

BEING CONFIDENT IN PRACTICE:

A study on the influences on confidence in new graduate nurses

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Contents

Contents	i
Acknowledgement	v
Abstract	vi
Chapter One: Introduction and Background	1
Introduction	1
Aim of the study	3
Background to the study	3
New graduate nurses.....	3
The New Zealand context.....	5
Confidence	8
Theoretical background to confidence	9
The study environment.....	9
Methodology	10
Organisation of the thesis	12
Chapter Two: Literature Review	14
Search term strategies	14
The meaning of confidence	15
Confidence and nursing.....	16
Personal attributes influencing confidence	21
Relationships	24
Influencing confidence	26
The New Zealand context.....	29
Conclusion	30
Chapter Three: Methodology	31
Introduction	31
Quantitative and qualitative methodologies.....	31

Appreciative Inquiry (AI).....	32
The Principles of Appreciative Inquiry.....	33
Implementing the Four-D (4-D) cycle.....	34
Relevance of Appreciative Inquiry to this study.....	36
Ethical considerations	38
The principle of beneficence	38
The principle of justice	38
The principle of respect for human dignity	38
Power imbalance during data collection	39
The Treaty of Waitangi	39
Cultural Safety and the Code of Conduct	40
Sampling.....	40
Recruitment of participants	41
Data collection	41
The interview and dialogue	42
Interview questions	43
Transcription	43
Analysis.....	45
Reflexivity and bias	46
Rigour	47
Conclusion	48
Chapter Four: Findings.....	49
Introduction	49
Understanding confidence	50
Self-awareness	53
Reflection.....	56
Self-doubt	58
Over-confidence	63

Feigning confidence.....	64
Resilience	65
Relationships	66
Collegial Relationships	66
The culture of the environment	71
The patient's influence	74
Feedback.....	77
Trust	78
Developing learning and experience	80
Learning and knowledge.....	80
Experience.....	84
Looking to the future	85
Conclusion	89
Chapter Five: Discussion	90
Introduction	90
Understanding confidence	91
Self-awareness	91
Knowing.....	94
The meaning of confidence	95
Reflection.....	96
Self-doubt	97
Over-confidence	98
Feigning confidence.....	99
Developing a professional identity.....	100
Resilience	101
Relationships	102
Collegial relationships.....	103
Culture of the environment	104
The patients' influence	106
Feedback.....	106

Trust	107
Developing learning and experience	108
Learning and knowledge	109
Experience	110
Critical thinking and decision making	111
Looking to the future	111
Recognition and Celebration of study findings:	112
Implications for practice and education	114
Implications for research	115
Limitations	115
Conclusion	116
Post script	116
References	1
Appendices	1
Appendix 1: Consent to participate in research.....	1
Appendix 2: Ethical approval.....	2
Appendix 3: Research information sheet	3
Appendix 4: Interview Plan.....	5

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Abstract

The purpose of this study was to understand influences on new graduate nurses' confidence in their nursing practice. Confidence is a self-belief that an affirmative outcome will be achieved in a situation, and is influenced by factors individual to each person. New graduate nurses commence nursing practice feeling somewhat confident or not confident at all, and this feeling of confidence changes and evolves over their first year of practice as they navigate transition from a nursing student to a professional nursing role. Being confident is an important attribute of a nurse as it assists nurses to make decisions in their practice to achieve the outcomes they, or their patients and families and/or whanau require. Being confident will assist new graduate nurses to perform clinically, and to help them to face any challenges in their practice.

This study used the principles of Appreciative Inquiry as a methodology. Appreciative Inquiry is a flexible and positive approach to research, placing an emphasis on dialogue, collaboration and affirmation. It sought to discover what was working well with regards to confidence and its influences for the new graduate nurse. Utilising the elements of Appreciative Inquiry, I have analysed the dialogue of nine new graduate nurses who shared their stories of their nursing practice. Five themes were identified: firstly *understanding confidence* and the subthemes of *self-awareness, knowing confidence, defining confidence, reflection, self-doubt, over-confidence, and feigning confidence*; secondly *developing a professional identity* with the subtheme of *resilience*; thirdly *relationships* with the subthemes of *collegial relationships, culture of the environment, the patients' influence, feedback, and trust*; and the fourth theme of *developing learning and experience* with the subthemes of *learning and knowledge, experience, and critical thinking and decision making*, and finally the fifth theme of *looking to the future*.

The study dialogue identifies influences on the nurses' confidence, and their reflective practice particular to each nurse which consistently permeate their nursing practice. Recommendations are made for further nursing practice, education and research.

