as independent staff nurses and being responsible and accountable for patients’ care provoked stress. In addition, many of them felt they lacked experience due to their limited clinical exposure as students. They found themselves prepared to work more in wards where they had previous clinical exposure during their advanced clinical course or internship period.

There was also a mismatch of expectations between SQU NGNs and that of the hospital staff about their competency and knowledge. SQU NGNs thought they would be treated different as degree graduate nurses compared to diploma graduates. They also thought that they would be given leading positions and many of them wanted to deal more with administrative issues rather than patients’ direct care. These high expectations were fuelled by others who made them believe that they will lead the nursing profession at SQUH and in Oman.

Moreover, initially NGNs had a sense of lack of job security because they were working under temporary contracts. This made them face financial constraints and distracted their focus from working. Yet, the feelings of job security and getting paid increased their satisfaction and made them more committed to work. In addition, working shift duties affected SQU NGNs’ health and strained their social relationships because they were not able to visit families. Not able to visit families made some NGNs feel lonely and increased their stress.

There is a wide agreement in this study that internship programme is important for NGNs because they lack experience. The internship period assisted NGNs transition and allowed them time to learn and adapt to the working environment. Also, NGNs were given the opportunity to spend a period of the internship abroad, which was perceived as positive. However, the issue of the internship abroad is controversial. The internship period had been described by NGNs as “stress free” period. Yet, some interns have experienced being used as “extra hands” mainly by senior nurses to complete the routine and basic care of the wards.

On the other hand, preceptors played a major role in assisting NGNs’ role transition. However, it is clear that preceptors were not always portraying the ideal role-model image. In
fact, some preceptors were teaching NGNs some rituals rather than evidenced based nursing. Moreover, some NGNs had conflicts with their preceptors, which disturbed their relationship and therefore their learning. Furthermore, there is an issue of preceptors having no time for teaching because of the pressure of workload. This is believed to make some preceptors lose interest in teaching and do not feel committed. This study highlighted that the working environment is the most important asset in providing a good teaching climate.

On the other hand, collegiality and teamwork assisted in reducing NGNs stress during their transition period. Yet, some NGNs experienced working in stressful environments resulted in making some nurses aggressive and unsupportive. It is worth noting that many NGNs believed the support of the head nurse in particular played a major role in creating a supportive working environment. In fact, despite the negativity of some working environments, the positive support from head nurses played a major role in retaining NGNs in such wards.

NGNs also commented on how important positive support from the administration of the nursing department or the hospital was for their transition. It seems working at SQUH is considered a motivation for NGNs because of the status of SQUH and due to the fact that it offers different opportunities for professional development and good salary. SQU NGNs adopted some coping strategies to overcome their stress. Subsequently, they found themselves able to adapt and adjust more to the staff nurse role and their working environments.
5.4 The Working Conditions

The “Working Conditions” theme describes the actual experience of NGNs working as staff nurses in the hospital setting, dealing with different aspects of their working environment. Their experience dealing with their working environment will be discussed under two main themes:

- The Realities of Practice.

5.4.1 The Realities of Practice

In this section, NGNs experience of dealing with different aspects of the working environment at SQUH during their transition period will be elaborated in subthemes.

**Increased Workload**

Many NGNs in this study talked about their experiences of trying to deal with increased workload. Despite being juniors, many of them found themselves dealing with the extra pressures of caseloads of different patients with different needs. Some of them experienced taking care of many bed-ridden and critical patients at the same time in a single shift which was challenging and stress provoking. Some NGNs believed increased workloads created a stressful work environment in general where everyone is stressed out and irritable. Moreover, they believed that the increased workload did not only result in increasing levels of stress but also errors levels. They found themselves doing their work fast to be able to finish it all which affected its quality. Many head nurses agreed with NGNs that nurses in the wards are pressurised with increased workload of large caseloads of high acuity patients and specialised treatments.

“If you see the condition of the patients they are ICU patients, not ward patients, you see I am a beginner but sometimes I was taking care of 7 patients, one day 7 patients, 2 in Dopamine, 1 in Amiodarone, 2 were bed ridden, and I am still a beginner, it is so hard”

NGN3

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15 Intravenous medication acting on the sympathetic nervous system
16 An antiarrhythmic agent used for irregular heart beat

159
In addition, many NGNs believed that beside the increased workload they were also doing some extra non-nursing work which does not require any scientific knowledge. Some NGNs referred to completing doctors’ work, dealing with lots of paper work for the hospital or even cleaning the ward. Many NGNs referred to their experience mainly doing medical orderlies’ work where they shift patients or machines to different departments or wards in the hospital or outside the hospital. Many head nurses and preceptors agreed that nurses in the wards are busy doing many non-nursing work, mainly the medical orderly job. It seems there is a culture in the wards that if there is no one to do the job, nurses are expected to do it. Despite NGNs regarding these as extra jobs, other nurses insisted that NGNs should learn and do them. This can be related again to the “extra hand” theme discussed earlier in Sections 5.2.2 and 5.3.2, which was experienced by both students and interns. All NGNs agreed that doing non-nursing extra work is usually time consuming and it massively increased the pressures of the workload. NGNs continued to complain about the non-nursing extra work throughout their transition experience. At the 2nd set of interviews, many of them still referred to doing medical orderly’s work or completing doctors’ work. They insisted that they were expected to do the work because there was no one else to do it.

“60 or 70% of the nurse time she doing nurse aid work only, without applying any knowledge, without doing anything scientifically. I know positioning is something scientific, because we have to monitor and observe all patients. I know that, patients’ skin and all these things, but for example transferring the beds, sometimes we were going to another ward to bring medications. It is overwhelming, sometimes we were transferring patients alone without any medical orderly, taking the patient from one ward to another ward, sometimes we were transferring machines from one ward to another ward, these things can really be done by other people” NGN5

“The non-nursing job that we have to do is still the same nothing change, and we still doing the same no improvement in these things. You know when we were telling them that this is not our job they will tell ‘who is going to do it, nobody is going to do it’” NGN1 (2nd interview)

**Time Pressures**

Initially, almost all NGNs experienced time pressures in trying to manage the increased workload. A few NGNs highlighted the pressures of spending so much time trying to do some procedures such as collecting blood samples or setting an intravenous line. Many NGNs
felt frustrated with their increased workload and time pressures. A few of them believed that they as nurses need to manage their time and be able to delegate work to others. They believed this helped them to overcome the work pressures. However, based on many NGNs experience this was not always possible. Some NGNs stated that they were criticised by their colleagues for leaving some work for the next shift or initially for not being able to manage the increased workload as described in Section 5.3.2. Some NGNs and head nurses referred to nurses not being able to complete their documentation or missing their breaks because of time pressures. Yet, only a few NGNs only highlighted that they had to stay late sometimes to finish their paper work which could no be delegated to others.

“Really for me it is a matter of time, in the morning we have to change the bed and [give] bed bath, at the same time maybe the doctors want to see the patients and you will be assigned for one team in the rounds, maybe you have another assignment, maybe to do checklist for the CPR\textsuperscript{17} trolley, or maybe you have to collect the patient, you have one booked admission or to shift the patient to OT\textsuperscript{18}, sometimes really all these come at one minute and all done by the nurse” NGN13

Moreover, many NGNs in this study stated that sometimes they had to delay or not attend their patients’ needs because they were caught by other work which they had to complete. Delaying patients’ needs or not been able to meet their needs engendered guilt feelings causing distress for NGNs. In addition, many NGN believed due to time pressures they sometimes failed to provide patients with quality care. In fact, some NGNs talked about being busy dealing with some patients and having no time to provide care or even to see their other assigned patients. Consequently, they felt upset for their failure to provide care for all of their patients. Some NGNs carried this guilt feeling even after work. Yet, subsequently, there were some NGNs who found that their working area was not always busy which gave them more time to manage.

“Sometimes, I am blaming myself a lot, especially when I am sleeping, I am thinking I have two patients I have not seen, supposed to see the patients, so their right to get care from me, they have lose it, there is something wrong I have done” NGN2

\textsuperscript{17} Cardiopulmonary resuscitation.
\textsuperscript{18} Operation Theatre.
Cutting Corners and Compromised Standards

As mentioned earlier in Sections 5.2.2 and 5.3.2, during the advanced clinical course and the internship period, some NGNs and SNs highlighted their experience working with nurses who cut corners or sometimes compromise standards. As staff nurses, many NGNs also referred to the sterile technique which they observed their colleagues break or not do it the “correct” way as taught to them by the college. Also, some NGNs referred to the blood sugar checking in particular where it seems nurses do not stick to a consistent practice with the use of gloves. In this example, NGNs were mainly concerned about cross infection which this procedure might induce. Also, a few of them observed that nurses did not always maintain standards of care such as maintaining patients’ privacy and confidentiality or being culturally considerate which made them feel angry. There was an agreement in this study that nurses mainly failed to maintain standards or follow the hospital policy and procedures due to the workload and time pressures. A few head nurses believed that some nurses do not feel committed to follow the hospital policy and procedures or sometimes they are not aware of them. Many NGNs observed doctors also failing to maintain standards and comply with the hospital policies. For example, one male NGN observed a doctor taking consent from a patient while he was in the toilet which made him feel that the doctor had compromised some of the basic rights of the patient.

“They are not following the standards to give the best care for the patient like for example the privacy of the patient, they are exposing the patients not only the part they need, they will expose everything, and I feel here we should be more [careful] because we are Muslims and exposing female [body] to male unnecessarily, but they do not care about it” NGN1

“One patient, he was for surgery and I prepared him and I send him to the toilet, the doctor came from OT to take the consent, imagine he went to the toilet and asked the patient, he took the consent from the toilet and he did not give the patient at least 2 minutes to be on the bed and to explain to him. Really I felt like nervous, because this is some of the very important rights of the patients, to know about what the doctor will do for him, but because of our power I did not say anything” NGN14

Many NGNs believed that it is their duty to change the wrong practice because they are trained to high standards. A few NGNs during their initial few weeks of work were optimistic and felt they could impose changes to nurses “wrong” practice if they work in a supportive
environment. However, according to some NGNs, nurses did not accept their comments and criticism to their “wrong” practice because they viewed them as juniors. They also believed nurses were usually reluctant to change their “wrong” practice because they were used to it, which will be analysed further in the next section. Feeling unable to change made many NGNs feel powerless and frustrated. On the other hand, some other NGNs insisted that they avoided criticising other nurses’ practice because they needed to maintain a good relationship with them.

“But still when I see these wrong practices they are doing, I feel like if I cannot change this then why I am here? I feel like this, but we will try our best to change them, because this is what we have to do” NGN1

Despite spending more than six months or even completing one year in the working environment, some NGNs still compared the standards of the working environments to that of the College of Nursing. Some NGNs found a difference in the resources between the working environment and their college which might be the reason for different standards. For them, the college environment was ideal with ideal equipment in-place while the working environment lacked resources and equipment sometimes. Therefore, some NGNs felt it was difficult to try strictly to apply what they have learned to their working environment. They believed they need to be flexible in their practice and work according to time and resources available for them without jeopardising patients’ safety.

“Trying our best to do like what we have learned but sometimes we will face situations that things are not available, so you need to manage” NGN2

**Routinisation**

Many NGNs and SNs believed that nurses’ work in the wards was mainly about ritual and carrying the routines without any updates. Each ward has its routines, for example nurses wakeup all patients to do bed making or bed bath at specific times. Some NGNs believed that sticking to routines might be an approach adopted by nurses to organise the huge workload they have to do, ensure the smooth running of the work and avoid leaving work over for the next shifts. Some NGNs remarked that some nurses strictly followed routine work and did not allow any change whatever is the reason. Moreover, some NGNs felt some nurses labelled NGNs who delayed the routine for any reason as “not willing to help”. Yet, some
NGNs, who were interviewed in their initial weeks in practice, remarked that they did not always accept to strictly following the routines and they prefer to take into consideration the ward and patients’ condition.

“We are mostly given the routine care, learning from them what is the routine, even for example we are changing pamper [nappy] at four o’clock when I told them ‘I want to change it at six o’clock no need to change it now’, they said ‘no, change it at four o’clock we will not wait until six o’clock’ even if I have a reasonable reason for that but still” NGN9

“I do not care about the other nurses, I do what I feel I am comfortable to do, I will not wakeup any patient for only bed making, let him sleep, maybe he did not sleep at night” NGN4

Moreover, some NGNs felt that doing routine work made them feel that their work at the hospital is monotonous. This seemed to reduce their interest in work and also increased their level of stress. In addition, some NGNs felt angry that they were wasting so much time doing the routine work and not attending to their individual patients’ needs. However, many NGNs believed that doing the routine was also important because some routine work helped them feel prepared for any situation. It also helped them to maintain and organise their working environment and patients’ care. One NGN rejected the word “routine” because she believed such tasks are essential in the provision of patient care and should not be looked at as routine. In fact, even on the 2nd follow up interview, this particular NGN still believed that routine work is important and it has to be done. On the other hand, one manager commented that nursing practice at the hospital is either based on rituals and routines or on orders from above. He claimed that nurses at the hospital either copy each other or only follow the orders from the administration to improve or change their practice. This emphasises that nurses rarely utilise evidence to support their practice.

“I am not happy with this word ‘routine’, it is something we have to do, if we will not change the patient bed sheet it will become dirty, the patient will not feel comfortable, there are some tasks or some duties we have to do because it will affect the patient care, it is part of patient care” NGN13

“In reality in this place mainly the source of knowledge is tradition or authority. I have seen this nurse do it this way so I will do it this way, that’s tradition. Things comes from the
nursing directorate to them and they have to do it this way, that’s from authority, that leaves a smaller room for people initiatives and knowledge” M2

Task-Oriented Work

Through the different stages of their experience, all NGNs in this study believed that nurses in their working environments were task-oriented. They found that specific nurses were given specific tasks and responsibilities to do, such as; the medication nurse or the vital signs nurse. Many NGNs believed that task-orientation work means nurses in the wards tend to deal objectively with patients trying to address physical tasks without paying much attention to the patients themselves. They experienced observing some nurses who tended only to carry the physical care such as giving a bath for the patients without even communicating with them. Also, some NGNs found it was difficult for them to attend to different aspects of patients care when they were stressful with so much work and time pressures.

“Some nurses I really feel they are dealing with the patient as a machine because they are doing functional work only, not caring, for example they are just cleaning the patient and even they do not speak to the patient, they do not give the care, only they do their job and that is it” NGN11

“There is some nurses still they deny that they are dealing with a patient, with human, they are moving the patient even if the patient said ‘I don’t want’, they say ‘no you have to’, [they] force the patient to do that” NGN12 (2nd interview)

Some NGNs felt that some nurses tending to be task-oriented because they do not value the importance of addressing different aspects of care other than the physical care which is consistent SNs remarks mentioned in Section 5.2.2. Many NGNs stated that many times nurses did not allow them to spend time with their patients to counsel them or attend to their psychological and emotional needs. On the contrary, nurses preferred NGNs to spend that time to finish some other physical tasks.

“When I sit with my patient for five minutes, they will start sending to me other nurses ‘why you sit with the patient? Come and do this’. Yesterday, I was sitting with sickle cell disease patient, free of pain, but he wanted IV cannula19 because he wanted more morphine, I gave

19 Intravenous access.
him health education. But the other staff were saying ‘why you are sitting with him? Come and do other work’” NGN7

**Lack of Communication with Patients**

Many NGNs believed that there was a lack of communication between nurses and other healthcare professionals and their patients. This was mainly because of the language barrier between most of the healthcare professionals who are mainly non-Arabic speakers and the Omani patients. Many NGNs believed that both patients and nurses are suffering because of the language barrier. They felt this language barrier hindered the provision of some essential aspects of nursing care such as holistic care or nursing education. Many times, expatriate nurses were not able to understand and deal with their patients’ concerns. Some NGNs and also head nurses referred to “pain assessment” as one of nurses’ roles that is compromised because of the nurse-patient communication gap. They believed that expatriate nurses might understand when a patient complains of pain but they will not be able to assess the nature and intensity of pain which will affect the care provision. According to a few NGNs, due to the patient-nurse communication gap; patients assumed that nurses do not understand patients’ healthcare issues. However, they remarked that patients change their views when nurses show them that they care and try to establish a relationship with them.

“When I started I have noticed that when I sit in the nursing station, for example the bell is calling from that bed, I will go, after a while I have noticed that I am the only one who was going to the patient and the in-charge. Other staff will be sitting inside. And if there were things they will not go directly. It was like routine for them and there was no responsibility for them toward that patient” SN1

Many NGNs and SNs believed that patient-nurse communication has improved with them being at the hospital. They believed that Omani patients preferred to communicate with Omani nurses who can understand them. However, a few NGNs found that there was also a lack of communication between some Omani nurses and their patients mainly due to time limitations and increased workloads. Initially, some NGNs felt they were having more time to spend with their patients compared to other nurses which added a positive aspect to their transition experience.
Many managers and all head nurses and preceptors emphasised that there is a nurse-patient communication gap and having SQU nurses has indeed improved it. They believed that Omani nurses are able to understand patients more and work as patients’ advocates which ultimately improve the provision of nursing care. Expatriate head nurses and preceptors commented that they are pleased when there is an Omani nurse in duty because they can use her/him to explain and translate for them. Many NGNs and SNs felt that working as translators for both nurses and doctors added some pressure on them. Furthermore, many NGNs remarked that patients and relatives usually approach them for information which sometimes increases their workload pressures. Some NGNs felt that due to their limited authority and time, they are not always able to attend to patients or relatives’ queries. Conversely, one NGN claimed that she moved to ICU mainly to avoid communicating and interacting with patients and their families. Furthermore, some managers, head nurses and preceptors highlighted that some NGNs did not care much about communicating with patients rather they focused on technical issues or machines which will be discussed further in some other themes.

“I am very happy when one of them [Omani nurses] is around because some of us do not speak Arabic so they translate for us, and yes we always use them to explain something” HN4

On the 2nd follow up interviews, some NGNs observed that their relationship with their patients have improved because they tried to communicate with them rather than work functionally. They believed spending time with patients made patients feel that nurses are knowledgeable and started to establish a trusting relationship between them and the patients. Yet, some NGNs still faced some situations where nurses ignored patients and did not try to communicate with them. In fact, some NGNs referred to how disappointed they feel when they compare how expatriate nurses deal with Omani patients at the hospital and how nurses during their internship abroad respected their patients and spent time communicating and attending to their needs.

“Most of the patients are respecting me because I am not always caring about medication; I always try to talk to them” NGN14 (2nd interview)
Devaluation of Health Education

Almost all NGNs and SNs in this study valued patients’ health education as an important aspect of nursing care that is totally ignored by nurses in the working environment. They believed the health education is one of patients’ rights that might have a positive effect on their health outcome. Yet, many of them found no time for health education due to increased workload and time pressures. Moreover, a few of them believed working as a team and trying to help other nurses finish their work, reduced the time available for them to educate their patients. Some NGNs and SNs also commented on some nurses’ devaluation of the importance of health education to the patients. Some preceptors and head nurses stressed that expatriate nurses did not provide “health education” because of language barriers. They all stated that the presence of Omani NGNs improved the provision of health education.

“I feel the health education which is one of our major roles, they are not given the patient a lot of their time, they are busy I cannot say [with] silly things, but things that can be done by other people” NGN5

Many NGNs and SNs believed that they enjoyed spending time educating their patients and it helped them to build a rapport and trusting relationship with them. Moreover, they felt patients appreciated the health education they gave them and it improved their health conditions. According to some of them, patients preferred to communicate with nurses who gave them time to explain and provided them with health education compared to other nurses. Being able to provide health education made NGNs feel that as staff nurses they are at least practicing some of what they have learned at college. However, none of the NGNs referred to providing health education in the 2nd set of interviews.

“We are always very busy, very, very busy, and sometimes when we are free we try to apply for example patient education, which is very important, at least if you educate the patient he will not get readmitted again with the same problem. This is not happening because we do not have time to teach the patient. For example, a patient with hypertension and diabetes, why this patient admitted with CVA20? Always we will find patients are not compliance with treatment, or with their diet. Some patients do not know, nobody told them because nobody has time to tell them. If somebody at least guides them, I think by this we will decrease the number of readmission of some patients” NGN3

20 Cerebrovascular accident or stroke
5.4.2 The Context of the Working Environment

In this section, the effect of the context of the working environment on SQU NGNs’ transition experience will be elaborated in subthemes.

The Boundaryless Role of the Nurse

Many NGNs and SNs participating in this study believed that there were no job boundaries for the staff nurse role at SQUH which increased their workload. Some NGNs believed their job description was vague and contributed to them feeling confused about some of their roles at the hospital. At SQUH, NGNs were given the title of staff nurse 2, which is called N9 grade on the nursing grading scheme. In reference to SQUH N9 job description, a list of the duties expected of N9 is provided. However, it stated that N9 grade nurses are expected to perform other duties if required which might entail non-nursing work.

“This job description in no way states or implies that these are the only duties to be performed by the employee occupying this position. The employee is expected to perform other duties necessary for the effective operation of the department/ward/unit” SQUH Staff Nurse 2 (N9) Job Description.

“I face some work that a nurse should not be doing, like for example the ECG\textsuperscript{21}, I thought that only the doctors are doing ECG, but now sometimes they [nurses] are saying ‘no the doctors have to do it’ and sometimes they say ‘no the nurse has to do it’” NGN6

Most of the NGNs believed that their role as staff nurses was very broad and there was no focus on nursing care. They believed that nurses were expected to do everything for their patients at the hospital especially since there were no nursing aids to help them. A few NGNs reflected on their internship abroad where nurses were not doing some of the tasks done by nurses at SQUH. This made them feel they were misused and abused by the hospital to do so much exhausting non-nursing work. Many NGNs blamed the administration for adding extra work to the nurses’ role and expect nurses to work all the time. They believed the administration should investigate the real work nurses are doing in the wards and the challenges they are faced with and try to improve their working conditions. Many NGNs believed that adding so much work to them is compromising and restricting their application.

\textsuperscript{21} Electrocardiography
for high standards of care. This also limited their abilities to practise what they have learnt at college. One of the NGNs, who had her training mainly at SQUH, raised the question if nurses in other hospitals in Oman are performing the same role as staff nurses at SQUH.

“Most of the job that is the direct care that patients receive is carried out by nurses, that is real because we are doing most or all, everything. This makes me sometimes think why nurses? Why not others?” NGN6

The Culture of the Organisation

Many NGNs and SNs referred to nurses’ working hours at SQUH to be longer and erratic compared to other governmental hospitals in Oman. This made some of them considered leaving SQUH for better working hours. Also, some NGNs believed there was a culture at the hospital that nurses can work 24/7. They felt as nurses they were expected by other nurses to be on their feet all the time and should not complain or rest. A few NGNs reported that some of their colleagues tried to impress other nurses by looking busy and showing them that they work hard and even skipping their breaks. NGNs continued to experience nurses expecting them to work all the time throughout their first year of work and even after that. Some NGNs blamed the administration again for instilling this picture about the role of the nurse. Some head nurses and preceptors believed the nursing staff shortage and the lack of support services to be the main reasons for the increased workload of nurses. In contrast, some managers insisted that the nature of contemporary healthcare services to be challenging and there are high expectations put on nursing services at SQUH to work hard and provide high quality care. Moreover, they insisted that the nurse-patient ratio at SQUH is adequate and is based on international standards. One manager believed that the issue of “increased workload” is not on the nursing management top list because there is a belief that all nurses complain about the workload.

“They look at nurses as they can do everything and even we can work 24 hours, this is the problem of the administration of the hospital. Actually they do not accept someone feeling tired. It happened that I was feeling tired and I sat on a chair and they (other nurses) were doing the things and if they required something I will stand and give it to them. Then one of the staff nurses said ‘why are you sitting and not standing up?’ I asked ‘why to stand up like that? They do not need me and whenever they need anything I will stand up to give them’, they have this attitude that nurses should stand up all the time, they should not sit, they
should not get tired, should not get sick. Even some times when I get sick leave, the next day when I come to work they will ask me ‘what happened? Why you took sick leave?’ I took it because I was sick, but they make me feel that they do not accept this and it will affect me” NGN1

Despite the difficulties NGNs faced working at SQUH; many of them felt happy to work at SQUH and believed SQUH is better than other hospitals in the country. Many of them preferred to work at SQUH and considered it the best hospital in Oman in terms of staffing and standards of care. Moreover, many of them felt they were more familiar with SQUH’s structure compared to other hospitals. They also felt they were more aware of SQUH’s policies and procedures. Many of them believed it is difficult for them to leave SQUH and work at other hospitals. In comparison, some head nurses in particular stated that they preferred to have SQU NGNs because they are more aware of the setting and policies and procedures of SQUH. However, some NGNs stressed that nurses’ roles at the hospital has to change for them to stay. They stated that they are trying to tolerate and cope with the role of the staff nurse at the hospital which they might not be able to do for a long time.