Chapter One: Introduction and Background

Introduction

Twelve months after commencing her nursing career, a new graduate nurse reflected upon her beginning nursing practice:

Right at the start you don't feel confident at all. I didn't feel confident in the least actually, I realised very quickly that I didn't know a lot. I knew from my degree and things like that and all that study, but I kind of struggled to have something to hang that off, and just being able to feel like I was on top of things, and to not be nervous. (Rachel: 12)

This thesis is a qualitative study of the influences on confidence of new graduate nurses in nursing practice. New graduate nurses regularly express feelings of 'anxiety, insecurity, inadequacy and instability' they have experienced during their transition from nursing students to professional nurses (Duchscher, 2009, p. 1103). The transition period can be challenging, and a stressful time for them (Missen, McKenna & Beauchamp, 2014). In my role as a registered nurse, new graduate nurses have expressed similar feelings which has led me to reflect about confidence and how the new graduate nurse perceives the influences on their confidence.

My experience in nursing has led me to have an interest in undertaking this study. As a nurse educator and clinician in New Zealand I have taught nursing students and new graduate nurses working alongside both these groups of nurses and their nurse colleagues. I have developed and evaluated transition to practice programmes and other nursing education, assessed new graduate nurses' practice and knowledge, and facilitated reflective meetings. I have an awareness that the new graduate nurse requires support in clinical practice, and they develop critical thinking and decision making skills as a result of many factors, for example their undergraduate education, reflective practice, discussions with colleagues, and by gaining new knowledge and experience in practice. I also have an awareness of how new knowledge, learning and experience influences future nursing practice and patient care. But there is still further

knowledge and learning that I require for my role, and questions that I seek explanations for, about the new graduate nurse and their practice.

In clinical practice I am aware that some new graduate nurses will query aspects of practice or patient interventions and follow through on their concerns; yet other new graduate nurses may hesitate to question, yet these nurses find the courage to speak up when concerned about practice. I have reflected about the ability for new graduate nurses to question or speak up and seek to understand if it is a result of time and experience in practice or their individual personality.

My current role includes recruitment of new graduate nurses. On occasion senior nurses from District Health Boards and the primary health non-government organisations have been influenced in their employment choices based on their perceptions of the new graduate nurse being too confident, confident, or not confident at all when considering the applicant's team 'fit' within the workplace. When reflecting upon this, and particularly the comments from colleagues about applicants being 'over confident' or 'not very confident', I have strived to understand why senior nursing groups see confidence as a defining attribute when employing a new nurse. The nursing profession is teaching and guiding new nurses to critically analyse, question and speak up in moments of nursing care where there is a risk or a concern in practice. Some assumptions about new graduate nurses' confidence have resulted in nurses being employed based on their confidence as it is perceived by others, and not necessarily on the professional factors required for a nursing position.

My reasons therefore for undertaking this study were to gain an understanding of what influences or helps the new graduate nurses' confidence in practice. As a nurse interested in education and competency issues in practice, I am seeking to improve the education delivered to new graduate nurses, and to further support and assess what can be termed the 'soft skills' of nursing practice - those skills which are professionally innate in nursing for example communication, the therapeutic relationship, ethical practice, values and attitudes. I also desire to improve the outcomes of our transition education delivery to new graduate nurses. For this an evaluation framework is utilised

for assessing how new graduate nurses' education and learning is integrated into practice. I am also developing further transition to practice education for the senior nursing groups in the District Health Board regions I am employed in, to improve support of the new graduate nurse in practice.

Aim of the study

The aim of this study was to investigate what influences confidence in the new graduate nurse. I sought to understand how the new graduate nurse experiences individual moments of confidence and what this means for their nursing practice. In this thesis I will report on confidence from the nurses' perspective utilising dialogue, appreciation and affirmation to seek out the positive moments in their practice.

Background to the study

New graduate nurses

Nurses are practising in increasingly complex healthcare environments which are shaped by individual and national, social and economic issues. Within this health environment, the graduate nurse commences their first year of professional practice. The new graduate nurses' ability to manage their way through the transition to a professional nurse may be stressful and challenging (Cheeks & Dunn, 2010; Dyess & Sherman, 2009) as their experiences are often new and unknown, diverse and unpredictable.