“I am not saying I am really 100% satisfied, but in somehow, really I am happy because it is really a good place to work, and it is really a good service and a good place to learn and to develop” NGN11

“Until now I am patience to continue, I do not know when my patience will be over” NGN3

**Working with Expatriate Nurses**

NGNs in this study highlighted working with expatriate nurses as one of the factors which influenced their experience at SQUH. SQUH is a multicultural environment holding a workforce of health professionals from different cultures and background such as Indians, Filipinos, Malaysians, South Africans and others. The nursing workforce was the largest at the hospital of about 1068 nurses. Of those there were only 212 Omani nurses. According to SQUH resignation analysis for the year 2010, SQUH was losing expatriate nurses because of family commitments and the search for better work opportunities. Therefore, as mentioned in Section 2.1, hospitals in Oman are trying to reduce their dependency on expatriate nurses by implementing Omanisation.
A few NGNs found that expatriate nurses tend to aggregate together and it is difficult to establish friendly relationship with some of them. Also, many NGNs in this study felt that expatriate nurses do not always accept them because of the Omanisation strategy the hospital has implemented. Many of them found expatriate nurses throwing comments that Omani nurses are going to replace expatriate nurses and steal their positions or even become “the future boss”. Many managers and head nurses believed that the SQUH management plan to nationalise the nursing workforce is an important step not only in stabilising the nursing workforce but also to improve nursing services. According to them, expatriate nurses care more about securing their jobs rather than improving nursing practice. However, many head nurses highlighted that expatriate nurses feel their jobs are threatened and Omani nurses will replace them. Head nurses insisted that they try to support expatriate staff and ensure them that if they work hard and make themselves indispensable then the organisation will always need them. Therefore, it might be the job instability that some expatriates nurses’ experienced which affected how they perceived and treated NGNs. On the other hand, the expatriate preceptors interviewed in this study stressed that it is their role to develop Omani nurses and they always welcome NGNs and try to teach them.

“I do not know why they are feeling we are stealing their positions, they are threatened of course, they are telling us ‘you are the future boss of our ward’, they are telling us like a joke but inside them we know they are thinking about it a lot” NGN2

“If you go to any non-Omani nurse and you ask them what their priority are. Job security is number one, they want to make sure that they are working here for certain years because they have their own plans, but it will not work always in that direction, it could come times we will need to nationalise and that is coming” M2

A few NGNs believed that expatriate nurses misuse Omani nurses and make them do their basic nursing work. This might be linked to the issue of some interns feeling senior nurses were using them to do their basic nursing care due to the fact that most senior nurses are expatriate nurses as mentioned in Section 5.3.2. A few NGNs had experienced expatriate nurses making jokes in their own language about how some Omani nurses pronounced some English words. NGNs were surprised at how those nurses treated them and treated their Omani colleagues.
“From years this is happening, for all Omani staff, not only interns, they are keeping Omani nurses doing bed making and they are doing something else” NGN4

“When I sit for endorsement, he [expatriate nurse] starts joking, laughing about any single word coming from my mouth, why?” NGN7

Moreover, many NGNs and SNs referred to their expatriate colleagues as passive nurses who are working without asking and accepting any work from the doctors and the seniors. It seems expatriate nurses only obey orders and never discuss. One female NGN witnessed a doctor throwing a pair of scissors at an expatriate nurse’s face but she acted passively and showed no reaction. Many NGNs suggested that expatriate nurses acted passively because they wanted to secure their jobs and therefore tried to avoid conflicts. Also, many expatriate preceptors who participated in the preceptor course insisted that they avoided commenting on NGNs’ performance or having a conflict with anyone including head nurses because they were scared that they would lose their jobs. In fact, these preceptors were reluctant to share anything with other nurses and approached the researcher to share their experience confidentially. There was a great fear that the comments they shared would be taken against them and threaten their job security.

“Sometimes I think because most of them [nurses] are expatriates. They do not want to refuse things. They are afraid they will be taking out from the hospital. So I think that’s why they are doing everything. Even if a doctor throws anything in their face they would not say anything. I have seen this many times. Like if they give something to the surgeon, wrong scissors he will throw it in their face” NGN1

Many managers and head nurses believed that SQUH still needs experienced expatriate nurses because most Omani nurses are still juniors who lack experience and need time to adjust and develop and this might be a challenge for Omanisation at this stage. Moreover, they believed having expatriate nurses created a competitive environment where nurses worked harder. Many of them believed that having nurses from different cultures and countries is healthy for the organisation and improved the quality of care. It seems due to the shortage of experienced Omani staff, the hospital was trying to retain some experienced expatriate nurses by giving them some motivations and privileges. This made a few NGNs feel there are inequalities between them and expatriate nurses as they found that some nurses from some nationalities are paid higher than them.
“If the experienced person leaves, you need to recruit another experienced person, not the novice and beginner, until they develop, if I am getting this many number of staff that does not mean they will replace the senior, they will only replace the first level of nursing workforce, but you recruit for the other levels, for example in the cardiothoracic unit or in specialised area, these interns are not trained for specialised areas, you cannot immediately utilise them as specialised nurses, so you need to recruit from outside until these people are able to work in that area” M1
5.4.3 Summary: The Working Conditions

Throughout their transition experience, NGNs had to deal with a changing and challenging working environment, which they felt not fully prepared for. NGNs found the workload to be overwhelming with high acuity of patients and much routine work. Moreover, they were pressurised with time to complete their work and attend to their patients’ needs. Therefore, according to NGNs, nurses tend to be task-oriented rather than attending to patients’ individual needs. Nurses did not attend to patients’ needs especially in regard to health education. Also, NGNs remarked that not all nurses maintained standards and complied with policies. Resources in the working environment made it difficult sometimes to maintain standards and as nurses NGNs found that they needed to utilise what they had rather than strictly trying to follow the college teachings. Moreover, it seems there was a communication gap between nurses and patients at the hospital mainly due to language barriers. It is believed that the presence of NGNs help in improving the nurse-patient communication. However, this is thought to increase the pressure of workload on NGNs.

The standards at SQUH are perceived as better compared to other hospitals which made some NGNs feel reluctant to move out of SQUH. This reflects that NGNs had a sense of loyalty and belonging to SQUH. However, some of them stated that they might consider leaving SQUH because of the working conditions they experienced during their transition period.

Working with expatriate nurses affected NGNs transition period at SQUH. Expatriate nurses mainly comprised the senior nurses’ population while Omanis comprised the junior population of nurses. There was an issue of expatriate nurses’ feeling that their jobs are under threat by the increased number of Omani NGNs who might replace them. Despite SQUH plan for Omanisation, some believed it is difficult for the hospital to nationalise at this stage. This is because most Omani NGNs are juniors and therefore expatriate experienced nurses are a necessity if standards to be maintained. However, some argued that expatriate nurses focus only on doing the work without any contribution on developing the nursing profession and improving its status.
5.5 The Status of the Nursing Profession

The “Status of the Nursing Profession” theme describes how the role and image of nursing affected NGNs’ transition experience. Three key themes are identified. These are:

- Basic Nursing Care.
- Doctors versus Nurses.
- The Context of the Nursing Profession (in Oman).

5.5.1 Basic Nursing Care

Providing “basic nursing care” is one of the key themes identified in this study. In this section, the effect of basic nursing care on NGNs’ transition experience will be elaborated in subthemes.

Why we are doing Basic Nursing Care?

In general, many NGNs, regardless of their gender and stage of transition, expressed concerns about basic nursing care. Some of them believed it is important component of care but they posed the question “why they have to provide simple basic nursing care when they are equipped with high knowledge which they can utilise in a more scientific nursing care?”

Many of them referred to the five years they spent at college studying biosciences and how disappointed they feel about not utilising them into practice. The main basic skills NGNs referred to are “bed making”, “bed-bath (sponging)”, “positioning” and “nappy changing”.

Many head nurses, preceptors as well as clinical instructors referred to some NGNs showing resistance to carry out basic nursing care as staff nurses because they have studied for five years at college and have so much theory, thinking that they should only care about “high” level of skills. Many head nurses and preceptors believed that NGNs’ negative attitudes toward the basic nursing care are instilled in them by the nursing curriculum. However, some clinical instructors insisted that despite their graduates having wide range of theoretical knowledge they still expect them to provide basic nursing care to patients.

“We studied for five years, we studied pathology, path-physiology, anatomy, a lot of science, even sometimes we are better than medical students in recognising pathology and path-physiology and anatomy, so sometimes we feel that some of our roles in the hospital is to do...
bathing to the patient, I know this is humanistic things, this is something we have to do, but these things can be done by other people, people who know little, they can do it perfectly. Why we have to waste all of our time positioning patients?” NGN5

Some NGNs tended to hide their involvement in providing basic care from their families and expressed feelings of embarrassment that their families might know. In fact, the majority of NGNs felt that doing basic nursing made them feel embarrassed and perceived nursing as a low profession. Some head nurses witnessed male NGNs hiding behind curtains feeling embarrassed saying that they do not want anyone to see them collecting urine or giving body-care. Some NGNs had an initial expectation that with increased experience and knowledge nurses should move away from basic nursing care. Yet, some of them were disappointed when they found that their seniors were still doing basic nursing care despite their advanced knowledge and skills. Managers, head nurses and preceptors insisted that basic nursing care is part of a nurse’s job and all nurses are obliged to care for the basic needs of their patients, which make NGNs no exception. Some head nurses highlighted that they themselves do basic nursing care sometimes when it is required.

“We are feeling shy and embarrassed by doing this bed making. One time I told my colleague ‘imagine your husband come and see you doing this’; she said she would be embarrassed. I am embarrassed, when we are doing other work we are proud, but when we are doing this [basic nursing] we feel we [are] little sad and we feel our self as low and down. We are not telling them [family] what we are doing here and also when they are asking what you are doing in the hospital. We are not telling them, we are just laughing” NGN4

“Some of them also feel frustrated, upset, you know because when they come they expect they will be [in different positions], they don’t mind to work in the ward but all this like basic care have to done by others, not for the trained staff or by BSc holder” HN4

Many NGNs preferred to work in wards where there is less basic nursing care and more “higher” nursing skills. However, most NGNs agreed that they need to provide basic nursing care in some wards such as ICU. In fact, some NGNs regarded ICU nursing as at a higher level than nursing in other wards because of the fact that ICU nurses are dealing with sophisticated machines, specialised treatments and critical patients who need close observation and monitoring. Moreover, most NGNs who were interviewed in their first few months of their internship programme expressed their preference to work in ICU because
they feel it is a better place for them to apply what they have learned. In fact, in the follow up stage, it is found that all interns have moved away from medical wards where work is mainly about providing basic nursing care to other wards where there is less basic care. On the other hand, many key informants stated that many SQU SNs and NGNs tend to avoid working in wards with so much basic nursing care and avoid providing basic care to patients. They highlighted a gender difference where male SNs and NGNs showed more resistance to provide basic nursing care and preferred to deal more with paper work or focus on machines or medications rather than working as nurses.

“We are doing basic nursing care there [ICU], but I do not know I am feeling that I am in higher level because in ICU, the patients are critical, they are in need, so even basic nursing care somebody will see it more [higher]. As ICU nurse, I think nurses work is higher a little bit because they are dealing with critical situations, they are supposed to be scientific, updated, know everything” NGN8

Seeing Nurses as Servants

Many NGNs felt that doing basic nursing “contaminates” the image of the professional nurse. According to them, doing basic nursing made people perceive nurses as servants, which made NGNs feel embarrassed and ashamed. In fact, one NGN shared his experience as a student when his medical student colleagues joked about nurses because they give a bed bath. Due to nurse-servant image, some NGNs regretted becoming nurses and believed excluding basic nursing care from their role would make them feel better about nursing. It seems this was also the belief of other experienced expatriate nurses working at the hospital. They believed basic nursing care should be done by staff assistants. They also believed that doing basic nursing care makes patients distrust nurses to do other “higher” skills such as administering medications.

“Sometimes I feel I am like servant for that patient, he look down at me, I feel shame, and also sometimes I have the idea why I enter this field, why I choose to be like that” NGN12

“I was surprise that we have expatriate staff from other places who were saying that ‘certain actions we are doing here are not done by nurses’, they were not doing [them] in their places. I was shocked, for example the nurses in one of the countries they do not empty the urinary bag. They have especial staff they call them medical aids, they empty the urine bags
and they change pamper [nappy] for the patients, because the patients are expecting nurses to be higher than that. One nurse told me that ‘if they [patients] see us changing for an example the pamper [nappy] or dealing with the urine and all that, they will not allow us to give medication or take blood, they will feel we do not know’. Their [nurses] image is going to be destroyed” NGN6

In addition, many NGNs felt that there is an assumption by patients and their attendants that since nurses deal with basic care they can do any work for them such as preparing a cup of tea. Some NGNs felt there is a difference between female and male patients and attendants in perceiving nurses as servants. Some NGNs experienced more cooperation from male patients and their attendants in assisting nurses in the provision of basic care than from female patients and their attendants. Again, some NGNs tried to move away from the “servant image” by moving away from the wards with large proportion of basic nursing care to other out patients departments (OPD) or even specialised units such as ICU. They believed patients and their caregivers respect ICU nurses more and do not perceive them as servants.

“You know in the wards, people look to nurses in the wards that they can do anything, even if a patient ask a nurse for a cup of tea she or he will make it, but in ICU, as ICU nurse, I think maybe my look, people look, I do not know, but somehow it is higher because she is dealing with critical situations” NGN8

**We Need Assistants**

As mentioned in Section 2.3, there is no nursing assistant service at SQUH. The entire nursing workforce is made up of qualified nurses. The majority of NGNs believed qualified nurses should not do basic care. Some of them reflected on their experience working in other hospitals in Oman or outside Oman where assistant staff provided the basic nursing care. Therefore, they proposed that the hospital employ assistant staff to do basic nursing care rather than wasting qualified nurses’ time. Some head nurses also highlighted that NGNs requested to have assistant staff that can perform the basic care. Some NGNs remarked that having assistant staff is what the working environment demands with the increased acuity of patients and time pressures. The majority of NGNs believed that having assistant staff would allow them more time to spend with patients and enable them to apply theories they have studied at college such as giving health education.
“They ask me ‘why we don’t have auxiliary nurse?’ it means like for throwing the urine, doing the bed bath, why should we do that? I told them we don’t have that in the system”

HN3

This study showed that NGNs’ perceptions about basic nursing care have changed over time. On the 2nd set of interviews, despite NGNs continuous insisting about the need for employing assistant staff to takeover the basic nursing from nurses’ role, many NGNs who had finished their first year of practice accepted basic nursing care as an important part of their role. A few of them started to enjoy working in medical wards regardless of the amount of basic care they have to do. Many of them also felt that despite basic nursing been exhausting, embarrassing and destructive to their professional image, it gave them some spiritual comfort by allowing them to help others.
5.5.2 Doctors versus Nurses

The doctor-nurse relationship affected NGNs’ perception about the nursing profession in their transition experience. The experience of NGNs dealing with doctors will be discussed in subthemes.

_Hierarchical Relationship: Treating Nurses as Subordinates_

Many NGNs and SNs believed that nurses play the most important role in patients’ care and other healthcare professionals could not function without them. Nurses carried out most of the work and mainly they were the one who was conducting and executing patients’ care. Some managers also highlighted that nurses have a key role in the contemporary healthcare setting. They believed doctors depend mainly on nurses and cannot function without them. However, many NGNs and SNs believed that doctors and even some other professionals treat nurses as subordinates. Many of them observed doctors, in particular, asking nurses to do simple work or even sometimes to complete their work. They felt this is due to doctors’ lack of awareness about the nurse’s role. Also, some NGNs and SNs believed that doctors do not involve nurses in the patients’ care plan undermining the importance of nurses’ contributions. They felt that doctors do not recognise and treat nurses as professionals which engendered angry feelings. Some managers, head nurses and preceptors agreed with NGNs and SNs that some doctors treat nurses as subordinates and do not respect them as autonomous professionals. Some NGNs continued to believe that some doctors lack the understanding of nurses’ role through out their experience. Furthermore, in the example given by one NGN about the doctor taking the consent of the patient in the toilet, mentioned in Section 5.4.1, that NGN realised that he needed to work as the patient advocate but he stated clearly that he felt helpless because of the power difference between him and the doctor.

“Some of the doctors cannot understand nursing, they will look at nurses as they just helping, they are aides for them, they will not deal with the professional nurse as what they are supposed to be, they will just give orders to the nurse, do this, take this, give this, sometimes they will not share the idea even and they will not accept the idea of the nurse” NGN5

In addition, despite NGNs and SNs limited experience, some of them had experienced mistreatment from some doctors or had witnessed doctors mistreat other nurses throughout their transition experience. Some NGNs stated that doctors shouted at them and embarrassed
them in front of others such as patients, other staff or medical students. Consistent with what was mentioned earlier in Section 5.4.2, many NGNs and SNs believed that doctors’ perception about nurses as subordinates in the hospital is based on their experience working with passive expatriate nurses who just obey their commands. One pregnant female NGN stated that she shouted at a junior doctor because he made her push a patient in a wheel chair to the Radiology Department to have a scan that was not arranged. According to her, the head nurse appraised her action and encouraged other nurses not to act passively with doctors. Some NGNs believed that some doctors, male in particular, are careful in how they treat Omani nurses compared to expatriate nurses.

“One day the doctor writes some investigation in the notes but she did not come to the nurse to tell her about this investigation. At the end of the shift this doctor came to ask her [the nurse] about the investigation, the nurse told her 'see in the computer yesterday we did these investigation’, when she showed her, she[the doctors] said 'yes this is from yesterday, I ordered another investigations today’, she told her ‘but doctor you did not tell me about that’, she had a paper (SN5 was using her hand to show the group how the doctor through the paper on the nurse face) and she told her ‘I have to go behind each nurse and tell her what to do’, I felt there is poor communication between doctors and nurses but always the doctors are shouting at the nurses but I have never seen a staff (nurse) shouting at doctors” SN5

Many NGNs and SNs believed that nurses working at the hospital have strong scientific knowledge, which if communicated well to doctors might make them change their attitudes about nurses and treat them as partners. In fact, some NGNs experienced working in wards where doctors treated them as professionals. Cooperative doctors tend to directly approach nurses and value their contribution to patients’ care. It is important to note that NGNs who identified more doctors respecting nurses, worked in surgical wards and ICU. Many NGNs believed that doctors view and treat ICU nurses different to the ward nurses because they play the most important role in providing care. Moreover, many male NGNs and SNs in particular believed that more senior doctors treated them better than junior doctors. They referred to male consultants being more understanding and cooperative.

“In [ICU] you cannot differentiate the doctor from the nurse; really, because they are all together in planning the care, while doing the rounds, the doctors and the nurses will be there, everyone will be talking, sometimes I found the doctors are asking the nurses and the
nurses they can order the doctors, you know they tell the doctors to do something and this is what I like most about them. In ICU the doctors they are depending on me, and they trust me really, I am the most effective one in the care of the patient, so I like it very much” NGN8

A Communication Gap

Many NGNs and SNs believed there is a communication gap between doctors and nurses. Some of them witnessed doctors writing their “orders” on the computer not usually communicating them directly to the responsible nurses as in the quote (SN5) mentioned above. They believed doctors do not always realise the importance of communicating with nurses which made them feel there is a lack of respect from doctors to nurses. Many NGNs and SNs found that nurses in the wards waste so much time calling the doctors or trying to locate them to finish their work or to put their requests in the computer database. Also, it seems there was no familiar or collegial relationship between doctors and nurses. Many times, nurses did not know the responsible doctors for their patients. In addition, some NGNs believed that some doctors are not fully aware of their responsibilities as doctors. This is evident in some NGNs experience where they had to ask and request the doctors to do their work. Some NGNs and preceptors commented on doctors sometimes delaying their work by entering their requests into the computer database by the end of the shift. This increased work pressure on the nurses and therefore, increased their role stress. In fact, some NGNs experienced that some nurses preferred to complete doctors’ work rather than wasting time trying to locate them which added to nurses’ workload.

“When we come to the computer we will find the notes of the doctor and the orders there, I do not know who is the doctor, what is happening, so really this made me not comfortable in the wards” NGN8

Many NGNs in this study believed communication with doctors was stressful. One of the NGNs described how she tried to inform the doctors that her patient is a known hypertensive case and she needed to be started on her regular anti-hypertensive medication. It seems this NGN tried to convey the message many times and through different routes but she was not successful. She was frustrated that a simple thing as starting a patient on her regular medication might be complicated. This incident not only reflects a gap in nurse-doctor communication but a possible gap in doctor-doctor communication.
“I informed the doctor this patient is a known case of hypertension and she is on treatment at home, please doctor start anti-hypertension medication. I informed the next shift staff and I informed the on-call doctor, by the next day they started the anti-hypertensive medication but from the zero, what does that mean? They did not give her the same medication that she was getting at home, she is a known case of hypertension from long time, why they started the medication from zero, she was not getting any benefit, she was not improving, again the next day I took the same patient, still with high BP, the on-call doctor said I cannot start anti-hypertensive drugs because the consultant should take care” NGN3

A few NGNs believed that some doctors considered them as juniors and did not put much pressure on them. Yet, a few of them reported that some doctors did not consider them as juniors and demanded their requests to be carried-out. This reduced NGNs’ confidence and made them feel unsupported. Moreover, a few NGNs felt that doctors usually avoid them and prefer to communicate with more senior nurses. They believed this is mainly because doctors assume that senior nurses have more knowledge and information about the patients. In the follow up interviews, many NGNs believed that their communication and relationship with doctors have improved. This has increased NGNs’ confidence on their practice. Yet, many of them still believed nurses are wasting time trying to find the doctors. Moreover, NGNs at this stage of their experience found that they are facing a new problem of needing to teach junior doctors how to do paper work or use the computer system, which added to their workload.

“It is the same actually, it is honestly going worst, I do not know, every four months they will bring new interns, this medical graduates, they will bring them, put them in the ward, they do not know anything about the system, how to punch medication, nothing at all, all their experience will be only theory, it will be very difficult for us, they will put them and the SHO22 and all registrars will be busy in other wards, only they give the order to the [medical] interns, they [medical interns] will not know how to put it in the system and it will be an extra effort for us to teach them everything about the computers, about the paperwork” NGN13 (2nd interview)

**Diminished Autonomy of the Nurse**

Many participants in this study used the phrase “doctors’ orders” rather than “doctors’ requests” which might highlight a hierarchical relationship between doctors and nurses and

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22 Senior House Officer
also that nurses’ work is based on doctors’ orders. Many NGNs and SNs believed the doctor-nurse relationship is determined by viewing doctors in the wards as “team leaders”. Some of them referred to the hospital protocols and policies limiting nurses’ practice and autonomy. According to them, nurses always need to ask for a doctors’ permission or order even for a simple prescription which made them feel they work based on doctors’ orders. Some NGNs and SNs found that despite the experience and knowledge of some nurses they do not usually take any action without the doctors’ orders, regardless of the experience and the knowledge of the doctor. A few SNs argued that despite the facts that nurses work according to doctors’ orders, there is a degree of autonomy which nurses can practice. Many other SNs disagreed with this and stated that as nurses they still work under the doctors’ orders and based on the nursing knowledge it will be difficult for them to challenge doctors’ decisions.

“I feel nurses are always under other professions in the hospital, if you see doctors they always see their self they are high, they feel they are high in their position, but nurses they do not have this attitude, not all nurses, some of them or most of them. I feel the problem is with the nurses themselves, nurses they do not have much authority as doctors or other professions” NGN3

Many NGNs and SNs believed there is a difference between what they were taught at college about the professional nurse and the status of the nurse at the hospital. Some SNs were determined to change doctors’ view about nurses. They believed they should convince doctors that nurses are knowledgeable and have an important role to play to make them treat nurses as colleagues.

“They always give us lectures that the nurse is independent, so for that it is a profession, but sometime when I go to the hospital I do not like some of the things, nursing is still weak, because it is dependant, depends on the doctors. Maybe this is because of the nature of nursing. We always need to ask the doctor what we should do. For anything we should ask the doctor to make an order” SN7
5.5.3 The Reality of the Nursing Profession

In this section, the effect of the context and status of the nursing profession on NGNs’ transition experience will be discussed in terms of subthemes.

The Low Status of the Nursing Profession

Many NGNs and SNs stated that people question them “why they have studied nursing when they have got high grades in their secondary school”. A few NGNs also stated that people questioned them about their salaries thinking that nurses are low paid workers. This indicates that, in Oman people view nursing as low status and low paid work. In fact, some NGNs stated that they perceived nursing as a low status profession before they started studying nursing. Many of them thought people’s negative views about nursing are due to their limited knowledge about the actual role of the nurse. They believed this mainly because people usually see nurses doing basic nursing care and care only about finishing their tasks without utilising any knowledge. Moreover, some SNs believed that seeing nurses only following doctors’ orders and usually having no power to make a decision determined the public’s view about nurses. Many NGNs and SNs believed that the public’s limited awareness about the role of the nurse make them underestimate its importance. Therefore, they stressed on the need to increase public awareness of nursing as a profession. Furthermore, many NGNs remarked that nursing in Oman is mainly laborious work and it is not a profession because nurses have no autonomy and only practice basic skills without utilising scientific knowledge. Moreover, some of them stated that nursing is not a strong profession in Oman like other professions such as medicine. They considered the absence of political representation for nursing affecting how people perceive nursing. Also, some expatriate head nurses and clinical instructors in particular believed that nursing is not seen as a profession in Oman.

“One time I faced one patient who asked me, ‘how you are working and how much you are getting?’ He thought our salary is very low, he asked me is it 200, 300 [Omani Riyal\(^{23}\)] or less, actually he was surprised because our salary is much more” NGN15

Some male NGNs working in medical wards in particular felt that there was a low social status stigma attached to nursing. Furthermore, a few NGNs were shocked with the negative

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\(^{23}\) Riyal is the currency of the Sultanate of Oman; OR 300 is around £ 480.
attitudes of some expatriate nurses about the nursing profession. It seems some expatriate nurses were not happy about being nurses and did not appreciate the nursing profession as a good one. Attributing a low status image to nursing reduced many NGNs confidence and self-respect. It also created an intrapersonal conflict in many NGNs and SNs and affected their satisfaction about nursing. A few NGNs and SNs expressed their confusion about the nursing profession been the right profession for them. However, some of them insisted that they do not care about how people look at nursing and they try to work according to what they believe nursing is. Despite having a low image of nursing, there were some NGNs in this study who never dealt with people who looked down at them as nurses. They experienced patients and people in the community always treating them with respect and not belittling them because they are nurses.

“I faced a lot of staff nurses they are telling what is nursing, what is nursing, ‘oh we lost our future because of nursing’ A lot of nurses are expatriate, I asked them why did you choose nursing? they will just say, ‘oh I was not good in my school, I was the last in my school, I had no chance, I just entered the nursing, what to do’ [I feel] disappointed, really disappointed, I feel I could go to another place, one nurse she told me ‘my mother was good in maths, my father was good in maths, everyone is clever in my family, only me I am not clever’ I told her ‘but you are in the nursing field’ she told me ‘yes because I am not clever I am here, otherwise I will not be here’” NGN5

The majority of NGNs were eager to improve and change the nursing practice and image at SQUH and in all Oman. Many NGNs believed SQUH can play a major role in improving the nursing profession by employing SQU degree graduates. They referred to having more degree nurses to improve the quality of nursing practice. Many managers, head nurses, preceptors expected SQU degree nurses to contribute to improving the status of the nursing profession at SQUH and also at a national level. Some academics believed having many SQU graduates at SQUH would make it a pioneer in nursing care development. They referred to SQU NGNs being better compared to other Omani diploma graduates. However, some NGNs remarked that due to the fact that degree nurses work only at SQUH, this means SQU graduates will not be able to change nursing outside the hospital to the wider population. On the other hand, a few managers and preceptors showed some disappointment with the effort some NGNs made to improve and change the nursing profession. They believed some NGNs got absorbed quickly in the system and started to follow ritualistic practices without any
change or improvement. Some managers were also disappointed that mainly NGNs approached them for personal problems or conflicts rather than ideas or innovations to improve practice. This might be also linked to some clinical instructors’ comments of some SNs “copy-paste” nurses’ practice without utilising critical thinking mentioned in Section 5.2.2. Also, some managers believed that nurses in Oman do not market the profession and instead they only work for their personal benefits. They referred to many Omani nurses focusing mainly on pursuing higher studies just to improve their working status rather than improving the status of nursing.

“Who is the person who is a nurse that has a high position in our country? You will not find a Minister of health who is a nurse, why? Because we are not like advanced country, developed countries, even the president of the hospital you cannot become because you are a nurse, why? The doctor only who can reach that position” NGN5

Cultural Limitations

As mentioned in Section 2.2, in Oman male nurses usually work in male wards. Yet, female nurses can work in both male and female wards. All female NGNs who worked in male wards believed that given nursing care to male patients is difficult due to cultural limitations. It seems male patients; young ones in particular, tend to perceive NGNs as females rather than nurses which affect the nurse-patient relationship. Moreover, due to cultural limitations, female NGNs stated that they do not feel comfortable providing some nursing care or carrying out some procedures which involved direct body contact to male patients. In contrast, all male NGNs and SNs participated in this study had very limited experience working with female patients. Many male NGNs anticipated they would face some difficulty in caring for female patients due to some cultural-gender barriers. However, many of them believed that they can work with female patients because they are patients but they have doubts that female patients will accept them.

“In sense of relationship you know for us we are not communicating with male patients but like in medical most of them they are old so it was easier for me, but in surgical it was very difficult, I am feeling reluctant to communicate with the patients. Sometimes I want to do simple things like assessing the patient, and doing some procedures, even some procedures
like cannulation\textsuperscript{24}, injection, sometimes I am really finding it difficult, for me I am a nurse and he is a patient, but according to the culture relationship, I am feeling it difficult” NGN8

“It is not from the religion, it is all from the culture, if they are religious they will accept what we are doing, they will appreciate what we are doing, but it is the culture, they think like females coming to them, it is something not acceptable, I feel like they are not respecting the female nurse who is dealing with a male patient” NGN9

Moreover, many female NGNs believed that providing basic care in particular to male Omani patients shatters the image of Omani nurses. Some female NGNs experienced that some male patients actually refused to involve Omani female nurses in providing their basic nursing care. Some male NGNs also remarked that Omani male patients refused them and preferred expatriate nurses, regardless of their gender, to provide them with basic care including body-care. This might be due to the Omani culture where people feel embarrassed to be exposed to others from their own cultures. This might be also due to the fact that patients respected Omani nurses and they did not want them to do basic nursing care because of its low status.

“Actually this is one of the things make the nurses image bad especially if the female is working in male wards and doing bed bath for the male patients, the male patients themselves when they will go out they will talk about that nurse, I remembered at AFH, one man, he told me the story about one Omani staff nurse, when he was admitted in ICU, she gave him bath and things like that and he said if he was ok, he will not allow her to give, but he thought the nurse wanted to give him bath [NGN15 is laughing]” NGN15

“One situation when really he [male patient] refused me and said ‘do not let her come’, he asked another female nurse, she is expatriate and he told her ‘if you do for me ok I am agreeing, but if she will come I will not allow anybody to touch me’ I was staying behind the curtain so I just went away” NGN8

As shown in Box 7 in Section 5.1, more than 30% of SNs and NGNs cohorts are male nurses. Some male SNs and NGNs felt that some people disvalue male nurses. Some Omani male nurses expressed to the head nurses some concerns about their culture not accepting them as male nurses. However, some male SNs in particular insisted that they are proud of becoming nurses and they do not care about how others look at them as “male nurses”. A few managers

\textsuperscript{24} Inserting an intravenous line
stressed that they preferred to have more male nurses. They believed there is increased number of female Omani nurses attrition due to the Omani culture where women usually are tied up more with their social responsibilities as wives and mothers. Therefore, increasing the number of male nurses might stabilise the nursing workforce. In contrast, a few managers highlighted that they preferred to have more female nurses because usually male nurses have different agendas than working as nurses. Many managers highlighted male nurses wanting to move from wards to OPD or more administrative work as mentioned in Section 5.5.1.

“The more male you have the better stability in the nursing workforce. In this culture female might be taking a long maternity leave, followed with annual leave, if the husband is leaving for a study, they have to follow, that’s the culture” M2

Nursing is Hard Work

Based on many NGNs experience, nursing is physically exhausting work. Many NGNs stated that nursing work strained their health status and social relationships. They believed the nursing role entails doing basic nursing care and sometimes carrying heavy patients or managing large caseloads of patients. This made many of them feel tired. In fact, some of them complained of suffering from lower back pain. Moreover, many NGNs stated that after work they need to sleep to overcome the tiredness which affect the time available for them to spend with their families. NGNs who worked in medical wards complained more of back pain and tiredness. Yet, also some NGNs who worked in other wards complained of back pain and tiredness especially during busy days.

“It is hard, I just started, this is my 3rd week or 4th week and I [already] have back pain. It is really hard to start the day with back pain” NGN4

A few NGNs reported that nurses are daily dealing with patients with different infections which made them vulnerable and increased their occupational hazards. This clearly increased some NGNs occupational stress as staff nurses. Moreover, despite the fact that NGNs were initially happy about the salaries paid to them by the hospital, they felt that they were underpaid with the significant workload they have to do as nurses and the health hazards they encounter. However, a few NGNs felt that despite nursing work being hard and stressful they still enjoy working as nurses especially when they see the care they provide make patients feel better.
“I am really stressed every time [deal] with this Acentobacter, every day I am dealing with it, I do not know whether I will be infected or how can I deal with infected patients” NGN11

“Sometimes we are feeling the work we do is more than the salary actually, it is very hard, every shift we go home we cannot sit, we cannot do anything only sleep” NGN4

**Dealing with Emotional Issues**

Many NGNs felt that nursing is an emotionally draining profession and as nurses they had to deal with stressful situations such as death and dying. Some of them got emotionally involved with their dying patients and did not know how to manage or control their feelings. Encountering dying or dead patients made some NGNs think about their own death. Many of them agreed that dealing with death and dying is stressful and affects their life and some of them started to have nightmares about their dead patients. A few NGNs avoided seeing dying patients or spending time with them to protect themselves from emotional drain. On the other hand, a few NGNs said that they expected to see patients dying therefore it did not affect them emotionally. Yet, it is worth mentioning that NGNs who worked in medical wards dealing with elderly chronic patients expressed more acceptance of death compared to NGNs who worked with paediatric patients or patients with Haematology/Oncology disorders. Some head nurses and preceptors also commented on some NGNs expressing fear dealing with death and dying patients especially those who worked in Haematology/Oncology wards. Some head nurses underpinned the fact that due to emotional issues, some NGNs refused to work in some wards where they have to deal more with death and dying. They believed NGNs need to be emotionally supported when dealing with death and dying issues. On the other hand, one NGN felt angry that some of his colleagues reacted carelessly to issues such as death. He has observed that some of his nursing colleagues and doctors laughed and joked when there was a patient dying.

“It is really difficult to deal with them [dying patients], I cannot maybe even stand with them during dying, it is difficult, Actually in the beginning it is really difficult for me and I always have nightmares, every day, every day I am having bad dreams about them and sometimes I just sit with myself and just think about them” NGN15

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25 Gram-negative bacteria
“You can see a lot of them [nurses and doctors] smile like nothing is happening in front of them and even if a person is dying in front of them, I do not know really because I am also surprised seeing someone is dying in front of me and someone is laughing at the same time. It is difficult, it is not normal, really it is not normal, if I am seeing a person is dying in front of me and I am smiling like nothing is happening in front of me, there is a problem” NGN2

Moreover, many NGNs felt they do not know how to provide support for the dying patients or their families. Some of them tried to be compassionate to relatives but were not sure how to help them. Some NGNs blamed their nursing education for not preparing them to deal with such situations. However, a few clinical instructors believed that their graduates are exposed to death and dying as students and they should be able to deal with such issues. Subsequently at the end of their first year, many NGNs believed they are able more to deal with issues of death and dying. They described mainly trying to avoid getting emotionally involved with their patients and distracted their thinking about death.

“Most of the things we have done theoretical things and even about death and seeing people dying. Not that much we have been prepared for these situations” NGN2

“In the beginning I was involved too much emotionally. Now I am trying not to think too much emotionally and also to divert my mind from thinking about these things” NGN11

Moreover, doing emotionally difficult roles such as translating or breaking bad news challenged many NGNs. As mentioned earlier, NGNs speak Arabic, thus, they were asked to translate bad news to patients and their relatives. Some NGNs found it difficult to translate some bad news which has a catastrophic effect on patients and their relatives. They found themselves translating word by word without knowing how to reduce the impact of the news. However, it is also worth mentioning that NGNs working with specialised treatment found translating bad news to be more challenging than those working with elderly and chronic patients.

“When you are translating, some words it will be difficult to translate, you will think more than one time how to say it, but you will say it, and the person who is facing you he will be shocked because you have just said this word” NGN2
Some NGNs and SNs experienced having conflicts with their patients or patients’ relatives and they were not aware how to deal with them. Yet, many of them believed as nurses they have to control their feelings and tolerate patients’ comments or insults. In addition, many of them believed their relationship with patients changed when they spent more time with them.

“At the first day of orientation, immediately when I came [to the ward] one patient relative was asking to have a blanket, ‘sister can you bring a blanket for me’, I told him, ‘I reached now I do not know where are the things, I will ask and I will bring to you’, then he was shouting and screaming at me, not in a good way, I did not shout at him, I told ‘ok I will bring for you’ I went and brought the blanket and I gave him, I felt so angry and then after I came out, did you know what I told myself, if any patient or any patient relative again shouted at me I will not let him, I will also shout at him, like that I first said, but I said also if she is a patient I will be patience to her, because she is a patient and she is in need, but if patient relative or patient attendant I will shout at him” NGN3

**Nursing as a Caring Profession**

Despite all the challenges and difficulties NGNs faced, they believed nurses play the most important role in the hospital. Moreover, they believed nurses played a very integral role in changing people’s health for the better by caring and educating. Many NGNs used the word “caring” to express the human touch that nurses provided to patients by attending to their different needs. Many of them expressed their love of the nursing profession and felt pleased that they are nurses providing care and contributing to improving people’s health. In fact, again some NGNs linked their caring role to the spiritual benefits they believe they gain when they care for people.

“There are lots of things that are positive. This profession means you are caring for people who are sick and whenever you are sick you need someone to help you, who is attending you in a nice way, attending your needs either for reliving your pain, even emotional support. So when you give this you feel really satisfied. You feel you are doing something to help people and at the same time you get from them the good rewards, they pray for you” NGN6
“It is a profession regarding humanity, caring for people because I want to get what it means the spiritual benefits, thoab” NGN10

However, due to contemporary work pressures, some NGNs felt they are not working as caring professionals. They felt nursing is losing its meaning and becoming more task-oriented. Many NGNs believed becoming task-oriented affected the quality of care they are providing to their patients. They remarked that they are wasting their time doing non-nursing work and ignoring the most important of nursing which is “care”. Failing to provide care for their patients made many NGNs felt disappointed with the nursing profession.

“It really affect me because we are nurses and we are not doing what we supposed to do as caring person, just they only want to finish their work, and this is not what we are supposed to do, this will affect really the patients also” NGN11

However, some managers, head nurses and preceptors believed that some SQU NGNs do not have the passion for nursing. They believed some NGNs have no caring attitudes as nurses and instead see themselves as mini-doctors trying to focus on medications, machines or paper work. In fact, many of them highlighted that there is a significant number of NGNs who are not interested in nursing. They stated that some SQU NGNs treat nursing merely as an occupation and showed no passion for the profession. A few of them stressed that SQU nursing curriculum needs more emphasis on the caring aspect for the quality of nursing care to improve.

“Some of them actually believe that they are mini doctors or they want to be mini doctors. That is another concept, it is a different profession, nursing since it started it is concentrating on care, whether in Egyptian history or in Islam or even during Nightingale’s time, it focuses on care and how to organise that care and how to plan it, but the time have come where the healthcare system depend a lot on technology and with that they know people in healthcare sectors, they would like to know about the technical issues and how to deal with faulty machines, maybe the curriculum need to be changed, maybe” M2

26 Spiritual rewards
**Feeling Proud**

Despite the fact that most of the NGNs did not initially choose to become nurses and all the challenges and difficulties they faced during their experience, many of them felt happy and proud that they became nurses. They accepted nursing as their profession and their role as nurses. NGNs believed that studying nursing and becoming nurses changed their attitudes towards the profession of nursing and also changed their personalities for the better. They felt becoming nurses made them more able to understand and manage their health and promote their families’ and society’s health. Many SNs also felt proud of becoming nurses and excited to finish studying and start to work as qualified nurses. Some NGNs attributed their feeling proud and love of nursing to be instilled in them by the nursing curriculum.

“I am really proud of my work; I have this feeling of the ability to work in any situation. So I am more confident really to become a nurse, I am confident, my self-esteem is going up, now I am really proud to be a nurse” NGN13

“They [academic staff] are changing our attitude; really they affected us, to change from a person who really cannot imagine himself to become a nurse to become a proud nurse, a proud of this profession” NGN15

Some NGNs believed the working environment played a major role in making their experience a positive one. They mainly referred to having less workload, being able to complete all their responsibilities and being able to work as independent and responsible staff nurses. Furthermore, some NGNs believed working with happy staff created a supportive environment which they enjoyed working in. Moreover, positive reinforcement and appreciation from others motivated NGNs and increased their satisfaction about their work. It seems for the NGNs who were still in their internship programme; a good working day included learning more and giving them more trust and responsibility. Also, some NGNs considered having more time to spend with their patients to understand their needs and provide them with support to make a good working day for them. Having good working days increased NGNs’ satisfaction about being nurses

“It is when I work responsible, and independent, and do all the responsibilities, no one will come and say, ‘you did not do this’, I did not miss anything and I did everything correctly for the good of the patient” NGN1
“My good day when I come to work I see all the nurses are happy, smiling in the ward doing their job with happy faces, when communicating with the patients and helping each other, that is really a happy day for me” NGN11

On the other hand, many NGNs in this study believed that they have been treated differently because they were SQU degree nurses. Many of them referred to how different their families, patients or even their healthcare colleagues made them feel compared to diploma nurses. This made NGNs feel that there are high expectations put on them and they are pressurised to meet these expectations. This feeling of being treated different was also highlighted in the follow up interviews. Still many of them believed their families and community respected them more because they are SQU graduates, working at SQUH. Many managers, head nurses and preceptors highlighted that SQU NGNs are special. Some of them referred to SQU graduates in general as the “children” of the hospital because they are brought up and trained at the hospital. However, a few managers insisted that despite viewing SQU NGNs as special, all staff nurses are treated equally.

“They are putting more expectations on us, because from the beginning the college prepared us to work here, so they are saying ‘you are the future for this hospital’, so they are expecting more from us, we try to be the best nurses here in the hospital, and they are saying ‘you are the kids of this hospital’” NGN1

“To us they are special, they have been growing here in the hospital and in the college of nursing, that make them really special, we care for them but at the same time this does not mean we ignore others, everyone is really of value to us, so every staff in the hospital is valuable to us and we take care of everyone” M4

In addition, some NGNs and SNs believed that they are different or even better in terms of skills and knowledge compared to diploma graduates. This can be linked to their expectations and beliefs that their college of nursing prepared them well in terms of knowledge and skills, which external examiners commented on as mentioned in Section 5.2.2. This feeling of being different and prepared well was also highlighted by some NGNs in the follow up interviews. Many managers, head nurses and preceptors also highlighted that SQU NGNs are highly trained compared to other nurses in terms of knowledge and standards. They remarked that despite their limited experience many SQU NGNs demonstrated constant improvement in their skills. They believed that SQU NGNs provide higher quality care because they tend to
base their practice on evidence and theory. They also commented on NGNs commitment and initiative by working hard and being punctual. Moreover, some of them referred to a group of NGNs being “high flyers” that are already taking the lead and becoming active members of the nursing team. Yet, a few managers, head nurses, preceptors and clinical instructors highlighted that some SQU NGNs have an “ego” of feeling different or better to other nurses. Some managers in particular believed that the nursing curriculum instilled in them that they are better than other nurses. However, a few preceptors believed that NGNs feeling proud about being SQU graduates is a positive thing because it makes them work hard to improve their skills.

“I feel that we were prepared more than enough because I feel from my experience that our college was highly standardised, and the hospital is highly standardised from some point of view, they are at a standard but not that much so they need to improve more to meet the our college qualification” NGN5 (2nd interview)

Despite feeling proud of becoming nurses, during the first set of interviews, a few NGNs considered the possibility of leaving the nursing profession as a whole and doing something totally different to nursing. Furthermore, initially, almost 50% of the NGNs stated that if they could have their time again they would not consider nursing as their future career. Subsequently, most NGNs accepted nursing as their profession and felt proud to have become nurses. Yet, many of them felt they were still not completely satisfied with the context of the nursing profession at the hospital or/and their own competencies as staff nurses. Moreover, at this stage, NGNs have realised that some nurses in the wards are frustrated with nursing work and consider leaving nursing.

“Really sometimes you will feel like I will not work like a nurse again. I get this feeling so many times; I do not want to be a nurse” NGN2

“I am really very, very, very satisfied, I am really proud to be a nurse, and day by day this feelings is growing in me more and more” NGN13 (2nd interview)
5.5.5 Summary: The Status of the Nursing Profession

NGNs’ transition experience and satisfaction with nursing had been largely affected by their study experience and their initial experience in dealing with the real context of nursing work, their relationship with others and the status of the nursing profession. There are negative attitudes toward basic nursing care held by NGNs. They believed that basic care should not be carried out by staff nurses and felt disappointed that they are mainly doing the basic care and not utilising the science and theory they learnt at college. Moreover, they remarked that doing basic-nursing care shattered their image as professionals and made people see them as servants. Many of the basic-nursing care NGNs referred to, is about dealing with patients’ bodies, which can be linked to the theme of “bodywork” in the literature. This will be discussed further in the next chapter. There was a belief that the hospital should employ assistant staff who can take over the basic-nursing care and the non-nursing work from nurses’ role so nurses will have more time to provide other patients’ care. On the other hand, a number of NGNs expressed that despite them feeling that doing basic care is embarrassing and should not be done by them, it had given them some spiritual satisfaction.

Moreover, NGNs referred to nurses at the hospital being treated as subordinates by doctors. Some of them have experienced or witnessed some doctors mistreating nurses. NGNs believed that doctors lack understanding of the nurse role because they usually work with nurses who deal only with basic care, follow their orders and have no autonomy. However, working in wards where nurses exercise more autonomy and deal with advanced medical and technical issues made doctors treat nurses as professionals and include them in the decision making process. Furthermore, NGNs observed that senior, male doctors treat them better than junior doctors.

Many NGNs believed that there is a low status image attributed to the nursing profession because nurses are seen as doers who only focus on mechanical tasks and follow orders. Also, some expatriate nurses held some negative views about nursing as a low status profession and insisted that they became nurses because of their low academic grades. This shocked NGNs who are mainly “A” grade students.

Nursing is physically and emotionally exhausting job which affected NGNs’ health and made them complain of back pain. Moreover, dealing with dying patients, young ones in particular was stressful for many NGNs. This made some NGNs withdraw themselves from difficult
situations and avoid dealing with dying patients or their relatives. Some others transferred away from wards where they experienced lots of death and dying or even difficult emotional situations such as Haematology/Oncology wards. Moreover, NGNs in this study experienced being used by expatriate doctors and nurses to translate bad news to patients and families. In addition, some NGNs found they need to control their feelings when they are dealing with patients and their relatives which clearly reflect the theme “emotional labour”, which will be discussed further in the next chapter.

Many NGNs valued nursing as a caring profession and valued their role in changing people’s life. However, there is a belief that nurses in the working environment become more task-oriented focusing on completing tasks. In contrast, there were some beliefs that NGNs themselves move away from direct patient care and focus more on managerial, medical or even technical tasks.

Despite the initial ambivalent feelings about nursing, many NGNs felt happy and proud that they are nurses. In fact, many of them felt proud as SQU degree graduate nurses. Moreover, some of them described the positive experience they have when they are able to work as independent and responsible staff nurses. They commented on the effect of positive reinforcement and working in a happy environment on improving their experience. Also, spending more time with patients increased NGNs satisfaction with nursing. However, due to the challenges they faced in their working environment and the status of the nursing profession, a significant proportion of them stated that if they could turn the clock back, they would not choose nursing again as their future career.
Chapter Six- Discussion

Analytical/conceptual themes are developed to discuss SQU NGNs transition experience with relevance to the existing literature. In the discussion, the term “interns” will be used to denote NGNs during their internship programme and the term “preceptees” will be used to denote both students and interns working under the supervision of preceptors. The analytical/conceptual themes identified are:

- Motivation, Choice and Retention.
- Academic Stress.
- Bridging the Gap and Assisting Transition.
- Role Stress.
- The Status of Nursing.

6.1 Motivation, Choice and Retention

Newton et al (2009) suggested a relationship between the intention to study nursing and the motivation to work as a nurse. To understand the reasons for SQU NGNs choosing nursing, it is important to explore the factors associated with making the choice. The main issues related to SQU NGNs’ choice of nursing as a career are discussed below.

6.1.1 Nursing is not an Attractive Career Choice

Many studies done in the UK, Australia and the USA identified “caring attitude” and “wanting to help others” as the main reasons for choosing nursing (Miers, et al, 2007; Dockery and Barns, 2005; McCabe, et al, 2005; Brodie, et al, 2004; Larsen, et al, 2003; Holland, 1999; Barriball and While, 1996). However, the data in this study suggested that only a few NGNs and students applied to study nursing as their first choice. Only a minority explicitly wanted to care for people and were happy to be accepted by the College of Nursing. The majority had no real intentions of studying nursing, which resulted in them feeling disappointed and ambivalent and wanting a transfer to a different college. This indicates that nursing is not an attractive choice for Omani students to study and pursue as a future career especially for those with the highest grades. This might not be unique to Omani
students as a survey of female high school students in Kuwait\textsuperscript{27}, indicated that high proportion of them will not choose nursing as their future career despite the fact that the entry requirements to the Nursing College in Kuwait were not high and Kuwaiti nationals received around $1000 to $1500 a month from the government to retain them into nursing (Al-Kandari and Lew, 2005). Moreover, many other studies done in the UK, USA and Australia have shown that in these countries nursing has lost its attractiveness as a future career for high school students mainly because it is seen as low paid, low status and physically demanding. In addition, women in these countries now have a wider range of alternative job opportunities (Dockery and Barns, 2005; Brodie, et al, 2004; Cohen, et al, 2004; Staiger, et al, 2000).

Furthermore, the huge demand from Omani students to study at SQU resulted in students been accepted at the College of Nursing with high grades close to those accepted at College of Medicine. On one hand, this might enhance the academic success of such students. On the other hand, this might induce dissatisfaction as many students compared themselves to their medical student colleagues and showed some resistance to work as nurses. Also, due to their high academic grades, many SQU NGNs and students wanted to become doctors rather than nurses. This might be because medicine is more highly respected and has a better status compared to nursing in the Arabian Gulf countries (Maben, et al, 2010). In the literature, many nurses chose to study nursing because of low academic scores (Lai, et al, 2006; Cohen, et al, 2004) and students with high academic scores, females in particular, disregarded nursing as a future career (Dockery and Barns, 2005; Cohen, et al, 2004).

In contrast to the situation in Oman, in the UK it has been argued that the pre-entry requirements for nursing students have been determined by educators with very limited evidence (Wharrad, et al, 2003) resulting in a significant number of students failing academically (Glossop, 2001). Therefore, some authors have suggested increasing the level of qualification required to enter nursing courses in the UK in order to enhance students’ academic success and improve their retention into nursing (Pryjmachuk, et al, 2009). However, a study done in Australia showed that universities had to reduce the admission requirement for entry to nursing programme in order to attract students (Rella, et al, 2009). This might also confirm that nursing is not an attractive choice for students to study especially if they have other alternatives and options.

\textsuperscript{27} A country that shares almost the same culture with Oman
6.1.2 Future Prospects and Male Nurses

Viewing nursing as female dominated work affected the decision of male students in applying for nursing and their acceptance of nursing at SQU. In the literature, nursing is also viewed as a female dominated occupation and therefore males in particular do not usually consider it as a future career (Dockery and Barns, 2005; Brodie, et al, 2004). However, as shown in Box 7 in Section 5.1, there are relatively high numbers of male nursing students and NGNs at SQU. This is also evident in the West as recent nursing workforce statistics in the USA showed a marked increase in the number of male nurses (U.S. Department of Health and Human Services, 2010). This raises the question why the number of male nurses is increasing.

This study provided some answers in that male students and NGNs, in particular, stated that they pursued nursing as a future career because it offered a secured and guaranteed job. Other studies also found that nursing became an attractive occupation choice for men for the same reasons (Buerhaus, et al, 2005; Dockery and Barns, 2005; Zysberg and Berry, 2005; Cohen, et al, 2004). A survey done in the USA showed that men were more attracted to nursing because they expected good future prospects for themselves in nursing and the opportunity to become leaders (Zysberg and Berry, 2005). However, some other studies showed that this is not only confined to men as the high employment rate in nursing is motivating both men and women to study nursing (Cho, et al, 2010; McCabe, et al, 2005). Despite the limitations of these studies, there is evidence which is supported by the findings of this study that due to the current global financial crisis, nursing is regaining its attractiveness as a secure future career. However, there are concerns that more students will study nursing simply because of this.

6.1.3 Family Role

Families played a major role in encouraging and retaining SQU NGNs and students into the nursing profession which is consistent with some studies conducted in the USA and Taiwan (Lai, et al, 2006; Buerhaus, et al, 2005; Larsen, et al, 2003). In this study, families encouraged their members to study nursing mainly because it was a new degree offered by SQU and some families considered it appropriate for their female members. Conversely, this study showed that some families were against their male members studying nursing. A study done in Kuwait (Al-Kandari and Ajao, 1998) and another one done in Australia (Dockery and Barns, 2005) showed that families also played a negative role by discouraging their members
from studying nursing because of its physical demands, shift duties and many of them considered nursing as low status and low paid work.

**6.1.4 Attrition and Limited Options**

There were no statistics available about the attrition rate of SQU student nurses but this study’s findings suggest that the attrition rate from the College of Nursing was low and might not be an issue for discussion, but it is a well-documented problem in many countries. It seems that the problem of nursing students’ attrition in the West started a long time ago. Some estimated the interest in nursing students’ attrition to be at least 60 years old (Urwin, et al, 2010; Glossop, 2001; Gunter, 1969). Attrition and low numbers of students coming into nursing create the threat of a shortfall in NGNs with an ageing nursing population in the UK and in other Western countries (Urwin, et al, 2010; Andrew, et al, 2008; Buerhaus, et al, 2005).

This study showed that despite the ambivalence of some SQU NGNs and students about studying nursing, the majority studied nursing because of limited options. Many students accepted studying nursing because they mainly wanted to study at SQU. For them, the priority was the selection of the university rather than the selection of the profession. However, it can be argued that if students were offered more options to study, then a few of them would stay in the College of Nursing. There are not many studies that explore the decision made by students to study nursing rather than studying at a specific university. Cho et al (2010) found that nursing students in Korea placed more priority on deciding to study nursing rather than where to study nursing, which is different to SQU NGNs’ experience.

Moreover, many SQU NGNs stated clearly that they selected nursing as one of their options to study because it was at a degree level. However, it seems there was lack of clarity about degree nursing. SQU NGNs expected degree nursing to be different to diploma nursing in terms of their subsequent role and status as nurses. They mainly thought degree nursing to be more like a doctor’s assistant rather than a traditional nurse. Worldwide, increasing the qualifications of nurses has affected the expectation of the status and the role of nurses. According to Luker (1984), choosing a university nursing degree course in the UK made families and school teachers valued students’ choice of career. While this might be an old study in the UK, it reflects the current position in Oman where degree nursing have been
recently introduced. Therefore, it can be argued that students are attracted to SQU mainly because of the high prestige associated with degree level study; even if it is nursing.

6.2 Academic Stress

This study showed that SQU nursing students suffered from stress during their studies. In general, many studies from different countries have shown that student nurses suffer stress which increases burnout and attrition (Urwin, et al, 2010; Pryjmachuk, et al, 2009; Rella, et al, 2009; Andrew, et al, 2008; Gilmour, et al, 2007; Pryjmachuk and Richards, 2007a; Pryjmachuk and Richards, 2007b; Brodie, et al, 2004; Deary, et al, 2003; Lo, 2002; Timmins and Kaliszer, 2002; Glossop, 2001; Al-Kandari and Ajao, 1998). Studies found that student nurses suffer overwhelming stress in their first year (Jones and Johnston, 1997), which increases over time resulting in some senior students leaving the nursing profession (Rella, et al, 2009; Brodie, et al, 2004; Deary, et al, 2003; Lo, 2002).

The experience of stress in relation to studying nursing at SQU College of Nursing will be discussed under a number of subthemes.

6.2.1 Congested Nursing Curriculum

The main stressor identified in the SQU nursing curriculum was the overwhelming pressure of dealing with many theoretical courses including courses on nursing theories, social sciences and biomedical sciences. As shown in Section 5.2.2, the SQU nursing curriculum consisted of many more theoretical courses compared to other curricula in the UK. Having many theoretical courses including biomedical courses might be due to the fact that doctors were involved in designing the curriculum. This might resulted in the curriculum focusing on equipping students with scientific knowledge as their medical counterparts. In the nursing literature, there are different arguments about how much theoretical or biomedical knowledge student nurses need to learn. For example, some argued that students should not study much bioscience because it is marginal to nursing and might also confuse students about the role of the nurse (Jordan, et al, 1999). Having so many theoretical courses including biomedical might suggest that SQU NGNs are being prepared with a high level of knowledge to practice advanced nurses’ roles which contradicts with what SQU NGNs experienced.
Moreover, some contents of SQU nursing curriculum were thought to be repetitive. This has also been reported by some studies about other nursing curricula (Ross and Clifford, 2002). In addition, SQU NGNs highlighted that some materials taught to them were from different cultures and not relevant nor applicable to Oman. In fact, some of the theory and practice taught to them such as community nursing is not even implemented in Oman. Currently, there are some centres that are piloting community health services but there is no structured formal community service in Oman. In addition, one might ask why if SQU NGNs are being trained exclusively to work at SQUH, which is a hospital, they are being taught community nursing. This might be because the SQU nursing curriculum is striving to accommodate its graduates with a wide range of knowledge based on international standards. Moreover, since there is some progress made in Oman in piloting community nursing, it could be argued that providing such course might prepare SQU NGNs to be able to work in many settings and contribute to the development of such services. However, teaching “irrelevant” modules in the curriculum could be a result of the nursing curriculum being mainly designed and conducted by people who are not fully familiar with the healthcare services and settings in Oman. In this case, the curriculum would not reflect the needs of the Omani healthcare services. Clifford (2000) argued that curricula developed for nurses in the West might not be applicable for nurses in other cultures. Therefore, it can be argued that SQU nursing curriculum needs to focus more on the needs of the contemporary healthcare services in Oman taking care not to overwhelm students with theory that is not applicable to the Omani culture.

Despite the fact that SQU NGNs and students were able to get “A” grades during their secondary school, they frequently failed to get good grades at the College of Nursing. SQU students’ failure to get good grades at the college might be because the curriculum is not in their native language. In the literature, Pryjmachuk et al (2009) found in a university in England that not having English as a first language might be a factor in non-completion. However, the non-English speaking students in Pryjmachuk’s et al (2009) study were a minority compared to their colleagues who were native speakers. At SQU, all students were Omani who were Arabic speaking, which suggests that they all shared the same experience of learning a new topic in a relatively new language especially in view of the fact that primary and secondary education in Oman is conducted in Arabic language where English is only a subject. Despite the English support courses the university provides for students, it can be
argued that the theoretical courses might still require high English proficiency, which SQU students need time to develop.

Another issue that is controversial is the amount of theoretical components compared to clinical components of nursing curricula (O'Donnell, 2011; Jordan, et al, 1999). This study suggested that having limited hands-on-practice compared to a lot of theoretical courses in the SQU nursing curriculum indicated to students that there was little weight put on the importance of learning from practice. Worldwide, nursing curricula are frequently blamed for focusing on teaching theory and failing to prepare nurses for the reality of nursing practice (Delaney, 2003; Oermann and Garvin, 2002; Ross and Clifford, 2002; Duchscher, 2001). Bonis (2009) claimed that “Knowing” or knowledge in nursing is not only about theory but is more of individual dynamic experience in the clinical area.

SQU nursing curriculum contains nine clinical courses of which two clinical courses students do in each semester, two days a week for each course, spend only half a day in the clinical area and they work in groups under the supervision of clinical instructors. This is believed to restrict students’ time and freedom in the clinical area and limit their learning to what is offered by the clinical instructors. Furthermore, SQU students took clinical courses concurrently with theory courses. Therefore, it was difficult for them to balance learning from practice while dealing with other theoretical courses and preparing for examinations. This increased their stress and reduced the benefits they gained from both theory and practice courses.

Moreover, SQU students’ learning during their clinical placement was diverse and depended on the ward they worked in and the level of freedom they were allowed to attain. There is collective evidence in the literature that allowing students enough time and freedom to practice during their study fosters their self-confidence and competencies (McHugh and Lake 2010; Rydon, et al, 2008; Löfmark and Wikblad, 2001; Alavi, et al, 1997). Some studies found that clinical teachers play an important role in facilitating students’ learning in the clinical area by working as mediators and liaising with clinical nurses (Holmlund, et al, 2010; Landers, 2000; Dunn and Hansford, 1997). This study showed that working in groups with clinical instructors in most of the clinical placements reduced SQU students’ interaction with the real working environment.
As mentioned in the literature review, the theory-practice gap debate has had an impact on nursing education curricula. In the UK for example, nursing curricula are currently composed of 50% of theory and 50% of practice (Farrand, et al, 2006). The argument about the amount of theoretical courses compared to clinical courses might not be a priority in the UK. However, the College of Nursing at SQU should consider reviewing the curriculum to improve the balance between theory and clinical courses in order to bridge the theory-practice gap.

6.2.2 Home Sickness

Living away from their home towns reduced the support SQU students received from their families. Studies considered “family” as an important source of support for students and there should be a balance between “family/personal life” and “student/work life” for student nurses (Pryjmachuk, et al, 2009; Lo, 2002). Also, travelling a long distance to university was identified as stress provoking in one small quantitative study done in Australia (Lo, 2002), which might be applicable to SQU students who are originally from outside Muscat.

On the other hand, neither the NGNs nor the students commented on the social activities at the university, which might mean that there were no social activities available at SQU. This might reflect that SQU focused merely on the teaching and learning aspects rather than students’ social life.

Having summer semesters might reduce the free time available for students to socialise especially for those who live away from their families, which might increase their stress (Lo, 2002; Jones and Johnston, 1997). It can be argued that SQU should consider allowing students time to rest and be able to socialise with their families in order to support them and reduce their stress.

6.3 Bridging the Gap and Assisting Transition

SQU NGNs passed through two distinct phases of their role transition. Initially, they needed to move from being students to becoming interns. Then, they moved from being interns to becoming staff nurses. This study showed that there was a reality-shock experienced by SQU NGNs when they entered the workplace, which they found to be different to their university setting and teaching. NGNs referred to the “theory-practice gap” theme described in Section
1.2 to be the main reason for their reality shock, which is consistent with the literature discussed in Section 3.1.1.

SQU NGNs’ experience of the theory-practice gap included three stages. The initial stage is when SQU NGNs felt that they were well prepared by the college and showed a rejection of the values and context of practice at their workplace. There was a mismatch of expectations between the nurse role they thought they were prepared for and their real role in practice. SQU NGNs’ feelings of being well prepared were fostered by the comments of external examiners about them. However, there is a question of how precise the external examiners’ assessment of SQU students’ practice was especially since they were mainly international nurses who only come once a year to assess the students. This suggests that these examiners might lack experience and understanding of working practices at SQUH, and they are unfamiliar with the SQU nursing curriculum and the Omani culture and language.

The 2nd stage is when SQU NGNs started to realise that the college teachings were ideals and that it was not always possible to apply them in the real workplace. Dale (1994) argued that there is no theory-practice gap; instead there is a theory-theory gap. This means that the theory imparted at university is ideal and different from the theory which nurses use in their real practice. Allen (2004) argued that the gap between what nurses are taught at college and what they practice in the real world means that nursing education is failing to prepare nurses for their roles resulting in nurses’ dissatisfaction and low morale. For SQU NGNs, they found themselves needing to “learn” from their working environment. This might mean that at this stage they focused on learning clinical practice rather than relating their practice to the theories taught to them at college, which is also reported earlier by Ellerton and Gregor (2003).

The 3rd stage is when SQU NGNs distanced themselves from college teachings and accepted the reality of the workplace, which is also consistent with the literature discussed in Section 3.1.1 and will be elaborated further in Section 6.4.8.

This study showed that there is an awareness of the “theory-practice gap” by the college staff and also by the hospital staff and that there are some measures being utilised to bridge the theory-practice gap. The first one is the “advanced clinical course”; the 2nd one is the internship programme and the 3rd one is the orientation period. All of these measures utilised the role-modelling, apprentice approach where junior nurses learn from clinical nurses. Each
of these measures will be discussed in turn to assess their ability to bridge the theory-practice gap and assist transition.

6.3.1 The Advanced Clinical Course

There is much emphasis made on the importance of the “advanced clinical course” in the nursing curriculum to bridge the theory-practice gap. In the literature, there is substantial collective evidence from many studies done in different countries including the USA, the UK, Australia, Sweden, Hong Kong and Taiwan to suggest the positive effect of clinical placements involving supervision by clinical nurses in assisting students’ reflective practice; helping to bridge the theory-practice gap; preventing reality shock; and motivating students to nurse (Chung, et al, 2008; Kimberly, 2007; Lai, et al, 2006; Field, 2004; Nelson, et al, 2004; Ross and Clifford, 2002; Chow and Suen, 2001; Jackson and Mannix, 2001; Severinsson, 1998).

This study raised some doubts about the ability of the advanced clinical course to bridge the theory-practice gap. Firstly, there was a difference in how students and clinical instructors related to the “advanced clinical course”. Students believed this course improved their skills while clinical instructors believed it benefits students in learning holistic care, utilising critical thinking, socialisation with other nurses and increasing their confidence. This difference in focus of students’ learning from practice resulted in distracting students’ learning to focus only on theory. This was also highlighted by Bendall (1977) more than thirty years ago in the UK.

Secondly, the advanced clinical course was only thirty shifts in a whole semester, which means that students were only doing two shifts per week. Therefore, students did not have constant contact with their work environment and clinical nurses. This affected their ability to provide continuity of care for their patients and their familiarity with the settings, routines and hospital policy.

Thirdly, placing the “advanced clinical course” in the last semester of the nursing curriculum added to the overwhelming pressure on students. At this stage, students were busy preparing for examinations and graduation, which also affected their socialisation into the workplace.
Fourthly, SQU students have identified many stressors during their “advanced clinical course” that affected their learning such as, working with clinical nurses and under the supervision of clinical instructors and the limitations put on their practice. In the literature, some studies suggested that despite the benefits of clinical courses, they are still considered a source of stress for nursing students (Christiansen and Bell, 2010; Pryjmachuk, et al 2009; Lai, et al, 2006; Brodie, et al, 2004). Some studies showed that university students sometimes do not feel “as part of the team” or also “made to feel different to the norm” during their clinical placements (Chow and Sue, 2001; Luker, 1984). This might be different to SQU students’ experience because they are mainly trained at SQUH. They have received different treatment from hospital staff, which made them feel distinguished from other students. Therefore, it can be argued that wearing different uniform distinguished SQU students from other diploma students and made them feel different, if not special.

### 6.3.2 Working with Preceptors

In the literature, there is a tendency to call clinical nurses who supervise student nurses “mentors” while referring to those involved in supervising NGNs as “preceptors” without any obvious explanation. In addition, the terms “preceptor” and “mentor” are interchangeably used as discussed in Section 1.4. At SQUH, clinical nurses who were involved in teaching both students and interns are called “preceptors”. This study showed that preceptors played a major role in SQU students’ clinical learning and in assisting SQU NGNs transition, which is consistent with the literature (Smith and Chalker, 2005; Ellerton and Gregor, 2003; Spouse, 2001).

However, implementing preceptorship might indicate that these nurses mainly focused on teaching preceptees clinical practice. This might be referred back to the feeling that SQU students and NGNs have been prepared well in terms of theories and what they needed is time to improve their clinical skills. In the literature, it is argued that nurses focus on teaching junior nurses skills because they mainly have been taught in the apprentice model and rarely utilised critical thinking in their practice (Aston and Molassiotis, 2003; Spouse, 2001). There were also concerns raised in this study that preceptors teach preceptees rituals rather than evidenced based nursing.

It can be argued that working under the supervision of preceptors also limited preceptees’ hands-on-practice. This is mainly because of the policies and regulations of the hospital and
also because preceptors are held accountable for preceptees’ actions and therefore, controlling what they allow preceptees to perform. In addition, it seems that due to significant increased workloads sometimes preceptees were used in the ward to complete the basic and routine work. Preceptees experience of being asked mainly by senior nurses to do basic work has been reported in the literature (Earnshaw, 1995). By contrast, it has been found that some preceptors had high expectations of preceptees’ competency and allowed them to independently practice clinical skills, which required specialised knowledge and skills without supervision which is consistent with the literature discussed in Section 3.1.2. These preceptors might lack awareness about the hospital policies, which state that preceptees should always work under supervision. Furthermore, they might lack awareness about the preceptees’ competency level and learning objectives as well as the contents of the nursing curriculum. In the literature, some studies found that there may be a lack of clinical nurses’ awareness of preceptees’ competency level which caused a mismatch of expectations (Wolff, et al, 2010; Wilson-Barnett, et al, 1995). This mismatch resulted in preceptees being used merely to do the basic care in the ward (Elcock, et al, 2007; Chow and Suen, 2001; Jackson and Mannix, 2001). It has been suggested that preceptors need to know the contents of the nursing curriculum and the specific objectives of the placements in order to know what to expect from preceptees (Kim, 2007; Gray and Smith, 2000; Dale, 1994). However, all of these studies referred to students experience during their clinical placements rather than interns’ experience. No studies found in the literature suggesting that interns are used by clinical nurses to do the basic nursing care for the ward.

The lack of awareness of preceptees’ competency might be a result of preceptors at SQUH being prepared through two different courses offered by SQU College of Nursing and SQUH training department. The College of Nursing course mainly focused on preparing preceptors to teach students during the “advanced clinical course” while the other course offered by the hospital training department focused on preparing preceptors to teach interns. Despite the fact that students might be different to interns in terms of preparation and competency, it can be argued that preceptors should be prepared in one course to meet the needs of both students and interns. Moreover, based on the fact that the majority of new nurses employed at SQUH are SQU graduates, it can be argued that involving the College of Nursing in providing the preceptor course currently offered by the training department would increase preceptors’ awareness of the contents of the SQU nursing curriculum. This would make them able to match their expectations to the actual competencies of SQU students and interns.
On the other hand, this study found that at SQUH, preceptors largely believe that the teaching role is inherent in nursing and as nurses they should participate in teaching junior nurses. Furthermore, working as preceptors and having teaching activities at the ward level is thought to have a positive effect on improving clinical nurses’ knowledge and improve practice. However, it seems for this group of preceptors the workload and time pressures were major constraints for their commitment to teach and their ability to support preceptees, which is consistent with the literature (Christiansen and Bell, 2010; Holmlund, et al, 2010; Lillibridge, 2007; Aston and Molassiotis, 2003; Spouse, 2001; Humphreys, et al, 2000; Wilson-Barnett, et al, 1995).

Furthermore, this study showed that it is not always possible to have a constant relationship between preceptors and preceptees due to the limited time allowed for the “advanced clinical course” students and also for the interns during their internship programme. Studies done in different countries found that preceptees having a constant relationship with the same preceptor helped them to build trusting relationships, added continuity of learning and fostered their sense of confidence (Kim, 2007; Smith and Chalker, 2005; Ellerton and Gregor, 2003; Löfmark and Wikblad, 2001; Spouse, 2001), while inconstant contact with preceptors resulted in them failing to form trusting relationships which reduced their learning from practice (Chow and Suen, 2001; Watson, 1999). Therefore, it can be argued that there should be some attention given to reducing workload pressures and occupational stress on preceptors and allowing them more time to interact with their preceptees.

There are concerns raised in this study about preceptees developing a dependency on preceptors rather than learning from them. However, working in unfamiliar wards might make preceptees feel unsafe and they may try to depend on their preceptors in order to feel safe, a finding which has also been reported by Chow and Suen (2001) in Hong Kong. This might suggest that preceptees should be provided with more support from other staff in order to feel part of the team and reduce their dependency on the support and guidance of the preceptors.

Nevertheless, having a constant relationship is no guarantee of forming a trusting relationship between preceptors and preceptees. In the literature, it is argued that the successful relationship between the preceptor and the preceptee depends on the dynamics of the interaction between both of them (Godinez, et al, 1999). This study showed that there were some interpersonal conflicts between preceptees and preceptors. Some SQU NGNs faced
some rejection from other nurses including their preceptors because they tended to challenge
them. Also, some studies done in Canada showed that degree nurses tend to ask more
questions which was perceived as unacceptable by clinical nurses and affected their
socialisation into the ward (Wolff, et al, 2010; Daiki, 2004). Moreover, most preceptors
were experienced expatriate nurses and therefore there was a language barrier between them
and their preceptees, which might affect their interaction and prevented them from forming a
trusting relationship.

Some suggested that it is difficult to assign preceptors because there should be some kind of
personal compatibility between the preceptee and the preceptor. Therefore, it is argued that
junior nurses should be prepared and allowed enough time to identify role models from their
working environments whom they form a good relationship with (Thornley and West, 2010;

Furthermore, some SQU students and interns found their preceptors unsupportive and lacking
teaching skills, which have also been reported in the literature (Ketola, 2009; Aston and
Molassiotis, 2003; Landmark, et al, 2003; Shelton, 2003; Spouse, 2001; Gray and Smith,
2000; Atkins and William, 1995). This might pose the question of what are the merits
required of clinical nurses to be able to work as preceptors? At SQUH, preceptors were
mainly selected based on their years of experience rather than their teaching qualities. On one
hand, studies found that working with less experienced preceptors has a negative effect on
preceptees’ experience (Delaney, 2003). On the other hand, some studies showed that
preceptors themselves realised that having experience does not mean that they are good
teachers and argued that for clinical nurses to act as role models they need to be “experts”
and not only experienced (Ketola, 2009). This study also indicates that experience per se
should not be the main determining factor for a clinical nurse to become a preceptor and the
focus should be more on identifying expert role models who have teaching abilities or the
potential to acquire them if supported and educated.

Due to the difficulties and time limitations preceptees faced in working with their preceptors,
there were calls to increase the involvement of clinical instructors or employ clinical nurse
teachers to facilitate learning and focus on achieving students’ and interns’ learning
objectives. However, in the case of the advanced clinical course, the academic clinical
instructors argued that one of the main benefits of the course that it begins to distance
students from the university “umbrella” and make them feel part of the clinical team.
According to them, involving clinical instructors more with students support “spoon feeding” and distance students from the reality of the workplace. Thus, if clinical instructors or clinical nurse teachers are to be more involved in teaching students and interns; the question is how much will this benefit students and interns’ learning?

Some studies showed that working with clinical nurses to be more effective than working with nurse teachers in promoting theoretical knowledge and fostering students’ independence in the clinical area (Chung, et al, 2008; Corlett, et al, 2003). However, worldwide, there are also increasing calls to include academic teachers in practice or to have dual roles of being teachers and practitioners in nursing (Cheraghi, et al, 2007; Landers, 2000; Lee, 1996; Dale, 1994; Owen, 1993; Bendall, 1977). There are some studies which found that involving nurse practitioners in teaching nursing students have a positive outcome on students by making them feel they are learning from reality and are able to relate theory to practice and understand how theories can be utilised in nursing practice (Driver and Campbell, 2000). Also, involving nurse practitioners stimulated students’ interest and increased their motivation to practice (Chan, et al, 2011). However, these benefits resulted from involving practitioners in teaching theory, but what are the benefits of involving teachers in teaching practice?

The term “teacher practitioner” is widely cited in many articles in the literature to denote the dual role of being a teacher and practitioner at the same time. However, there are some ambiguities about the actual role of the teacher practitioner in practice. Some have questioned the real involvement of the teacher practitioner in hands-on-practice and view their role mainly to liaise and support (Duffy and Watson, 2001; Humphreys, et al, 2000; Landers, 2000; Lee, 1996). There are also some concerns about teacher practitioners’ lack of clinical credibility in teaching nursing skills (Cheraghi, et al, 2007; Humphreys, et al, 2000; Lee, 1996). All clinical instructors who participated in this study were international nursing educators who had no experience of working at SQUH or at any hospital in Oman. This might raise concerns about their clinical competency levels and therefore how much their involvement with students in clinical practice would improve students’ clinical learning. Bendall argued 30 years ago, that one of the main reasons for theory-practice gap is that nursing teachers have no clinical working experience. Many authors claimed that nurse teachers should refocus on developing their own practical skills to be able to teach students during their clinical placements (Cheraghi, et al, 2007; Landers, 2000; Dale, 1994).
Furthermore, it can be argued that international clinical instructors at SQU not only lack practical experience but also lack awareness of the Omani culture, the nature of nursing practice and the status of nursing in Oman. Therefore, they might fail to relate and translate nursing theories to the specific cultural needs of the Omani healthcare setting. Also, there are language and cultural barriers between students and some clinical instructors that affected their interaction and level of understanding. The example of the insistence of one of the clinical instructors for a female student to lift up her sleeves in front of males reflected the clinical instructor’s lack of awareness of how sensitive it is for a Muslim Omani female to expose any part of her body in front of males.

Moreover, it can be argued that involving clinical instructors more in supervising and teaching students during “the advanced clinical course” might not make students learn from real practice but focus more on learning theory. This is mainly because clinical instructors might easily focus on teaching students textbook or strictly try to achieve the theoretical objectives of the course. In addition, this might mean that student nurses will merely work with clinical instructors in all their clinical courses, which might not only limit their practice but also limit their interaction with clinical nurses and the real working environment.

The issue of duality of role might not be an option for SQU international clinical instructors, but involving nurse practitioners that have experience working in Oman in teaching may need to be considered.

6.3.3 The Internship Programme

There was a wide agreement in this study that the internship programme was important in supporting NGNs during their transition period and bridging the theory-practice gap, which is consistent with the literature (Park and Jones, 2010; Zinsmeister and Schafer, 2009; Beecroft, et al, 2008; Salt, et al, 2008; Young, et al, 2008; Halfer, 2007; Newhouse, et al, 2007; Altier and Krsek, 2006; Delaney, 2003; Goh and Watt, 2003; Crane, et al, 1988). However, there were concerns raised about limiting SQU NGNs learning and practice by calling them “interns”. There was a reference made that the “intern” means “prisoner” which might indicate that during the internship programme, NGNs’ practice is constrained and therefore, they might not be fully supported in transforming to the staff nurse role. There were also some concerns that implementing the internship programme was waste of resources since all SQU NGNs had almost all of their training at SQUH. Conversely, there were concerns at
how safe it is to suddenly confront SQU NGNs with the responsibilities of the staff nurse role. This study suggested that SQU NGNs had limited hands-on-practice during their study and they were not fully prepared to assume their responsibilities as staff nurses directly after graduation. Therefore, it can be argued that SQU NGNs needed the internship programme to assist their role transition.

There was the issue of ownership of the internship programme offered to SQU graduates at SQUH. Viewing the “internship programme” as an academic course and “interns” as students sent a message that NGNs were still under the college administration, which was confusing for both NGNs and others. In the literature, the partnership between academics and healthcare organisations is believed to bridge the theory-practice gap and therefore, ease NGNs transition (Souers, et al, 2007; Herdrich and Lindsay, 2006; Casey, et al, 2004; Roche, et al, 2004). However, all the studies found in the literature referred to the internship programme as a retention measure provided by healthcare organisations rather than universities (Park and Jones, 2010; Salt, et al, 2008; Halfer, 2007). It can be argued that sheltering the internship programme under the university umbrella might make interns behave as students rather than staff nurses and make them treat the internship programme as part of the curriculum rather than an assist for their role transition.

The internship programmes described in the literature usually consist of clinical practice, mentorship support and theoretical courses (Santucci, 2004). However, there were no differences found between SQUH’s “preceptorship programme” and SQU College of Nursing’s “internship programme”. In both programmes, NGNs spend six months and rotate to different departments and follow preceptors. The only differences found between the two programmes were being eligible for a certificate from the college and having an opportunity to go abroad. It can be argued that using the title “internship” might be misleading and give the impression of having a more structured programme. This poses the question of why SQUH does not utilise the “preceptorship” programme for SQU NGNs instead of having two different programmes. Furthermore, it has been found that during the preceptor course, reference was only made to the “preceptorship programme” document and there was no mention of the “internship programme” document. This might mean that there was a lack of awareness of the availability of such a document suggesting again that preceptors might lack awareness of the competency of SQU NGNs and about the objectives of the internship programme.
6.3.4 Familiarity and Transition

The importance of rotation during the internship programme was emphasised because interns could gain different experiences. Yet, this study showed that settling into a ward helped NGNs to feel part of the team, improved their communication with patients and other healthcare professionals. This ultimately improved their confidence and satisfaction, which is consistent with the literature (Malouf and West, 2011; Coeling, 1990; Crane, et al, 1988).

Furthermore, this study showed that NGNs who had prior exposure to their working environment during their study or during the internship programme were able to settle faster in their permanent wards. This suggests that familiarity with the ward setting and staff assists transition. Therefore, it can be argued that it is impossible to expect NGNs who have no previous experience to be able to assume their roles as staff nurses after a month’s orientation period. Added to this, due to the fact that the nursing curriculum does not prepare NGNs to work in specialised wards such as Haematology/Oncology, it can be argued that SQU NGNs who work in these wards with no prior preparation might be “novices” as described in the literature (Boswell, et al, 2004). There is no doubt that NGNs need sufficient time not only to learn and increase competency but also to become familiar with their working environment. It can be suggested that NGNs should be exposed to their permanent working area during their study or the internship programme. Otherwise, the internship programme might not be considered as a step for assisting transition, instead it would only be a time for NGNs to learn general skills.

6.3.5 The Internship Abroad

The issue of the internship abroad is controversial. There is not enough evidence in this study to assess the outcomes of the internship abroad and its effect on NGNs’ transition experiences. However, there are some benefits identified by NGNs from being exposed to different cultures and experiences. NGNs who worked in countries where the nursing profession is more developed compared to Oman, have improved their attitudes and perceptions about the nursing profession. However, it is important to consider that NGNs are new and not fully aware or familiar with SQUH setting. Therefore, there is a question of how transferable are their experiences abroad to SQUH working environment. It can be argued that working in different cultures with better resources and nursing status might have an adverse effect on NGNs’ satisfaction and result in reality shock. In fact, many NGNs in this
study showed dissatisfaction and helplessness about the nature of nurses’ practice, realities of the working environment and the status of nursing at SQUH compared to their experiences abroad.

It can be argued that having a period of internship outside the hospital or Oman interrupted NGNs’ socialisation into their work environment, affected their learning about the organisation and reduced the time available for NGNs to rotate in different wards. Furthermore, due to the fact that the College of Nursing arranged the internship abroad, the selected hospitals were not fully aware about the competency level of NGNs and they referred to them as students rather than graduate nurses. Therefore, it can be suggested that the internship abroad can be an elective clinical model in the nursing curriculum. This means the university would be able to plan it adequately and it would not affect the time NGNs have to socialise and learn from their working environments. Moreover, this might make hospitals abroad more aware of the competency level of students and thus what to expect from them.

6.4 Role Strain

Beside the reality shock; NGNs also suffered role strain due to the conditions of the working environment. The role of the staff nurse brought with it new challenges, responsibilities and uncertainties to the NGNs’ lives which provoked anxiety and increased their stress. The main stressors identified by SQU NGNs during their role transition are discussed below.

6.4.1 Increased Workloads

This study showed that despite having a short time in nursing, there is a significant number of NGNs who suffered from back pain related to increased workloads. Some NGNs referred to the long working hours as exhausting reflecting the intensity of the workload. At this stage, NGNs started to realise that they are paid less than the work they do, which has also been reported in the literature (Fung-Kam, 1998). Moreover, SQU NGNs found most of nurses’ work was mainly routine that required no knowledge. Routine work was condemned by most NGNs because it entails mainly technical work, which can be done by untrained staff. Yet, some NGNs remarked that the routine work is important for maintaining standards especially with increased workloads. Strange (2001) claimed that routine work or “rituals” are not associated with knowledge rather they are mainly associated with beliefs and emotions.
Nonetheless, rituals continue to persist in nursing because they serve psychological and social purposes (Strange, 2001).

Working in a monotonous environment dealing with demanding workloads and time pressures is directly associated with burnout and psychological distress resulting in nurses leaving their working organisations or even leaving the profession (Scott, et al, 2008; Gould and Fontenla, 2006; Bowles and Candela, 2005; Jasper, 1996; Barnett and Brennan, 1995; Karasek, 1979), while lighter workloads increased both nurses’ and patients’ satisfaction with nursing care (Leiter, et al, 1998).

There was a concern raised by NGNs that increased workloads put them under pressure and increased their chance of making mistakes leading to compromised standards, which is consistent with the literature discussed in Section 3.1.1. Moreover, SQU NGNs raised some concerns about clinical nurses failing to maintain standards of nursing practice in general. In nursing, nurses usually refer to “maintaining standards” as an important role of the nurse. However, according to Schurr and Turner (1982), there are no concise and precise outlines for standards and how can they be measured or evaluated. SQU NGNs might mainly refer to failing to maintain standards according to the standards of the university rather than the standards of the actual workplace which might be different and dependent on the context and resources of the working environment.

Leiter and Laschinger’s (2006) suggested that nursing management can have a fundamental role in improving the quality of nurses’ professional life and the quality of nursing practice. The findings of this study suggested that some managers seem un-convinced about nurses’ complaints of increased workload and believed that it is the nature of contemporary nursing practice. Moreover, managers’ thought the nurse-patient ratio to be satisfactory and within international recommendations. This ratio might not be applicable to the SQUH setting because it mainly refers to registered nurse-patient ratios only. At SQUH, nurses’ experiences in dealing with workload might be exaggerated by the absence of healthcare assistants (HCAs), which means that all forms of nursing care and other work is done by qualified nurses. This clearly indicates a gap between management and clinical nursing practice (Finn, 2001).
6.4.2 Task-Orientation and Losing the Essence of Care

There was an agreement in this study that nurses focus mainly on completing tasks and providing physical care to patients without utilising any theories or attending to other aspects of care such as holistic care. In the literature, there is a consistent theme that nurses’ work in developed countries is mainly “task-oriented” (Ketola, 2009; Allen, 2007; Cheraghi, et al, 2007; Maben, et al, 2007; Maben, et al, 2006; Gould and Fontenla, 2006; Allen, 2004; Delaney, 2003; Ellerton and Gregor, 2003; Crotty, 1985).

In this study, huge workloads and time pressures were considered major reasons for nurses to become task-oriented. This constrained their interactions with patients, which is consistent with the literature. Many NGNs in this study made reference to having no time to provide health education in particular; which is believed to benefit both the patients’ psychological and physical health (Latter, et al, 1992). NGNs’ reference to health education might be a result of the emphasis made in SQU nursing curriculum about it. This is not particular to SQU nursing curriculum as the need for incorporating health education into nurses’ professional role is a worldwide concern (Norton, 1998; Clarke, 1991). For SQU NGNs not being able to utilise theories or to communicate with patients or to provide them with different aspects of care made them have a sense of loss, provoked guilt feelings and induced a reality shock, which is consistent with the literature discussed in Section 3.1.1.

The ability to provide the care they expected to their patients made SQU NGNs have positive feelings about their role as nurses. However, there was some disappointment experienced by them for not being able to meet the “caring essence” of their role as nurses. In the literature, it has been found that nurses who were able to provide care have better professional self-image and performance and more commitment to nursing (Newton, et al, 2009; Zinsmeister and Schafer, 2009; Takase, et al, 2002; Spouse, 2000).

Caring is seen as integral in nursing and there are some assumptions made that caring and nursing are similar concepts (Galvin, 2010; Rawnsley, 1990). Some people including nurses themselves might use the two concepts interchangeably (Mackintosh, 2000; Rawnsley, 1990). Rawnsley (1990) argued that if nurses’ claim that caring is part of nursing rather than being human nature, then they are under obligation to prove it. This raises the question that if “care” in its lay definition as understood by people is one of the main roles expected from nurses to provide and currently nursing is a paid occupation, does that make “care” a pre-paid
product? This also raises questions about nurses’ preparedness to provide “care”. Also, how much care nurses can provide under contemporary working conditions and the complexity of healthcare services.

Indeed, in this study there was a difference of how SQU NGNs referred to caring and how others referred to it. SQU NGNs referred to care as more of a spiritual and psychological aspect rather than physical, while others referred to it mainly as a requirement of providing physical care. For SQU NGNs, the “caring” responsibility might be connected to their religious responsibilities as nurses. Rassool (2000) argued that caring is inherent in Islam and Muslim nurses are expected to care for the needy and the weak if they obey and follow the Islamic teachings. The experience of SQU NGNs suggests a connection of caring to spiritual benefits. Providing care made SQU NGNs feel that they have achieved the caring essence which Islam encourages them to do. However, not being able to satisfy their caring responsibility might be linked to feelings of lost ideals not only nursing ideals but also religious ideals. For SQU NGNs, failing to provide the care they expected made them try to move away from direct patient care which is mainly about providing physical care to more medical, technical and administrative work. Therefore, it can be argued that the concept of “care” needs to be clarified in the nursing profession in order to develop conceptual and operational definitions taking into account the complexity of current healthcare services and also the complexity and diversity of the recipients of care. This might provide clear guidance for student nurses, clinical nurses and nursing educators to be able to define clear constructs of the concept of care and therefore be able to provide it.

At SQUH, the existence of a communication gap between the majority of the nursing workforce (expatriate nurses) and the patients because of language barriers is one of the reasons believed to distance nurses from patients. In the case of health education for example, it can be argued that language barriers are detrimental. It is unrealistic to expect nurses who lack the main means of communication, which is the language to be able to play an active role in health education. Also, despite the emphasis on the benefits of providing different aspects of care and its profound effect on patients, the question is how SQU student nurses were taught and encouraged to provide such care if the majority of clinical instructors and clinical nurses were expatriate nurses who were not able to provide such care.

This study also identified the possibility that nurses might become task-oriented because of their ignorance of the importance of providing different aspects of care. In the literature,
some NGNs also raised the concern of nurses’ value of providing other aspects of care except providing physical care (Maben, et al, 2007; Maben, et al, 2006; Jarrett and Payne, 2000).

Mackintosh (2000) argued that nurses provide care according to the working environments and the level of socialisation they are allowed to have with their patients which is evident in this study. This again raises the question of the relationship between caring theories of nursing and its application into nursing practice (Maben, et al, 2007; Rawnsley, 1990). Allen (2004) concluded from a review of field studies done in the West that nurses work mainly as intermediaries in the provision of healthcare for patients. She argued that this role is important but it is far away from the caring role nurses claim they fulfil.

Moreover, SQU NGNs doubted their ability to provide different aspects of care including psychological care when they are distressed with the conditions of their work. Maben et al (2007; 2006) found nurses who were able to provide the care they expected worked in more supportive environments with lower workloads and fewer time pressures. Furthermore, many SQU NGNs who had just finished their internship programme insisted that despite time pressures, they were still trying to provide the care they regarded as right and important to their patients especially providing health education. However, none of SQU NGNs who completed their first year referred to health education in the 2nd set of the interviews. This might suggest that SQU NGNs started to follow what is practised in the ward rather than practising what they initially thought right and important. Furthermore, it can be argued that SQU NGNs at that stage realised and accepted the differences between the college and working environment in terms of resources and started to work within what is available at their workplace rather than strictly follow the ideals of the college.

This study showed that meeting the different needs of patients was almost ignored or even impossible to apply in the actual contemporary health setting where nurses were constrained by time pressures. This resulted in making nurses focus on completing the work rather than attending the holistic individualised needs of patients. This conflicted with the “ideals” that the college strived to equip NGNs with and resulted in them experiencing reality shock.
6.4.3 Skill Mix

There was a persistent belief by NGNs that there is a need to employ assistant staff at SQUH to take over some of the tasks done by nurses. According to them, this will not only reduce the pressure of the workload on nurses but it might also improve the quality of care; give nurses time to provide different aspects of patient care and subsequently improve the image of nursing.

Currently in some Western countries, the role of assistant staff has become integral to the healthcare service (Bosley and Dale, 2008; Buchan and Dal Poz, 2002; Barter, et al, 1997). The utilisation of assistant staff is different in different countries and greatly influenced by the needs of the healthcare services and workforce. Based on the literature, it seems each country has its own guidance and regulations for assistant staff and there are no international guidelines to regulate their practice. Added to that, there are many titles given to assistant staff that might be confusing but indicate the diversity of their roles within different healthcare services (Jack, et al 2004; McKenna, et al, 2004; Fletcher and Rush, 2001). In the UK, for example, the UKCC and the Department of Health proposed the title “healthcare assistants (HCAs)” to denote non-qualified staff (McKenna, et al, 2004). This term will be used in this thesis. In order to understand the effect of HCAs in healthcare services, the utilisation of HCAs in the UK health services will be reviewed as an example.

In the UK, the Information Centre census data, showed that the number of nursing support roles working in the NHS in England increased from 132,915 in 1998 to 144,892 in 2008 (NHS Careers, 2009). These numbers are estimated to rise due to cost effectiveness issues, the shortage of registered nurses, the reduction of junior doctors’ numbers and the expectation that staff nurses will take on new roles (McKenna, et al, 2007; McKenna, et al, 2004; Spilsbury and Meyer, 2004; Fletcher and Rush, 2001; Thornley, 2000).

Many studies showed that HCAs relieved registered nurses from the pressure of non-clinical tasks and allowed them more time to focus on more therapeutic tasks (Keeney, et al, 2005; Jack, et al, 2004; Pearcy, 2000; Workman, 1996). However, some studies found that HCA’s role is mainly about taking over most patient related care leaving nurses to deal more with technical tasks, management, documentation and liaising with other health professionals (Spilsbury and Meyer, 2004; Daykin and Clarke, 2000). This resulted in distancing nurses from patients (Pearcy, 2000; Workman, 1996). Some studies showed that patients were happy
to receive care from HCAs because they were more approachable compared to nurses (Keeney, et al, 2005). Studies have already shown a concern raised by some nurses that their holistic approach to care provision is threatened by replacing them by HCAs (Keeney, et al, 2005; Daykin and Clarke, 2000; Workman, 1996). Therefore, it could be argued that employing HCAs might greatly reduce the frequency of the nurse-patient interaction and might have a detrimental effect on the ability of nurses to achieve holistic care which most SQU NGNs claim to strive to achieve. Furthermore, employing HCAs at SQUH would not guarantee that nurses would have more time to spend with patients but it might mean that nurses would go through a role transformation where new responsibilities will be added to their roles such as supervision and paperwork (Keeney, et al, 2005).

According to the NHS careers website, the HCA’s job includes mainly basic nursing care such as bed making, feeding, washing and even monitoring vital signs. However, it states clearly that the scope of practice of HCAs may vary depending on where they work which suggests that there are no clear descriptions of their roles. In the literature, there is some ambiguity surrounding the role of HCAs. Studies showed that the exact role of HCAs is largely determined by the decision of managers, senior nurses or even HCAs themselves (Spilsbury and Meyer, 2004; Pearcy, 2000). Moreover, studies showed that some HCAs believed there were few differences between their roles and that of the nurses (Spilsbury and Meyer, 2004; Workman, 1996). Furthermore, many studies showed that the scope of practice of HCAs is more than non-clinical work and may encroach on the role of registered nurses. In fact, HCAs themselves claimed that they were involved in many clinical tasks including those which require advanced knowledge and which are supposed to be done by qualified staff such as deciding on wound dressings; blood glucose monitoring; venepuncture and providing education for student nurses and NGNs (Spilsbury and Meyer, 2004; Jack, et al, 2004; Pearcy, 2000; Thornley, 2000). Despite some methodological limitations in these studies, there is an indication of an overlap between nurses and HCAs roles, which make the boundary between the two blurred.

In contrast, there are some calls to expand the role of HCAs to include more tasks. Managers participating in a study by Jack et al (2004) supported the expansion of HCAs and showed no major concerns about HCAs performing some clinical skills. HCAs themselves suggested that they need to take-over some duties such as giving injections to relieve work pressure on registered nurses and give them more time to do other work (Workman, 1996). In fact, some
HCAs believed they are able to make more patient care related decisions because they spend more time with them (Pearcy, 2000). Patients also welcomed HCAs taking more advanced role conditioned by proper training (Keeney, et al, 2005). However, there are concerns about how prepared HCAs are to take on clinical skills or even to expand their role. In fact, in the literature, some referred to assistant staff as untrained and some others referred to them as unqualified (Jack, et al, 2004). Furthermore, there are some concerns about the quality of care and patients’ safety when relying heavily on HCAs to provide patient care (Daykin and Clarke, 2000). There is also an issue of accountability as HCAs are not professionally accountable for the care they provide (Workman, 1996). Mckenna et al (2004) argued that there is a need to regulate HCAs practice to ensure that patients are not subjected to harm.

It could be argued that cost effectiveness and registered nurses taking over the roles of junior doctors has played a major role in increasing the dependence of UK healthcare services on HCAs, which might not be the case in Oman. Nevertheless, the need for HCAs to relieve nurses from the pressures of the workload and allow them more time to attend other aspects of care and facilitate the teaching process of students and interns was seen as an important issue by many informants. However, there is a need for clear clarification of HCAs’ roles and their training requirements. Furthermore, care should be taken to avoid misusing HCAs in providing all aspects of direct patient care and moving registered nurses to office work, which might make them lose their identity. The hospital management should implement strategies of continuous monitoring and supervision to ensure that HCAs are not allowed to provide tasks, which are beyond their limits and knowledge. It should also balance the number of qualified and non-qualified staff to ensure that standards of care are maintained.

6.4.4 Occupational Hazards

SQU NGNs referred to the increase in occupational hazards within the staff nurse role as a cause of stress. It can be argued that a working environment of increased workloads and time pressures might directly affect the increase in occupational hazards. Ramsay et al (2006) argued that nurses’ roles and working environments place them in the frontline of occupational hazards including communicable (or contagious) diseases, musculoskeletal injury exposures and chemical and workplace violence exposures. For these NGNs, being new and working under pressure might affect their coping and management of occupational hazards. Therefore, it can be argued that NGNs should be supported in managing and
reducing injuries related to occupational hazards by reducing their workload and allowing them enough time to carry out clinical procedures.

6.4.5 Emotional Stress

Many SQU NGNs referred to the emotional stressful situations they have to deal with on a daily basis such as death and dying, which is consistent with NGNs’ experiences discussed in Section 3.1.1. Some SQU NGNs tried to cope with emotionally stressful situations by withdrawing themselves from such situations or transferring from wards with high levels of emotionally stressful situations such as Haematology/Oncology wards to other wards.

Some NGNs found that they need to control their feelings when dealing with patients and their relatives. This might reflect the theme of emotional work (labour) described in the literature where nurses are expected to control their emotions as part of their job. Nurses are expected to maintain their image as caring professionals and absorb all their negative feelings and always keep smiling (Gray and Smith, 2009; Zapf, 2002). It is argued that the emotional work is controlled by “display rules” which are norms and standards of behaviours indicating which emotions are appropriate in a given situation and how these emotions should be publicly expressed (Smith, 1991). It is believed that controlling emotions is inherent in the traditional image of nurses being mainly females who are expected to control their feelings as caring personnel (Gray and Smith, 2009).

This study showed that over time NGNs were able to deal better with stressful situations by trying to avoid being emotionally involved with patients. This is believed to be part of the emotional work which nurses should adopt to protect themselves from emotional drain (Smith, 1991). Being able to control feelings has been found to help in sustaining a caring environment between nurses and their patients and to improve practice and standards of care (Gray and Smith, 2009). However, it is argued that following the rules of emotional work might conflict with inner feelings resulting in emotional dissonance and increase the level of burnout which some SQU NGNs initially suffered (Mikolajczak, et al 2007; Zapf, 2002).

On the other hand, this study showed that some healthcare professionals including nurses and doctors did not always adhere to the display rules of expressing emotions, which are considered appropriate in a situation of death for example. Observing seniors not adhering to the “emotional work” responsibility of healthcare professionals was distressing for NGNs and
resulted in an emotional conflict. This might also suggest a difference between the ideal image of the nurse that NGNs expected to have and the actual image of the nurse they found, which might mainly depends on the personality of the individual and the culture of the majority.

6.4.6 Lack of job security

Despite the fact that NGNs did not refer to financial constrains during their student experience, almost all of them believed that dealing with financial problems was a major stressor during their role transition, which has been reported in some studies done in New Zealand and the USA (Rydon, et al, 2008; Casey, et al, 2004). The feeling of job security and getting paid increased NGNs satisfaction and made them more interested and committed to work which is consistent with the literature (O’Shea and Kelly, 2007; Goh and Watt, 2003).

6.4.7 Working Shift Duties

None of the NGNs had worked for a full rotation of shift duties during their study, thus, many of them found working shifts to be exhausting and to have an impact on their social life, which is consistent with the literature (Kapborg and Fischbein, 1998; Maben and Macleod Clark, 1998). Initially, SQU NGNs experienced more home sickness after graduation than when they were students because they were not able to balance their life while working shift duties. In the literature, it is suggested that NGNs go through a grieving process due to loss of the fixed academic scheduling of weekends and holidays off (Boswell, et al, 2004). Stress related to working shift duties is not particular to SQU NGNs but it is a global problem in nursing. Some studies found that nurses who are working fixed social hours are more satisfied with their schedules than those working shift duties (Gould and Fontenla, 2006; Roberts, et al, 2004). In the literature, it is recommended that NGNs need to be supported in order to be able to adjust to the changes and challenges brought to their life by becoming staff nurses (Halfer and Graft, 2006; Boswell, et al, 2004).

Moreover, some female SQU NGNs in particular anticipated that working shifts might affect their life after getting married and having families. In the UK, family-friendly policies have been introduced to support working parents (Gregg and Wadsworth, 2011). This has been seen as a positive support for nurses and increased their retention (Gould and Fontenla, 2006;
Roberts, et al, 2004). Introducing such policies should be considered for nurses working in Oman especially for those with families far from where they work.

On the other hand, it has been found that there was a cultural and personal aspect of SQU NGNs’ transition period which greatly affected their experience. NGNs participating in some studies experienced stress related to personal life, family and relationships (Duchscher, 2008; Rydon, et al, 2008; Casey, et al, 2004). Duchscher (2008) argued that the changes brought to NGNs’ personal life during their transition are usually ignored. Female SQU NGNs faced different cultural and personal aspects, which is social acceptance as a group of females living alone. Living alone in private accommodations in a conservative Islamic country might mean that these NGNs’ social lives are isolated from the whole community and limited only to the interactions with their flat mates. Moreover, some female NGNs raised concerns about their safety and their accessibility to services, especially when there is no safe public transport system in place. This massively contributed to increasing the stress and anxiety of female NGNs during their transition period.

6.4.8 Support and Adjustment

SQU NGNs passed through role adjustment, which follows the reality shock phase in the Schmalenberg and Kramer (1976) model of transition experience. Beside the formal support NGNs had in their first six months, this study showed that allowing them sufficient time and support had greatly assisted their transition in the next six months of their first year, which is consistent with the literature (Grochow, 2008; Boswell, et al, 2004; Goode and Williams, 2004). NGNs valued the positive support they received from their colleagues in helping them to adapt to their working environments especially when the environment was stressful. For SQU NGNs, the support from head nurses in particular played a major role in creating a supportive working environment and retained them in the wards. In the literature, working in supportive environments helped NGNs develop a sense of belonging (McKenna and Newton, 2008), increased their confidence and made them committed to nursing (Maben, et al, 2007; Maben, et al, 2006; Sveinsdóttir, et al, 2006; Rafferty, et al, 2001) and was found to reduce their burnout at work (Laschinger, et al, 2009; Boswell, et al, 2004; Rafferty, et al, 2001; Munro, et al, 1998). SQU NGNs stated clearly that they tried to be assertive in communicating with other nurses to prevent conflict, which is consistent with the literature
discussed in Section 3.1.1. This indicates that SQU NGNs are fully aware of the importance of maintaining relationships with their colleagues in their working environments.

However, some NGNs have worked in environments where nurses were not supportive. This increased their anxiety and made them feel alone, which is consistent with the literature discussed in Section 3.1.1. Stressful working environments made some nurses aggressive with NGNs, which has also been reported in the literature (Rowe and Sherlock, 2005).

Through their transition period, SQU NGNs utilised some strategies to cope with the stress they experienced. Some NGNs referred to nurses’ coping with the challenges in their work by laughter. Using laughter as a mechanism needs further investigation. Moreover, some NGNs who faced difficulty in adapting to their working environments moved to other wards where they felt more supported and comfortable at work, which has also been reported in the literature (Kelley, 1998).

6.5 The Status of Nursing in Oman

Despite the fact that most of these NGNs did not intend to study nursing and the negative experiences they had during their first year of work, many of them felt happy and proud that they became nurses. They realised that nurses are the most important personnel in the healthcare team and that their provision of care have a direct effect on patients, which is consistent with the literature (Zinsmeister and Schafer, 2009; Siebensa, et al, 2006). However, NGNs were disappointed with the low status of the nursing profession in Oman. This created intrapersonal conflicts in many of them, reduced their satisfaction about the nursing profession and their confidence, which is also reported in other studies in the literature (Gould and Fontenla, 2006; Takase, et al, 2002).

The effect of the status of the nursing profession on SQU NGNs’ transition experience will be discussed through a number of subthemes.

6.5.1 The Development of the Nursing Profession

It has been suggested that the status of nurses is determined by the public and by other members of the multi-disciplinary team (Radcliffe, 2000; Warelow, 1996). SQU NGNs mainly described the public, doctors and also some nurses as influencing the status of nursing. Warelow (1996) argued that the public tend to stereotype the roles of doctors as
males and nurses as females in a way that sustains the nurse subordinates status compared to doctors. SQU NGNs were mainly dissatisfied with the “servant” image they believed the public have about nurses. There was a reference made to nurses seen as “servants” also reported in Australia by Bolton (1981) cited in Warelow (1996). According to Bolton (1981), nurses’ activities are almost similar to those of servants and nurses are passive and powerless (Warelow, 1996). However, Bolton’s account is relatively old and might not reflect the current status of nurses in Australia.

Furthermore, this study showed that some expatriate nurses explicitly expressed that nursing is a low status work, which requires no knowledge or intelligence. These negative attitudes shocked NGNs who had been accepted at the College of Nursing because of their high grades. Studies showed that explicit negative comments of nurses about nursing reduced NGNs’ self-esteem and their satisfaction about the nursing profession (Lai, et al, 2006; Goh and Watt, 2003; Last and Fulbrook, 2003).

In order to understand the status of the nursing profession in Oman, it is important to understand how occupations such as nursing develop to become a profession. The social scientist Everett Hughes (1963) claimed that all professions consist of implicit or explicit “licences” which denote the activities allowed for the members of a certain profession to carry in exchange for incentives. Hughes (1963) argued that if a group of people is able to define a sense of identity and power then it will be able to demand and reform its own “mandates” which are the culture and theories that regulate the profession activities. According to Hughes (1963), mandates have an important role in encouraging the profession members to achieve its’ ideals in a constrained work setting. He also argued that the constructs of professions’ licences and mandates are not static. He identified the efforts to extend the mandates of a specific profession to improve their status as a major characteristic for professional building. However, due to the competitive market it is challenging for occupations to build on their mandates, which can grant its members better status and rewards. On the other hand, he argued that over-ambitious mandates could distance the profession from the reality and reduce the self-esteem and satisfaction of its members.

In Oman, there is a claim that nursing practices are highly influenced by the historical nurse image in Islam (Alghemini and Denham, 2008). However, it has been found that the contemporary image of the nurse in Oman conflicts with the noble image of the nurse in Islam. Nurses in Islam were mainly knowledgeable women from high class, who were
devoted to care and helping the needy. In fact, the role of nurses in Islamic history for more than 1400 years has been regarded as vital (Aldossary, et al, 2008; Alghemini and Denham, 2008; Jan, 1996). Women did nursing as part of Islamic duty to care for the needy. Helping and caring for the needy are considered acts of worship which make people close to their God (Rassool, 2000). Moreover, there is always a reference to Muslim nurses helping people but there was no information that those women worked with doctors or under doctors, which might indicate that Muslim nurses had a sense of autonomy and decision making. This might have contributed to their picture as important people who have made a mark in Islamic history. However, currently the image of Muslim nurses might not be applicable because nursing is an occupation, which nurses do for return of money rather than as a religious obligation.

It can be argued that SQU NGNs faced a real challenge because of the difference between the licences and mandates of the nursing profession in Oman. While the SQU College of Nursing strives to teach students about the professional nurse and equip them with wide scientific background knowledge, nurses’ practice in reality is constrained by the conditions of the working environment, the service the public expect nurses to provide and what the organisation allow nurses to provide. Allen (2007) argued that the contemporary nursing mandates are based on what she calls “armchair theorizing”, where the mandates are driven by what nurses “must” do rather than what they “really” do or even what are the real “needs” of patients.

6.5.2 The Low Status of Bodywork

Carrying out basic care and dealing with the bodies of patients made NGNs feel embarrassed and try to hide their true identity of being nurses from others in their working environment and the public. In the literature, work dealing with bodies is mainly called “bodywork”. According to Twigg (2000; 2004), bodywork is seen as dirty and low status work because it entails handling others’ bodies and dealing with different body secretions, which requires no education or training and it is frequently done by unskilled workers. This study showed that bodywork is perceived to adversely affecting the image of nursing. It subjected NGNs to humiliating comments from the public, doctors and nurses themselves. Therefore, it seems SQU NGNs rejected the image of nursing as bodywork and show resistance to providing body-care to their patients.
Twigg (2000) argued that despite its importance to patients, there are uncertainties in nursing of how much nurses need to deal with patients’ bodies. Moreover, nursing is increasingly seen as a hierarchical job where nurses are distancing themselves from body-care in favour of more technical or administrative work as they professionally progress. It has been suggested that changes in nursing education worldwide have moved the focus of nursing from body-care to a different level (Twigg, 2000; Schurr and Turner, 1982). Due to the fact that the provision of body-care was believed to require no knowledge and training, SQU NGNs questioned why they needed to do body-care when they are trained to high standards and equipped with so much knowledge. Therefore, they were trying to move away from wards where there was much body-care to more wards where they could practice “higher” skills. Twigg (2000) argued that the status of an occupation increased as it moves away from bodies. For example, doctors have higher status to nurses because they deal less with bodies. However, NGNs accepted carrying out body-care in specialised units such as ICU. This is because ICU nurses are highly knowledgeable and deal with more sophisticated interventions other than only providing body-care, which made them have “higher” status compared to other nurses. In fact, a study done in Hong Kong by Fung-Kam (1998) showed that nurses who dealt more with medical treatments and technical interventions were seen as more important compared to their counterparts who were working in long term care where their work was mainly about providing body-care. Furthermore, studies showed that nurses dealing with more medical and technical interventions were more satisfied compared to other nurses working in long-term care (Ingersoll, et al, 2002; Fung-Kam, 1998), which is consistent with this study findings.

SQU NGNs faced a conflict about their duty as nurses to provide holistic care including body-care with the image of nursing they wanted to hold, especially since they could not delegate such work to any assistant workers. Female NGNs in particular faced humiliation and a lack of respect when they tried to provide body-care for male young patients. It seems male patients did not understand that body-care is part of nurses’ work and thought that the female nurse herself wanted to be involved in such care. This might be due to the strict rules about the segregation between women and men in the Omani culture rather than the Islamic culture. Despite the strict rules, which control the relationship of women and men in the Islamic culture (Clifford, 2000), nursing in Islam has historically been provided by women (Aldossary, et al, 2008; Jan, 1996). There is an Islamic rule that controls healthcare provision. This is “Althrorarat tobeh almahthorat”, which means, “Needs know no law”. This implies
that in time of need there are no restrictions to control behaviours. This Islamic rule is usually cited when people are in need of help such as sick patients. Worldwide women are expected to provide care to both women and men because of their perceived caring and mothering nature and also due to the fact that women’s sexuality is considered “passive” (Twigg, 2004; Twigg, 2000). However, it can be argued that the provision of nursing care should consider the barriers between men and women in order to provide culturally sensitive care and also to increase nurses’ and patients’ satisfaction with the care provided.

This study showed that there are more than cultural limitations in the provision of body-care because even male NGNs received some rejection from their patients when providing body-care. Patients often preferred expatriate nurses regardless of their gender to provide basic care for them. Due to the fact that body-care is seen as low status work, this might indicate that male Omani nurses were given a higher status compared to expatriate nurses. Therefore, SQU NGNs reluctance to provide body-care might be as a result of the public making them feel that providing body-care makes nursing seen as a low status work.

6.5.3 Male Nurses and Power

SQU NGNs and students referred to nurses having no power in Oman and there is no political representation for them. Worldwide, nurses have been found to rarely involved in politics or have the power to influence healthcare agenda. This is attributed mainly to nurses’ traditionally being females (Clifford, 2000; Warelow, 1996; Schurr and Turner, 1982). Thus, it can be argued that increasing the number of male nurses might increase the profession’s power and therefore increase its status.

The increased number of male nurses is considered positive by managers who mainly argued that despite the fact that male nurses usually have different agenda for becoming nurses (Zysberg and Berry, 2005), having more male nurses in a country like Oman can ensure the stability of the nursing workforce. The main argument is, despite the fact that organised nursing education in Oman started early 1970; there is limited number of experienced nurses which raised the question of where these female nurses have gone. Women in the Omani culture are mainly seen as wives and mothers, which mean that their families are priorities. Therefore, due to lack of family friendly policies, women usually tend to leave their work to take care of their families. However, family commitments might not be the only reason for the instability of the Omani workforce. The Omani culture, low status of nursing and the
limited training programmes has also contributed in limiting the number of Omani nurses in the 70s and 80s of the last century.

This study showed that some male NGNs were not satisfied with being nurses because “nursing” is mainly seen as a female job. Twigg (2004; 2000) argued that viewing nursing as a female job affects male nurses’ masculine image. However, as shown in Box 7 in Section 5.1, male NGNs constituted around 34% of the total number of NGNs. This might be related to the increased employment rate in nursing discussed in Section 6.1.2.

There are some limitations put on male NGNs practice to strictly work in male wards because of their sexuality and masculinity which is also the case in some Western countries (Twigg, 2004; 2000). It can be argued that increasing the number of male nurses might not guarantee stability in the nursing workforce because male nurses might stay in nursing but not in clinical practice.

The increasing number of male nurses is thought to affect how they relate to body-care in the nurse’s role. Twigg (2004; 2000) claimed that the masculine image makes male nurses view body-care as beneath them and that it should not be their job. Therefore, it can be argued that the increased demand that body-care should not be the work of qualified nurses and should be taken over by other support workers, result from the increased number of male nurses who are trying to withdraw themselves from providing such care.

6.5.4 The Presence of Expatriate Nurses

There is no doubt that since the start of organised nursing practice in Oman in the 1970s, expatriate nurses have played a major role in the provision of nursing care. However, due to the competitive market as mentioned in Section 2.1, having expatriate nurses caused instability in the nursing workforce and therefore, there are efforts to reduce the dependency on expatriate nurses by increasing the Omani workforce through “Omanisation”. Implementing “Omanisation” seemed to cause some threats and job insecurity for expatriate nurses which affected their acceptance of Omani nurses; NGNs in particular. Some SQU NGNs faced difficulty in forming good relationships with their expatriate colleagues, had interpersonal conflict with them or even sometimes experienced verbal abuse which clearly affected their collegial relationships. This resulted in SQU NGNs preferring to work with Omani nurses with whom they share many similarities.
Expatriate nurses worked under temporary contracts and faced a threat of losing their jobs. This resulted in a significant proportion of the nursing workforce focusing on just their work and avoiding conflicts in order to secure their jobs. This may arguably affect their contribution to the development of professional knowledge and the status of nursing. According to Holland’s (1979) theory of vocational choice, cited in Fung-Kam (1998), people choose work environments which are congruent with their personality type. Therefore, according to Fung-Kam (1998), the context of the work environment is determined by the presence of the majority personality type. In the context of this study, it can be argued that the culture of the work environment is determined by the presence of the culture of the majority of nurses. If this is applied to the fact that nurses working at SQUH are predominately expatriate nurses from the Indian subcontinent, thus, Indian nurses determined the values and context of nursing work and the status of the nursing profession at the hospital. Furthermore, it has been argued that each organisation contains two underlying organisations. The first one is visible with a clear structure and policies. The other one is the invisible structure determined by the working staff, which is powerful and might lead to the rejection of NGNs (Coeling, 1990). Therefore, it is considered essential for NGNs that they understand the culture of their organisation in order to adapt (Coeling, 1990).

At SQUH, SQU NGNs found a culture of nurses accepting all the work, never complaining and always trying to look busy to prove that they are working hard. In fact, this study showed that expatriate nurses tend to be passive and accept working under difficult conditions and did not object when they were given extra work to do. This might have sent a misleading message to the administration that nurses at the hospital are able to manage the increased workloads and even to do other non-nursing work.

Moreover, SQU NGNs found that they were expected by their expatriate colleagues to conform to the norms of the ward of working hard, never complaining and also showing others that they are always busy which has also been reported in the literature (Maben, et al, 2006). This study showed that NGNs had to follow the routine and norms of the culture of the majority of nurses to feel accepted which they found stressful and conflicted with their own ideals of nursing.

Despite the fact that there is no research in the literature to explore the effects of having increased numbers of expatriate nurses on the quality of care provision and the fact that this study intended mainly to focus on the experience of SQU NGNs during their transition
period, there were concerns raised that employing expatriate nurses who speak a different language and from different cultures might have a profound effect on the provision of the most integral aspects of nursing care. In the West, nurses identified a lack of communication with patients from ethnic minorities to affect the care provided to them (Chevannes, 2002; Murphy and Macleod-Clark, 1993). This might be related again to the argument discussed in Section 6.4.2 about the lack of communication between nurses and patients making nurses task-oriented.

There is an argument that increasing the recruitment of indigenous nurses is a step towards breaking the language barrier and providing more culturally sensitive nursing care (Aldossary, et al, 2008). This study suggested that the presence of SQU NGNs improves the nurse-patient communication and might increase patients’ satisfaction with nursing care. However, due to the limited number of Omani nurses, their ability to communicate with patients greatly increased their workload pressures. SQU NGNs were used as translators not only by nurses but also by doctors. In fact, some NGNs in this study experienced being used to translate bad news to patients and relatives. This is considered a particular source of stress for them especially given that they lack experience in how to break bad news and how to react to or support patients, relatives and themselves.

The presence of expatriate nurses might also contribute to the low status image of nursing. As mentioned earlier, at SQUH expatriate nurses are predominantly Indians and thus nurses’ status can be argued to be determined mainly by the culture and values of Indian nurses. Nursing as a profession in India is influenced by socio-cultural constrains where the social structure position of women affects their ability to work as autonomous practitioners. Indian nurses usually work under others including doctors or administrators and have inferior status and low pay in comparison to them (Patel, 1992; Nandi, 1977).

Moreover, in the Arabian Gulf countries, expatriate nurses are recruited in the same way as domestic labour such as servants. Therefore, the public tend to view expatriate nurses as domestic servants (Alotaibi, 2008; Al-Kandari and Ajao, 1998; Stevens and Walker, 1993). In fact, based on the servant image it seems there is a lack of respect for nurses. In a Kuwaiti study, the majority of nurses who were abused by the public were expatriate nurses (Adib, et al, 2002).
Though Omanisation is important, it is constrained by the lack of experienced Omani nurses due to the attrition of Omani female nurses caused by family commitments and Omani male nurses moving out of clinical areas. There were concerns that Omanisation will result in an increased ratio of inexperienced nurses in direct patient care which might affect the provision of quality of care (Santucci, 2004). Therefore, Omani NGNs will need time to develop and until then the workforce in Oman will continue to depend on experienced expatriate nurses. On the other hand, recruiting expatriate nurses based on their experience might not be the most important predictor for providing expert care for patients where expatriate nurses will still need to gain experience working in Oman to develop expertise. In fact, it can be argued that if employing expatriate nurses is a must, why not consider employing Arabic speaking nurses who are able to communicate with patients and understand their cultural and religious needs or even make Arabic a requirement for nurses to be able to work at the hospital. Employing non-Arabic speaking nurses who are not able to communicate with patients or even understand their cultural and religious needs indicate lack of awareness about the importance of nurse-patient interaction or communication or even the nurses’ role in providing other aspects of care than physical care. Furthermore, it can be argued that while implementing Omanisation, the organisation should pay attention not to impose the threat of job loss on expatriate nurses. Rather, expatriate nurses should be reassured that Omanisation is a strategy to improve the provision of quality of care and encourage collegiate working environments where both Omani and expatriate nurses strive to work as a team.

6.5.5 The Doctor-Nurse Relationship

It seems SQU NGNs’ relationship with doctors is mainly about feeling subordinate. Warelow (1996) argued that in the nursing literature there is always a reference made to doctors being team leaders without making any justification about what qualifies doctors to be team leaders. Unequal nurse-doctor relationship made NGNs dissatisfaction with nursing as a profession, which is consistent with the literature (Rosenstein and O’Daniel, 2005; Rowe and Sherlock, 2005; Daiski, 2004; Rosenstein, 2002). It is argued that for nurses to improve their status they need to balance their power relationship with doctors (Clifford, 2000). Being degree graduates and also having high grades in their secondary school like their medical colleagues, made NGNs strive for comparable professional status and reject the current hierarchical nurse-doctor relationship.
In the literature, the nurse-doctor relationship is not static but constantly changing. It has been argued that in the past, the nurse-doctor relationship was clear. Doctors represented the knowledgeable body that are able to treat people which made them superior and they were viewed as leaders while nurses who were mainly women were followers and just looked after patients until they get better (Radcliffe, 2000; Schurr and Turner, 1982). At the end of the 1960s, there was a reference made to “doctor-nurse game” where both doctors and nurses tried to preserve the hierarchical nurse-doctor relationship which added to the nurse’s role of not only looking after patients but also serving the doctors’ professional image (Stein, 1967). In the 1990s, it has been found that nurses were not playing the doctor-nurse game anymore. Nurses decided to move away from the handmaiden image and attain a professional image of being educated and responsible (Stein, et al, 1990).

From this study, there are four main reasons found to determine the nurse-doctor relationship at SQUH. The 1st reason is nurses making doctors behave as if they are holding power. This is mainly through obeying doctors’ orders, completing their work, reacting passively to their abuse, never showing initiative in decision making and always being busy doing menial work. According to Warelow (1996), nurses referring to doctors as team leaders imply that nurses accept and might also support the philosophy of the doctors’ role as more important than that of nurses. This is believed to promote doctors’ social power within the healthcare organisation. There is also some reference made in this study to senior nurses standing on the doctors’ side against other nurses. This made nurses feel the unequal relationship between them and doctors which is consistent with the literature (Daiski, 2004). Moreover, NGNs in this study referred to the passive reaction from expatriate nurses in particular, to doctors’ abusive actions or mistreatment as empowering doctors. This can be linked again to expatriate nurses’ sense of job insecurity by trying to avoid conflict with powerful professionals in order to secure their jobs. In addition, in this study, many NGNs referred to expatriate nurses holding the nurse-doctor traditional hierarchical relationship which they believed empowered doctors and made them disregard the importance of nurses. This might be related to the background culture of these nurses and their job insecurity as discussed earlier. Moreover, the passive reaction of nurses might be due to the fact that nursing is emotional work where nurses need to control their emotions as part of the job as discussed in Section 6.4.5.
The 2\textsuperscript{nd} reason is the existence of a communication gap between nurses and doctors, which increased the workload of nurses and also frustrated them. Lack of communication between doctors and nurses has been reported to reduce nurses’ job satisfaction and result in poor patient outcomes (Rosenstein and O’Daniel, 2005). Improving inter-professional communication between doctors and nurses in order to improve healthcare provision is one of the key mediators for introducing interdisciplinary education in the UK (Cooper, et al, 2001).

The 3\textsuperscript{rd} reason identified is the organisation’s policies and context which disempowered nurses and tended to make their work based on doctors’ orders. It has been found that many nurses used the phrase “doctors’ orders” instead of “doctors’ requests” in this study. In fact, it has been found that this phrase is widely used in the literature, in the nursing literature in particular (Ketola, 2009; Ellerton and Gregor, 2003; Wade, 1999; Schurr and Turner, 1982). According to the Oxford Online Dictionary, the word “order” refers to “an authoritative command, direction, or instruction”. Using this term widely in the literature might reflect the persistent existence of hierarchical relationship between doctors and nurses. Moreover, using the word “orders” shows nurses’ role to be dependent on doctors, which might indicate that nurses’ role is not autonomous especially if all of the nurse’s time is used to follow orders and complete routine work. This leaves no time for nurses to provide other aspect of care where they can practice autonomy or even utilise knowledge.

There is substantive evidence found in the literature to positively relate the ability to work as autonomous practitioner to increasing nurses’ job satisfaction (Greco, et al, 2006; Halfer and Graft, 2006; Leiter and Laschinger, 2006; Finn, 2001; Ingersoll, et al, 2002; Rafferty et al, 2001; Munro, et al, 1998; Blegen, 1993; Dwyer, et al, 1992; Spector, 1986), while reducing the feeling of control make nurses feel helpless and reduces their decision making (Munro, et al, 1998). Therefore, changing the nurse image to that of an autonomous and knowledgeable practitioner is suggested to increase nurses’ professional status and might also improve nursing remuneration (Tzeng, 2006; Wade, 1999).

However, nurses are still striving to define the concept of “autonomy” in relation to nurses’ practice. Kennan (1999) found difficulty in how to define the concept of autonomy but she suggested an operational definition which is “the exercise of considered, independent judgment to affect a desirable outcome”. Wade (1999) found that nursing autonomy is mainly described on the basis of partnership between nurses, healthcare colleagues, doctors in
particular, and patients. The freedom for the nurse to make a decision based on his/her knowledge and experience is considered an integral component of nurses’ autonomy.

In the Western literature, there is an increased use of the phrase “magnet hospitals”, which refers to hospitals that support a nursing model of care. Studies found that working in magnet hospitals increases nurses’ satisfaction and improves patients’ care outcomes (Manojlovich and Laschinger, 2007; Leiter and Laschinger, 2006; Rafferty, et al, 2001). This indicates that nurses’ exercise of autonomy is mainly dependent on the status and power of the nursing profession within the organisational setting and the capacity allowed for nurses to exercise autonomy. It can be argued that SQUH management shares responsibility in continuing the nurse-doctor hierarchical relationship. Therefore, if nurses are to be seen as professionals they should be trusted more and given time to act as autonomous practitioners.

The 4th reason to determine the nurse-doctor relationship is doctors not realizing that nurses are knowledgeable professionals and thus not including them in the decision making process. This study showed that doctors usually control how much they want to involve nurses and expand their professional role. In Nigeria, which might not be similar to Oman in all respects but it is one of the developing countries, it has been found that many doctors lack appreciation of the knowledge of the nurse and believe that they are able to complete their work without nurses (Ogbimi and Adebamowo, 2006).

NGNs emphasised that doctors treat them differently depending on the ward they work in. They believed doctors value ICU nurses more because they deal with more critical situations and exercise more autonomy. This is consistent with the results of other studies (Snelgrove and Hughes 2000). Therefore, it can be argued that for this group of NGNs they are trying to search for their professional image of being autonomous by moving to ICU or becoming specialist nurses. However, it can be argued that moving to ICU or assuming a specialist role does not imply that NGNs will work as autonomous practitioners and they may still be subjected to hospital regulations which might limit their autonomy. On the other hand, NGNs’ quest for the professional image might result in them moving away from their traditional image to more of a medical sense of obtaining qualifications and more medical roles. However, it has been argued that nurses are still serving doctors by taking up the roles that doctors usually dislike and prefer to be done by others such as some opposing arguments about the advanced nurses roles in the UK (Gould and Fontenla, 2006; Radcliffe, 2000). In this study, SQU NGNs found themselves pressurised to finish the work which doctors do not
want to do and have an extra responsibility of teaching junior doctors. However, teaching junior doctors might mean that SQU NGNS are forming partnership relationships with junior doctors.

This study did not seek doctors’ opinions about nurses, but the results indicate that doctors were believed to underestimate the importance of nurses’ professional roles because they are not aware of nurses’ knowledge and competency. It is therefore argued that for nurses and doctors to work closely in a partnership fashion they need to understand each other’s roles (Schurr and Turner, 1982).

SQU NGNs found senior male doctors, consultants in particular, more respectful to nurses compared to junior doctors; this contradicts the Western literature (Zelek and Phillips, 2003). It can be argued that senior male doctors being more respectful to nurses might be due to the fact that senior Omani doctors are usually exposed to other Western organisations where nurses have more advanced roles such as Canada. On the other hand, this might be again due to the increased number of male nurses. Male nurses found their relationship with doctors to be good, which is consistent with the literature (Porter, 1991). Moreover, this might be due to the fact that senior doctors are more aware of SQU NGNs’ competency because most of them are lecturers at the University or even contributed in designing the nursing curriculum.

6.5.6 Graduateness in Nursing and Professional Building

SQU NGNs connected increasing the qualification of nurses to degree level to increases in the quality of nursing practice and the status of nursing. Worldwide, nurses strive to make the degree level as the minimum requirement for nurses to be able to practice (NMC, 2010; Spear, 2003). Currently, nurses working in some countries have to attain a degree level to be allowed to practice such as in Canada (Spear, 2003), Australia and New Zealand (Sturgeon, 2010). In the UK, the NMC decided in 2008 to increase the academic qualifications for nurses to degree level by the year 2013 (NMC, 2010). There are great similarities found between the debate which was discussed in Section 1.2 about moving nursing education from the apprentice model to the academic setting and that of making nurses into degree graduates in terms of preparing knowledgeable nurses who are “thinkers” rather than “doers” (Clinton, et al, 2005; Spear, 2003). However, at this stage there is much emphasis put on the effect of increasing the nursing qualification to degree level on nursing professional status (NMC, 2010; Bowcott, 2009; Shukri, 2005; Spear, 2003). On the contrary, there are some arguments
that increasing nurses’ qualifications to a degree level makes nursing a hierarchical job where nurses attain a higher status with higher degree certificates (Ashworth, et al, 1999; Davis and Burnard, 1992).

The issue of increasing nurses’ minimum qualifications has been controversial. In the USA, a high proportion of the American nation agrees with increasing nurses’ preparation to a degree level (Spear, 2003). In the UK, the British media was full of debates, which suggested that increasing nurses’ qualifications could have a negative effect on nurses’ provision of basic care. Moreover, it can be argued that increasing nurses’ qualifications to degree level might increase the gap between theory and practice. However, the theory practice-gap debate is not specific to the degree courses as the debate started in the UK before even the diploma-level “Project 2000” (Greenwood, 2000).

One of the main debates around increasing nurses’ qualification is to increase the quality of provision of nursing care. Some studies showed a positive relationship between the increased number of degree nurses and reduced mortality rate in patients in hospital setting (Estabrooks, et al, 2005; Aiken, et al, 2003). However, these studies were not able to identify the high proportion of degree nurses as an independent variable, which reduced mortality and improved patients’ outcome. These studies instead, found that high rate of degree nurses at a hospital was associated with other variables such as low nurse-patient ratio (Aiken, et al, 2003), a richer nursing skill mix and better nurse-doctor relationship (Estabrooks, et al, 2005). These variables collectively reduced the mortality rate of patients. Moreover, some of these studies failed to control for levels of the experience and attributed nurses’ ability to reduce mortality rates to education rather than experience (McHugh and Lake, 2010; Aiken, et al, 2003). This might raise the question of which is more important in a practical profession such as nursing; qualification or experience or both.

According to Aiken et al (2003), the years of experience by itself did not predict mortality, which proves that experience is not more important than education background. However, some studies showed little difference between diploma and degree nurses in terms of practical competency at the time of graduation (Clinton, et al, 2005; Bartlett, et al, 2000). A study done by Ashworth et al (1999) in the UK showed that a number of nursing educators were not able to identify the different level of practice between degree and diploma graduate nurses. The lack of concise and reliable conceptual and operational definitions of competency in the nursing literature might limit these studies’ findings.
In addition, a survey done in the USA showed that degree nurses report that they perform more highly specialised skills compared to diploma nurses (Young, et al, 1991). However, it is not clear if this difference is due to differences in competency between diploma and degree nurses or is due to the existence of hospital policies and regulations, which might control the scope of practice of these nurses. Therefore, it is difficult to draw a clear and precise conclusion whether there is a difference between degree and diploma nurses’ competency and its direct effect on patients’ outcome.

Some studies suggest that degree graduate nurses have better future prospects and more job satisfaction compared to those with lower qualifications (Rambur, et al, 2005; Bartlett, et al, 2000). Yet, these differences cannot be merely attributed to them being prepared at degree level but might be a result of different resources, support and opportunities offered to degree graduate nurses in their workplace compared to lower graduates.

This study showed that being a degree graduate nurse meant a lot for SQU NGNs and indeed affected their expectations about their roles as staff nurses. There are high expectations put on these NGNs to lead the nursing profession in Oman. This is not confined to Oman as Luker (1984) claimed that moving nursing education to degree level poses expectations that degree graduates will lead the nursing profession and not work in low positions. This reflects the initial expectations of degree graduate nurses when degree nursing first started in the UK.

With no doubt, this caused some confusion for SQU NGNs as they thought that they would be given leading and senior positions. However, they were shocked that their job description is marginally different to that of the diploma nurse. Moreover, they found that diploma nurses could assume similar grade with only two years of experience. In fact, with the hospital policy of only taking nurses with minimum qualification of diploma with two years of experience or degree graduates, SQU NGNs found that they occupied the lowest grade in the nursing hierarchy at the hospital which was completely different to what they expected.

It is clear that in the Western countries, politics and policy makers have influenced increasing nurses’ qualifications to degree level. In Oman, it seems policy makers copy the nursing education model followed in these countries. Yet, in Oman it seems there is no consistency between education and practice where the nursing role is still following the traditional model which again relates to the differences between licences and mandates in the nursing profession in Oman.
6.5.7 Retention and Commitment

One of the main reasons for exploring the transition period of NGNs is their high attrition rate from healthcare organisations and from the nursing profession leading to nursing shortages. However, it might be argued from the data that attrition of NGNs might be less of a problem in Oman but retaining uninterested NGNs into nursing might pose many threats. This might be costly for the government, which invests in training these nurses and also might have a profound effect on the quality of nursing practice and nursing as a profession. In addition, due to the stressful transition experience and mismatch of expectations, there is a question of SQU NGNs commitment to SQUH and to nursing. Meyer and Allen (1991) cited in Meyer et al (1993), identified three distinct themes in the definition of commitment. These are, “affective commitment” as an affective attachment to the organisation; “continuance commitment” as a perceived cost associated with leaving the organisation; and “normative commitment” as an obligation to remain in the organisation. Usually, employees with a strong affective commitment stay with the organisation because they want to, while, those with a strong continuance commitment remain because they need to, and those with a strong normative commitment remain because they feel they must do. Moreover, according to Meyer et al (1993), nurses’ behaviours at work might be influenced by their commitments to the organisation and to the nursing profession. This might mean that nurses’ performance in their work is determined by their level and type of commitment.

Nurses are more committed to an organisation where they feel satisfied; their personal needs are met, feeling supported by seniors and other professionals and feel they are meeting their expectation of nursing (McCarthy, et al, 2007; Gould and Fontenla, 2006; Roberts, et al, 2004; Ingersoll, et al, 2002; Myer, et al, 1993). However, there are some studies which found that many of the most satisfied and committed nurses reported their intentions to leave nursing (Newton, et al, 2009; Ingersoll, et al, 2002). A large survey done in Canada showed older nurses to be more committed to the organisation and to nursing compared to young nurses (Tourangeau and Cranley, 2006). This might be due to older nurses’ loyalty to one organisation, which cumulatively develops with increased experience of interaction and socialisation (Meyer, et al, 1993). This again supports the need for supporting young nurses in particular to retain them into the organisation and into the nursing profession.
For these NGNs, there is a belief that SQUH is the best hospital in Oman with better resources compared to other hospitals. This might be largely connected to SQU NGNs’ familiarity with SQUH during their study and their internship period resulting in them developing a sense of belonging. However, NGNs lack of experience of working in other hospitals make them unaware of what to expect especially in terms of the staff nurse’s role. Additionally, high salary is considered a motivation for NGNs to stay at SQUH and might have increased their continuous commitment. Salary is seen to be very important motivation for NGNs in other studies (Boswell, et al, 2004).

The belief that SQUH offers continuous professional development for NGNs increased their “normative commitment”. In the literature, being able to participate in professional development opportunities is seen as important for NGNs and linked to increases in satisfaction and commitment to the organisation (Gould and Fontenla, 2006; Halfer and Graft, 2006; Boswell, et al, 2004; Shields and Ward, 2001; Tovey and Adams, 1999). Furthermore, SQU NGNs were made to feel special by the public because they work at SQUH. Thus, some of them showed hesitation in losing such privileges. However, despite all of this, there were some NGNs who already considered leaving SQUH mainly due to social issues or even searching for better working conditions after being confronted with increased workloads and time pressures.

Krausz et al (1995) found that the intention to leave nursing developed as a consequence of the intention to leave the ward or the organisation. According to them, a nurse first decides to leave the ward, then the hospital and finally the profession. SQU NGNs’ affective commitment to the nursing profession is at risk because of the mismatch of expectations between what NGNs believed about the status of nursing and the frustrating reality they found. In fact, this study found that many NGNs said that if they turned the clock back they would not consider nursing as their future career which is similar to some other studies’ findings (Siebensa, et al, 2006; Mills and Blaesing, 2000). Therefore, SQUH as an organisation should review its policies and job description and treat nurses’ burnout due to workload and lost ideals as priorities not only to improve quality of care but also to improve job satisfaction.

In addition, there is a conflicting literature about degree prepared nurses’ commitment to nursing. A survey done by Ingersoll et al (2002) in the USA, found that degree prepared nurses reported an increased intent to leave their organisations but not nursing. According to
Ingersoll et al (2002), this suggests that degree level nurses are prepared more for the realities of the work. However, a more recent study done by McCarthy et al (2007) in Ireland, found that degree nurses have more intentions to leave nursing because of a mismatch of expectations between their preparation and their actual role in practice. Despite contradictory results, these studies suggest that in order to retain degree NGNs, there is a need for partnership cooperation between the universities and the working organisations to implement measures to bridge the theory-practice gap and collectively work towards improving the status of the nursing profession.
Strength and limitation of the Study

This study is the first which provides data about the experience of NGNs in Oman. It gives an insight not only on NGNs’ experience but also about the context of nursing work and the status of the nursing profession in Oman. Furthermore, it adds some insight into the effect of culture on the experience of NGNs in the Arabian Gulf countries. In addition, it provides lessons learned about the experience of studying and working at the same organisation. Its findings might not only reflect the experience of SQU nursing students and graduates, but it might also reflect the experience of SQU students and graduates from other colleges such as the Medical College.

However, its findings are limited by being a single case study, which might indicate that the results are specific to the case under investigation, which is SQU NGNs’ transition experience working at SQUH. The case study has been criticised by some authors for its limited generalizability. However, some authors suggested that case studies allow for “fuzzy generalization” (Bassey, 1999). Added to that, VanWynsberghe and Khan (2007) suggested that comparing and contrasting similarities and differences of a particular phenomenon in a particular case to other cases might be a way to make “tentative generalizations”. However, with this case study being qualitative, the concept of generalizability is less appropriate than the concept of transferability. The reader usually decides about transferability of findings to his/her specific setting. Therefore, the researcher is required to provide sufficient information for the reader to decide (Kuper, et al, 2008b; Graneheim and Lundman 2004; Hawker, et al, 2002; Mays and Pope, 2000). In this case study, rich description of the case, methods of data collection and analysis are provided to help the reader to make a decision about transferability of findings to his/her own setting.

This study has the strength of exploring NGNs’ experience through different stages of their professional development at two different points of time. Moreover, using triangulation of different methods of data collection strengthens the findings of the study. Triangulation is seen as a mean for ensuring comprehensiveness and helps in achieving congruence in data analysis (Barbour, 2001; Mays and Pope, 2000). Furthermore, despite English not being the native language for neither the participants nor the researcher, using English language in conducting the interviews with different participants helped in identifying common phrases used by different participants such as “extra hand” or “task-orientation”.
One of the methods of increasing the quality of research is to highlight and discuss contradictory data (Mays and Pope, 2000). In order to draw a balanced account and not only report negative experiences, a quantitative measure of reporting how many participants said something using “a few”, “some” and “many” is used. Additionally, this case study adopted a “fair dealing” or “fair go” technique as described by Dingwall (1992). “Fair dealing” is a technique which means that the study includes different perspectives rather than focusing on one viewpoint assuming that this accounts represent the truth. Efforts were made to represent different viewpoints of NGNs working in different wards and also others who are working with them. Furthermore, using purposive sampling including both male and female participants and also participants from different wards and groups, e.g. students, NGNs during different stages of NGNs transition, has an advantage of including different perspectives and experiences. To ensure the advantage of purposive sampling, a constant comparison method was carried out in almost all data analysis chapter detailing the difference between genders, perspectives and experiences. This is thought to reduce the understated differences (Barbour, 2001), which might be important in NGNs’ transition experience. Furthermore, using purposively sampled documents focused the data collection enquiry to gain an in-depth understating about different aspects of NGNs’ transition experience.

This study showed that some NGNs and SNs believed that participating in this research made them feel that their experience is valued. Some of them clearly stated that they felt relaxed after they participated because they were given the opportunity to express their feelings and experiences which they had never done before. Including student nurses in research have been found in other studies to have a positive effect on fostering their self, knowledge and practice (Bradbury-Jones, et al, 2011).

There was a huge data collected in this study. The researcher adopted a systematic procedure by using Microsoft Access database to organise data and followed a coherent analysis procedure.

There are some practical limitations to this case study since it is part of a PhD degree, which constrained its time and resources for only one researcher.
Conclusion

The transition period of SQU NGNs is complex and similar to a large extent with NGNs’ experiences in the West. However, SQU NGNs faced some different challenges which are more related to their social circumstance and the Omani culture. Furthermore, this study provided evidence that SQU NGNs’ experiences have been largely affected by the status of nursing as a profession at the hospital and in Oman. The mismatch of expectations between the status NGNs thought that they would attain as degree SQU graduates and the real status of nursing profession affected NGNs’ satisfaction with nursing.

This study showed a clear difference between the objectives of academia and nursing service providers which clearly contributed to creating a theory-practice gap. Therefore, there is a need to tailor the nursing curriculum to the needs of the healthcare service and also there is a need to review the clinical placements of student nurses in order to increase their clinical exposure and bring them closer to the reality of nurses’ work. Moreover, there was a concern highlighted in this study about the role of both clinical instructors and preceptors in student nurses’ clinical placements. It can be suggested that they need to work more in a partnership approach sharing the same learning objectives.

Furthermore, the argument of increasing the qualification of nurses to a degree level is controversial. Nurses in the Western countries are prepared for the expansion and advanced roles they are expected to perform. Nurses in Oman are trained according to the curricula developed in the West. Nonetheless, many constrains are put on their scope of practice emphasizing on the traditional role of the nurse without any provision of support. This caused “reality shock” where education prepared highly qualified nurses to take over more technically-medical oriented tasks while practice is still about nurses carrying out the routine work and task-orientation. Therefore, it can be argued that preparing highly qualified nurses and expecting them to carry out a basic role might not only cause a reality-shock for them but might also be seen as a waste of resources. Degree graduate nurses could be utilised to improve quality of care rather than simply completing basic tasks. This is not to disregard the importance of basic care but more about obtaining a balance between resources and the demands of work.

The absence of support from HCAs in the hospital, made SQU NGNs suffered occupational stress which further decreased their satisfaction with nursing. There is much reference made
by NGNs to body-care as the most negative aspect of their nursing role that they expected not to perform. Performing body-care for patients did not only increase workload on NGNs but clearly contributed to their views about nursing as low status work. NGNs made reference to body-care as making the public and doctors view nurses as “servants”. The image they tried to get away from by hiding themselves while doing the body-care, not informing their families about them doing the body-care and by trying to move away from wards where there is much body-care. Furthermore, the nurse-doctor relationship and the diminished autonomy of the nurse made SQU NGNs feel that they are treated as subordinates rather than professionals. This might also be one of the reasons for NGNs wanting to assume advanced nursing roles or work in wards where nursing roles are viewed by doctors as important such as ICU.

Furthermore, despite implementing supportive measures into SQUH, it can be argued that these supportive measures did not fully prepare SQU NGNs for the reality of the workplace. This is mainly because SQUH still treated SQU NGNs as students, did not include any structured programme and did not focus on developing NGNs to work in a particular speciality. Role models, supportive head nurses and a teamwork atmosphere seems to play a major role in supporting and retaining NGNs during their transition period.

With no doubt, there is a socio-cultural dimension of SQU NGNs’ transition experience. Long working hours, working shift duties and living away from families strained NGNs’ social life. In addition, for female SQU NGNs living in private accommodations away from the family home limited their family support and brought new uncertainties to their lives.

This study also showed that despite the fact that most NGNs did not intend to study nursing and the stressful experiences they had during studying and their first year of experience, many of them expressed that they are proud to be degree SQU nurses. They all realised the importance of nurses in the working environment but they struggled to show others that they are important. In time, SQU NGNs started to adapt more to their environment by conforming to the norms of their workplace rather than relating their education to their practice.
Implications for practice

This study has implications to both academia and nursing services:

1- **SQU College of Nursing should consider reviewing the curriculum to focus on teaching students practical related competencies to bridge the theory-practice gap by:**

- Considering introducing students to the nursing profession prior to enrolment in the degree programme to assist them in making an informed choice about their future career (Pryjmachuk, et al, 2009).
- Creating a balance between theoretical and practical courses.
- Introducing practical exposure earlier in the course.
- Introducing full shift work early in the course and encouraging students to work different shifts.
- Assessing the applicability of involving nurse practitioners in teaching student nurses.
- Considering employing clinical instructors who have clinical experience working at SQUH or any other hospital in Oman and aware of the Omani culture, or even consider allowing clinical instructors time to work at the hospital to become familiar to the setting and context of the hospital.

2 **The nursing service should look into the context of nurses’ work and employ strategies to increase nurses’ satisfaction:**

- Consider employing nurses or other health workers who are able to communicate with patients and more aware of the Omani culture.
- Consider employing trained staff who can work as interpreters and counsellors for patients rather than utilising NGNs to break or disclose bad news to patients.
- More attention should be given in employing magnet strategies and consider allowing nurses some degree of autonomy at their work.
- Introduce a whistle blowing policy where nurses can report any compromised standards, which they believe might jeopardize patients’ life or health.
- Consider providing clinical nurses with in-service continuous education to update their knowledge and help them to provide evidenced-based practice.
Consider having support staff to help nurses. It should be the responsibility of the nursing services to clearly identify the job description of the HCAs based on their training and qualification.

Consider employing strategies to improve doctor-nurse relationship and encourage more partnership.

Consider implementing family friendly policies to support staff nurses who are parents.

3 There is a need for partnership collaboration between the nursing college and the nursing services at the hospital:

- Academia and nursing services should invest in changing the “nurse image” relating more to the historical contribution of nurses in the Islamic world e.g. utilise media in its different forms.
- Nursing academia and services in Oman need to develop knowledge which reflects the Omani values and culture to base their teaching and practice on.
- The nursing curriculum should be tailored to meet the needs of the working environment, while the working environment should utilise graduate nurses’ skills and knowledge to improve and maintain quality of care rather than overwhelming them with basic work.
- Clear learning objectives for each clinical placement should be shared between teachers, students and also clinical nurses.
- Nursing services should identify role models who can act as mentors.
- Consider working in collaboration in order to prepare preceptors or mentors who can teach and support both students and interns. Involving both academia and services in preparing the preceptorship course contents and conducting the teaching activities might help them to come to a more common understanding and share the same learning objectives. This might also inform clinical nurses about the contents and expectations of the nursing curriculum and therefore might help them to have a clear picture of what to expect from students and interns.
- Consider involving more Omani nurses and educators in the teaching process of SQU NGNs and interns by recruiting them for clinical instructor and preceptor roles. It is acknowledged that the number of Omani staff nurses who can fit such roles might be limited; however, encouraging more Omani nurses to assume such roles is suggested to help overcome the language barrier between Omani and expatriate nurses specifically during the transition period.
• Students and interns’ feedback and evaluation about the preceptor performance should be formally considered. This might help in identifying role models that can provide both teaching and support.

• Encourage preceptors to teach by reducing their workload to allow them more time to spend with students and interns or even give them some incentives.

• The internship period should be constructed and planned to prepare nurses to work in the wards they will work in after graduation. Thus, it is suggested that they spend the last rotation of their internship period in that ward. This might allow them time not only to be socialised into and learn the environment but also to improve their knowledge and practical skills.

• The position of the college of nursing to the internship programme should be clarified. The internship programme should perhaps be certified by the nursing services rather than the College of Nursing. Moreover, the benefits of moving the internship abroad to an elective module during study should be considered.
Further Studies

There is a dearth of nursing research in Oman. For nursing in Oman to be recognized as a profession it needs to build its own body of knowledge that is specific to the Omani context and meets the needs of the healthcare services. This study raised many questions about the nursing education, nursing practices and nursing profession that can be further investigated and explored.

There is a need for longitudinal studies to investigate the effect of admitting and retaining students at the College of Nursing on their burnout, attrition after graduation or the quality of their care provision. There is also a need to determine the factors affecting nursing as a career choice in Oman. The Nursing College should invest on research aiming to provide rich knowledge about the needs of healthcare services in Oman and the public. There might be also a need to assess the applicability of involving nurse practitioners in teaching student nurses and how this might affect students’ relating theory to practice.

There is a room for interventional studies where organised support measures can be utilised within the internship period and tested for their effect on NGNs learning, adaptation and satisfaction. The role of preceptors in teaching and supporting both students and interns needs to be investigated further to determine how preceptorship services can be improved. The issue of “internship abroad” should be investigated more for its benefits for Omani NGNs.

Nurses’ job satisfaction needs to be assessed and followed up in order to determine their intention to stay or leave and why. There is also a need to determine what construct Omani nurses’ job satisfaction and utilise these to develop assessment tools, which reflect the Omani culture, working conditions and status of nursing in Oman.

The status of the nursing profession and public perceptions of nursing and their effect on nursing practices are areas that need further investigation and exploration. Added to that, the effect of having degree nurses on the provision of nursing care and the status of nursing in Oman needs to be examined.

Since nursing services in Oman will continue to depend on expatriate nurses for sometime, the effect of the present of expatriate nurses on the quality of provision of nursing care and the power and status of nursing in Oman are issues for research. Expatriate nurses’
perceptions and understandings of the patients’ needs in Oman should be sought to determine their learning and practical development needs.

This study raised many concerns about basic nursing care. Nurses’ general perceptions in Oman about basic nursing care and how it affects their professional image are important topics to explore. The role of the nurse in providing basic nursing care can also be studied from patients’ point of view.
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Appendices

Appendix 1 Clinical Instructors' Topic Guide

| Rationale | Clinical instructors usually supervise students during their clinical practice. In this study clinical instructors who mainly supervise students during their advanced clinical course were recruited. This is mainly to capture students’ experience during the advanced clinical course from clinical instructors’ perspective. |
| Aim | To explore the effect of nursing curriculum and the clinical practice, ‘the advanced clinical course’ in particular, on NGNs’ transition experience. |

| Topic guide: |
| Create a welcoming atmosphere and trust relationship | Introduce myself again and the purpose of the study.<br>Stress on confidentiality and that data will be used only for the purpose of the PhD study.<br>Stress on the fact that this study is independent from SQUH management and nursing administration. |
| The role of clinical instructors | Could you tell me about your role as a clinical instructor?<br>How would you describe your experience as a clinical instructor?<br>What do you like most about being a clinical instructor?<br>What are the most challenging or difficult aspects of being a clinical instructor?<br>What skills do you think clinical instructors need and why?<br>How you are maintaining your relationship with students and others in the clinical area?<br>How students treat you?<br>How do you usually deal with conflicts with students if occur?<br>Based on your experience, how do you plan and structure students learning? |
| Expectations about SQU students | What do you expect from your students to know and do?<br>What do you think about SQU nursing course clinical placements?<br>What do you think about the theoretical knowledge of SQU student nurses?<br>What do you think about the skills of SQU students?<br>Do you think SQU students are able to utilise knowledge and critical thinking and reasoning?<br>How do you deal with students who have high expectations of themselves?<br>Are you satisfied with the level of performance and attitude of SQU student nurses?<br>What do you encourage your students to learn in their placements?<br>How prepared you think your students are to become staff nurses?<br>Where do you see your student nurses after 5 years from now? |
| SQUH learning environment | What are the main issues or concerns you usually face with your students in the clinical environment?<br>What are the main issues or concerns you usually face when you deal with SQUH staff?<br>How ward environment assist or constrain you in carrying out your responsibilities?<br>How do you describe support given to you and your students from SQU nursing school and SQUH staff? (including nursing staff, other |
professionals and head nurses).

| Support | What do you think SQU student nurses need to maximize their learning and prepare them to be competent staff nurses?  
| What do you think about SQU internship programme? (period, rotation and objectives)  
| How do you think SQU internship programme can help interns learning and adaptation?  
| How do you think student clinical placements and the internship programme can be improved?  
| How do you support student nurses? |
| Closing up | Ask if he/she has something else they want to add  
| Thank him/her for contribution |
| Comments and Observations |  |
Appendix 2 Head Nurses' Topic Guide

| Rationale | • Head nurses from the same wards of NGNs were recruited. This is to understand the experience of NGNs from the perspective of head nurses.  
• Head nurses play a role in NGNs internship period because they are mainly responsible for assigning them to preceptors. |
|---|---|
| Aim | • To explore the effect of head nurses on NGNs transition experience by exploring their perceptions and expectations of SQU NGNs.  
• To explore head nurses experience working with SQU NGNs. |

**Topic guide**

| Create a welcoming atmosphere and trust relationship | • Introduce myself again and the purpose of the study.  
• Stress on confidentiality and that data will be used only for the purpose of the PhD study. Stress on the fact that this study is independent from SQUH management and nursing administration. |
|---|---|
| Perception and expectations of SQU interns and students | • Do you have any SQU interns/ students or NGN in your ward? What do you think about them?  
• What are your expectations of SQU students/interns/NGN?  
• What do you think of intern’s/NGN academic preparation?  
• What do you think about SQU interns/NGN competency?  
• What are the difference and similarities between SQU interns/NGN and other interns/NGN?  
• What do you think about the standard of nursing practice of NGNs/interns? Do you expect interns/NGN to work independently?  
• Do you expect interns/NGN to know and do the ward routine? |
| Management issues | • How do you assign interns to preceptors?  
• How do you allocate interns/NGN and make their duty roster?  
• How much do you involve interns/NGN in the ward activities and meetings?  
• In your opinion, what are the main problems faces the /SQU students/interns/NGN in your ward. How do you manage them?  
• Do you consider interns/NGN in your staff levels?  
• How do you assign interns/NGN in busy hours? |
| Supporting interns, students, preceptors and academic mentors in the ward | • What do you think about SQU internship period Programme?  
• How do you support interns and students in the ward?  
• How do you support preceptors and mentors?  
• How do you think interns training and the internship programme could be improved? |
| Closing up | • Ask them if they have something else they want to add  
• Thank them for contribution |
| Observation and comments | --- |
### Appendix 3 Managers' Topic Guide

<table>
<thead>
<tr>
<th>Rationale</th>
<th>• Managers are policy makers who their understanding of NGNs’ transition experience affect their intervention.</th>
</tr>
</thead>
</table>
| Aims and objectives | • The explore managers’ understanding of NGNs experience and their needs.  
• To explore the perception of SQU and SQUH management about SQU NGNs.  
• To explore the expectations of management about SQU new graduates.  
• To explore the vision and plans of the management for SQU NGNs professional development. |
| Topic guide |  
**Create a welcoming atmosphere and trust relationship**  
• Introduce myself again and the purpose of the study.  
• Stress on confidentiality and that data will be used only for the purpose of the PhD study.  
• Stress on the fact that this study is independent from SQUH management and nursing administration.  

**Perception of managers about SQU NGNs**  
• As a manager, how important do you think is nursing to the hospital?  
• What do you think about the provision of nursing care at SQUH?  
• Do you have a direct contact with SQU NGNs?  
• What do you think about the skills and knowledge of SQU NGNs?  
• What do you think about the nursing curriculum at SQU College of Nursing?  

**Expectations of SQU new graduates**  
• Do you think there is a difference between SQU graduates and other Omani staff graduated from other universities?  
• What do you expect from SQU graduate nurses to be able to do after they graduate?  
• Do you think SQU graduate nurses might add anything to the hospital or the nursing profession?  

**Support provision**  
• What are the challenges SQU NGNs face at the hospital?  
• Have you dealt with any concerns/ challenges about SQU NGNs?  
• What do you think about SQUH internship programme? How important do you think the internship programme for both the hospital and NGNs?  
• How do you think you can support SQU new graduates?  
• What are the plans to support SQU NGNs if available?  

**Closing up**  
• Ask if he/she has something else they want to add  
• Thank him/her for contribution  

**Comments & observations**
### Appendix 4 1st Stage NGNs Topic Guide

<table>
<thead>
<tr>
<th>Rationale</th>
<th>• To understand NGNs transition experience from their perspective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>• To explore why these NGNs studied nursing.</td>
</tr>
<tr>
<td></td>
<td>• To explore the effect of nursing education of NGNs’ role</td>
</tr>
<tr>
<td></td>
<td>transition.</td>
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<tr>
<td></td>
<td>• To explore how NGNs experience role transition.</td>
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<tr>
<td></td>
<td>• To explore the effect of the working environment on NGNs</td>
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<tr>
<td></td>
<td>transition experience.</td>
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<td></td>
<td>• To explore NGNs expectations of themselves, their</td>
</tr>
<tr>
<td></td>
<td>preparation and their working environment.</td>
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<tr>
<td></td>
<td>• To explore their perception about their competencies as staff</td>
</tr>
<tr>
<td></td>
<td>nurses.</td>
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<tr>
<td></td>
<td>• To explore the support available for NGNs in their working</td>
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<tr>
<td></td>
<td>environment.</td>
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<tr>
<td></td>
<td>• To explore NGNs perceptions and experience of the internship</td>
</tr>
<tr>
<td></td>
<td>programme.</td>
</tr>
<tr>
<td></td>
<td>• To explore NGNs plans for the future as staff nurses.</td>
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<tr>
<td><strong>Topic Guide</strong></td>
<td></td>
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<tr>
<td>Create a welcoming atmosphere and trust relationship</td>
<td>• Introduce myself again and the purpose of the study.</td>
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<td></td>
<td>• Stress on confidentiality and that data will be used only for</td>
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<td>the purpose of the PhD study. Stress on the fact that this study is</td>
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<td></td>
<td>independent from SQUH management and nursing administration.</td>
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<td></td>
<td>• Ask each participant to fill a questionnaire about: age, gender,</td>
</tr>
<tr>
<td></td>
<td>marital status, ward, Wilayate, where they live in Muscat.</td>
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<tr>
<td>General experience</td>
<td>• Why did you study nursing?</td>
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<td></td>
<td>• What does nursing means to you?</td>
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<td></td>
<td>• What do you like most about being a nurse?</td>
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<td></td>
<td>• What do you hate most about nursing?</td>
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<td></td>
<td>• Do you think what you are practicing is nursing?</td>
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<tr>
<td>Educational curriculum</td>
<td>• Could you tell me about your SQU nursing education course?</td>
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<tr>
<td></td>
<td>How much practice did you have?</td>
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<td></td>
<td>• What do you think about SQU nursing course?</td>
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<td></td>
<td>• What do you think the difference between what you have been</td>
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<td></td>
<td>taught at university about nursing and what you are really doing</td>
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<td></td>
<td>at practice?</td>
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<td></td>
<td>• In your opinion, what could be changed in SQU nursing course</td>
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<td></td>
<td>in order to prepare qualified nurses?</td>
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<tr>
<td>Change in role from a student to a nurse</td>
<td>• What are the differences between being a student and being a staff nurse?</td>
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<tr>
<td></td>
<td>• Have you had any difficulties to move from being student to the</td>
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<tr>
<td></td>
<td>staff nurse role and learn the responsibilities of staff nurse?</td>
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<tr>
<td></td>
<td>• Do you think you your skills were improved or compromised</td>
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<td></td>
<td>after practising as a staff nurse?</td>
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<td></td>
<td>• How do you feel about the changes in your responsibilities by</td>
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<td>taking full responsibility of patients care and being hold</td>
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<td>accountable for you acts?</td>
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<td></td>
<td>• Do you think you have everything required to fulfil the role of a</td>
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<tr>
<td></td>
<td>staff nurse? Could you explain?</td>
</tr>
</tbody>
</table>
| Expectations                                                                 | How do you perceive yourself as a staff nurse?  
|                                                                            | Do you feel there is difference between what you can do and the expectations of others including head nurses, other nurses, other professionals and the nursing administrators and even your academic mentors? Tell me more about it?  
|                                                                            | Do you think you are able to meet your own values and expectations? |
| Working environment                                                        | How do you describe your work environment?  
|                                                                            | What do you feel about working in a busy ward with staff shortage and increased workloads?  
|                                                                            | In the ward you are working at, are you able to complete everything on time?  
|                                                                            | How do you feel about leaving some work for the next shift or delegating work?  
|                                                                            | How the working conditions affect your relationship with others? (Your preceptor, other nurses, other professionals, patients and their relatives and head nurses)?  
|                                                                            | Do you do any routine non-nursing work in your department? How do you perceive doing routine non-nursing work? Why?  
|                                                                            | How important you think routine work is to patients, the ward and other staff nurse?  
|                                                                            | Do you think routine work may compromise patient’s care? How does this make you feel?  
|                                                                            | Do you think learning the ward routine is important for you to learn to blend with other staff in the ward? Why?  
|                                                                            | How important you think doing the non-nursing or routine work can affect your relationship with others? |
| Competency                                                                  | How prepared you think you are for the staff nurse role?  
|                                                                            | How do you think your initial experience at SQUH affected your skills and learning?  
|                                                                            | What do you think about the competency (Skills) of other nurses compared to yourself?  
|                                                                            | How do you think your education curriculum affected your competency (Skills)? |
| Support in the workplace                                                    | Before you started your internship programme, how did you expect the support will be in the work environment? Why?  
|                                                                            | Who do you usually turn to for support in the work environment?  
|                                                                            | How do you perceive the support provided to you?  
|                                                                            | How supportive is the nursing administration? Could you tell me more? How does this make you feel? Does this affect you work and patient care? Why? |
| The internship programme                                                   | What do you think about SQU internship programme and its period?  
|                                                                            | How the internship programme affected your experience?  
|                                                                            | What are the most satisfying elements of the internship programme to you?  
|                                                                            | What are the most challenging or difficult aspects of the internship programme?  
|                                                                            | How is your relationship with your preceptors?  
|                                                                            | How do you think your relationship with your preceptor can
<table>
<thead>
<tr>
<th>Section</th>
<th>Questions</th>
</tr>
</thead>
</table>
| Interpersonal conflict | - Have you ever encountered a situation where you were mistreated (abused) by others? Could you tell me more about it?  
- How do you usually deal with difficult situations if happened? |
| Social life (this section was added subsequently) | - Has being a nurse affected your social life? How?  
- Does your social life and family matters affect your work and your career plan? |
| Coping mechanisms | - How do you usually cope with challenges and difficult issues at work?  
- Do you practice or do anything particular to help you to cope with stress at work? |
| Positive aspects | - What a good day like for you?  
- What does make you happy at work?  
- What do you like most/least about nursing?  
- How do appraise your satisfaction with nursing as a profession? |
| Career and professional development | - Are you satisfied with nursing as your profession?  
- Where do you see yourself after 5 years from now?  
- How do you see your future as a nurse?  
- If you could start your career again would you choose to be a nurse?  
- What do you think about the nursing profession in Oman?  
- How do you think nursing profession can be improved in Oman? |
| Closing up | - Ask them if they have something else to add.  
- Thanking them for contribution. |

Observations and comments
### Appendix 5 2nd Stage NGNs' Topic Guide

<table>
<thead>
<tr>
<th>Rationale</th>
<th>• NGNs go through process of change through their first year of practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>• To compare NGNs experience at two different points of time during their first year of practice.</td>
</tr>
</tbody>
</table>

#### Topic Guide

| Changes in experience since last interviewed | • How do you feel about yourself now as a staff nurse?  
                        | • How do you find the environment of SQUH around you now?  
                        | • How others treat you at this stage?  
                        | • Have you seen any difference between now and when I interviewed you?  
                        | • How do you see your future now?  
                        | • Anything you want to add? |
|------------------------------------------------|---------------------------------------------------------------------|
| Closing up                                      | • Ask them if they have something else to add.  
                        | • Thanking them for contribution. |
| Observations and comments                       |                                                                     |


## Appendix 6 Preceptors’ Topic Guide

<table>
<thead>
<tr>
<th>Rationale</th>
<th>• Usually NGNs are assigned to work with preceptors during their internship programme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>• To understand preceptors’ role and its effect on SQU NGNs’ transition experience.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Topic Guide</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
</tr>
<tr>
<td>----------------</td>
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</tbody>
</table>
| **Create a welcoming atmosphere and trust relationship** | • Introduce myself again and the purpose of the study.  
• Stress on confidentiality and that data will be used only for the purpose of the PhD study. Stress on the fact that this study is independent from SQUH management and nursing administration. |
| **Preceptorship** | • Could you tell me about your role as a preceptor?  
• How would you describe your experience as a preceptor?  
• What are the most challenging or difficult aspects of being a preceptor?  
• What skills do you think preceptors need and why?  
• Why you became a preceptor?  
• How you are maintaining your relationship with your interns or students?  
• How do you perceive yourself as a preceptor? What do you think about being a preceptor?  
• What do you think is expected from you as a preceptor? |
| **Perception and expectations of SQU students and interns** | • What do you expect from your preceptee to know or do?  
• What is the level you expect your student or intern to be at after they finish their training (advanced clinical or internship period)?  
• Have you ever dealt with a student or intern who has different expectations of self to your expectation? How do you usually with those?  
• How is your relationship with preceptees?  
• Have you ever had a conflict with preceptee? How do you deal with difficult situations or problems with interns or students? |
| **Education** | • What do you think about SQU nursing training?  
• How prepared you think SQU graduates are for the role of the staff nurse (in term of skills or knowledge)? |
| **Working environment** | • How ward environment assist or constrain you in carrying out your responsibilities as a preceptor?  
• How other nursing staff, other professionals and head nurses treat you as a preceptor?  
• What are your needs to maximize preceptees learning?  
• How do you think preceptees can be supported in the work environment?  
• What do you think about SQU internship programme? (period, rotations and objectives)  
• How do you think the internship programme can be improved? |
| **Closing up** | • Ask them if they have something else to add.  
• Thanking them for contribution. |
| **Observation & comments** | |

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Appendix 7 Student Nurses' Focus Group Topic Guide

<table>
<thead>
<tr>
<th>Rationale</th>
<th>• To explore the effect of educational preparation on SQU NGNs’ transition experience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>• Explore student nurses’ experiencing dealing with the nursing curriculum and how nursing education affect their preparation for the role of the nurse.</td>
</tr>
</tbody>
</table>

| Topic Guide |
|---|---|
| **Topic** | **Questions** |
| Creating a welcoming atmosphere and trust relationship | • Introduce myself again and the purpose of the study.  
• Stress on confidentiality and that data will be used only for the purpose of the PhD study. Stress on the fact that this study is independent from SQUH management and nursing administration. |
| Perception towards nursing. | • What makes you come into nursing?  
• What do you think about nursing as a profession? Is this what you expect nursing to be?  
• What does it mean to you to be SQU student nurse?  
• How people (patients/ patients’ relatives/ the public) perceive you as SQU student nurse?  
• Have you had any upsetting experience during your clinical placements or advanced clinical course?  
• How do you usually deal with difficult situations if happened? |
| The Advanced clinical course | • What do you think is expected from you to know and do at this level as an advanced clinical student?  
• How do you plan your day and work?  
• Are you familiar with SQUH policies?  
• How SQUH environment supports your learning needs?  
• What do you expect from the ward, preceptors/ clinical instructors to assist your learning and prepare you for the staff nurse role?  
• How is your relationship with your preceptor/ clinical instructors?  
• How other nurses and/or professionals treat you?  
• Do you feel prepared for the “exit exam”?  
• In your opinion, how the advanced clinical course can be improved? |
| Professional development | • Which ward you are planning to work in after graduation? Why?  
• What do you expect your job description as a staff nurse to be?  
• Do you expect your relationship with others (other nurses and other professionals, head nurses) to change after graduation? Why?  
• How prepared you think for the role of staff nurse? |
<p>| Available of Support | • How important is the internship programme for you? |</p>
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>• After graduation, what support you require from SQUH as a staff nurse?</td>
</tr>
<tr>
<td>• Are you looking forward to be a qualified staff nurse and be responsible and accountable for your actions?</td>
</tr>
<tr>
<td>• Do you think being a nurse will affect your social life?</td>
</tr>
<tr>
<td>• Working shift?</td>
</tr>
<tr>
<td>• Do you want to continue working at SQUH after graduation? Why?</td>
</tr>
<tr>
<td>• Where do see yourself 5 years from now?</td>
</tr>
</tbody>
</table>

**Closing up**

<table>
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<tr>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>• Ask them if they have something else they want to add</td>
</tr>
<tr>
<td>• Thanking them for contribution</td>
</tr>
</tbody>
</table>

**Observations and comments**
Invitation letter to:

Study which aims to explore “The experience of new graduate nurses in the transition period in Sultan Qaboos University Hospital, in the Sultanate of Oman”.

You are invited to participate in a study aims to explore the experience of SQU new graduate nurses (interns) in their first year of practice – “the transition period”. The study will be conducted by Huda Al Awaisi, a full time PhD student at the University of Manchester in the UK. You were selected as a potential participant in this study because you have a unique experience which will help in understanding the experience of SQU interns in general.

If you are interested to participate, please contact me through my e-mail address to give you participant information sheet (PIS). If you have queries or need more information or explanation, please don’t hesitate to contact me. If you decide to take part in the study please sign the consent form.

Thank You

Huda Al Awaisi,
Full Time PhD student
School of Nursing, Midwifery and Social Work, The University of Manchester, Jean McFarlane Building, University Place, Oxford Road, Manchester M13 9PL, UK
Huda.Al-awisi@postgrad.manchester.ac.uk
The Experience of Sultan Qaboos University Newly Graduated Nurses during their First Year of Practice in the Sultanate of Oman

Consent Form for NGNs

If you are happy to participate please complete and sign the consent form below

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason.

3. I understand that the interviews will be audio-recorded and transcribed anonymously.

4. I understand that my information will be used solely for a PhD study and any resulting publications.

5. I agree to the use of anonymous quotes.

I agree to take part in the above project

Name of participant

Date

Signature

Name of person taking consent

Date

Signature
The experience of NGNs in the transition period in Sultan Qaboos University Hospital, in the Sultanate of Oman

Participant Information Sheet for SQU new graduate nurses

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

I am Huda Al Awaisi, currently doing a full time PhD degree at the University of Manchester, UK. I obtained my nursing degree from Queen Margaret University College, Edinburgh in 2000 and obtained a master’s degree in Advanced Nursing Studies in 2005. I have worked at Sultan Qaboos University Hospital (SQUH) since 2000, including work with the Oncology team as an Oncology Staff Nurse. In 2008, I was granted study leave from SQUH Study Abroad Committee to pursue my PhD.

Title of the Research

The Experience of Sultan Qaboos University Newly Graduated Nurses during their First Year of practice in the Sultanate of Oman

What is the aim of the research?

Explore and understand the experience of NGNs graduating from Sultan Qaboos University (SQU) during their transition period.

The purpose of the study is to explore the experience of SQU NGNs (interns) in their first year of practice -“the transition period”. The study will provide an understanding of the challenges that SQU new graduates face during the transition period. It will help in identifying the needs of SQU NGNs so that support can be offered in the future.

Why have I been chosen?

You have a unique experience as SQU intern. Sharing your experience will help understanding the different experiences of SQU interns in the transition period. By understanding interns’ experiences, it is hoped that provision can be made to support future interns. Supporting interns in their first year of practice might enhance their transition experience, increase their job satisfaction and ultimately retain them into the nursing profession.
What would I be asked to do if I took part?

You will be asked to take part in a 1 to 1½ hour audio-recorded interview during your internship period and another 45 minutes to 1 hour follow up interview after finishing your internship. In the initial interview, you will be asked to talk about your experience as an intern working at SQUH and your experience of the internship programme. In the follow up interview, you will be asked to talk about your experience after finishing the internship programme and compare it to your initial experience of being an intern.

What happens to the data collected?

Your data will be transcribed and analysed by me and incorporated into my PhD dissertation (and possibly published in peer reviewed journals at a later date). Any data incorporated into my PhD dissertation and/or published will be anonymised. The data will not be used for any other purpose or study. I will ensure no one have access to your data except my PhD supervisors.

How is confidentiality maintained?

Any audio-recorded interviews will be kept in a locked cabinet in a locked room in my own office at my house. Transcripts of interviews will be anonymised and stored in password protected file so my personal computer and my “P drive” at the University of Manchester. The interviews will be anonymised by using a code for each participant. Any master decoding file will be kept securely and separate from the main files. I will ensure that no-one will have access to the study data except me and my supervisors.

Once the study is complete and following the University of Manchester’s data retention period (5 years), the files, audio and video records will be destroyed.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. You will be given two weeks to digest the information and ask questions about the study. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

Will I be paid for participating in the research?

There is no payment given to participants.

Where will the research be conducted?

Individual interviews will take place in a part of the hospital convenient to both participants and the organisation (SQUH) or in Sultan Qaboos University. Interview sessions will be prearranged with you at times that are convenient to you.
What will happen after I take part?

Your data will be kept confidential and will be used solely for my PhD and any resulting publications. If I use direct quotes from your interview, I will ensure that there is no direct information in the quote which might identify you.

Contact for further information or questions

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What if I have a complaint?

To make a formal complaint about the conduct of the research, please contact my supervisors:

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level 1 code

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