Several studies over the last four decades have been instrumental in identifying the experiences of new graduate nurses in clinical practice. Reality shock, an element of culture shock, described the new graduate nurses' responses socially, physically and emotionally to the differing work values the nurses then experienced moving from the student role to their professional role in the clinical environment (Kramer, 1974). Kramer, Brewer and Maguire (2013) further identified the distress which occurred during the transition of the new graduate nurse, but discuss this as environmental reality shock, contending nursing practice occurs within a system of people, structures and practices which differs from the expectations of the new graduate nurse, again creating

a tension for the new nurse in their professional practice. They conclude that a healthy work environment will decrease the environmental reality shock that is experienced by the new nurse.

Duchscher (2009) built on Kramer's 1974 work asserting new graduate nurses experience 'transition shock' (Duchscher, 2009, p.1106) which occurred in the early stages of the new nurses' role transition. Participants from hospital based acute-care practice identified the transition process involved developmental, professional, intellectual, emotive, skill and role-relationship changes (Duchscher, 2009). The new graduate nurses felt vulnerable between four and six months of their first year in practice. This is a period where their skills and relationships change and evolve, yet they experience performance stress, moral distress, discouragement and disillusionment within the health care environment (Duchscher, 2009). While experiencing the personal and professional adjustments, at the end of this time the new graduate nurses feel exhausted and isolated and retreat from the intensity of this period.

Patricia Benner (1984), identified five levels of becoming a nurse. Benner's levels of novice, advanced beginner, competent, proficient and expert explain how nurses experienced nursing practice. The advanced beginner level is recognised where the graduate nurse develops their expertise by demonstrating their performance in nursing. They do this after gaining prior experience, and by practice which is based on principles, experiences and in real-time situations (Benner, 1984). Both Kramer's (1974) and Benner's (1984) writing have shaped nursing practice and education nationally in New Zealand and internationally, and are important in understanding how nursing practice of the new graduate nurse is now experienced.

As a result of the stressors within the graduate nurses' transition period, and to increase their satisfaction in nursing, orientation programmes or transition-to-practice programmes have been implemented internationally to assist the nursing student's transition into the role of the registered nurse (Chandler, 2012; Ulrich et al., 2010). During this transition period the new graduate nurse is developing professional nursing experience and applying knowledge and skills learnt as a student. This time however

continues to be stressful for the new nurse as they enter the workforce having been deemed competent to practice (Pfaff, Baxter, Jack, & Ploeg, 2014; Whitehead et al., 2013) yet requiring ongoing support, with some new graduate nurses not feeling confident enough to make the clinical decisions required of them (Etheridge, 2007).

The New Zealand context

The report of the Ministerial Taskforce on Nursing (Ministry of Health, 1998) evaluated the state of nursing in New Zealand, highlighting that health employers expected a registered nurse to be 'work ready' upon graduation (p. 52). The report validated the importance of the first year of practice as a transition period in which the nurse should 'consolidate knowledge and skills in decision making, priority setting and in gaining confidence through the increased application of what has been learnt as an undergraduate' (Ministry of Health, 1998, p. 52).

The health sector employing new graduate nurses is experiencing a changing health environment. Of the 47,488 practising registered nurses in New Zealand (Nursing Council of New Zealand, 2015a), approximately 1.9% of registered nurses with a current annual practising certificate are practising within their first two years of practice (Watson, 2016). In 2014 the Nursing Council of New Zealand (NCNZ) published their workforce supply projections going forward to 2035. The recruitment and retention of nurses, including the number of nurses entering the profession plus the average age of nurses, and the predicted rising nursing turnover, is a concern for the profession. Also a concern is the increasing patient complexity and disease patterns of the population nurses care for, and a growing and aging population which is increasing the demand for health care services (NCNZ, 2014). These issues are affecting nursing as a profession moving into the future, and may impact on how the profession employs and retains new graduate nurses in practice; with the supply of new graduate nurses needing to increase over the next twenty years to meet population growth and demand (NCNZ, 2014). Workforce supply projections for the next 20 years include the new graduate nurse and new graduate nurse programmes to support the nurses' retention in the workforce (NCNZ, 2014).

The New Zealand nursing undergraduate is educated in the tertiary education sector gaining a Bachelor of Nursing degree and registration as a nurse after three years of nursing education. Since 2014 nursing students who have a previous Bachelor's degree have also been able to gain a Bachelor of Nursing articulated with a Masters of Health Science, attaining registration as a nurse after two years of education. Nursing students develop knowledge and skills and problem solving techniques related to nursing, achieving 1100 clinical practice hours, with 360 hours allocated to their final semester in preparation for registration (NCNZ, 2011a). During their clinical practice hours, nursing students are supported in the health care environment by clinical lecturers who assist with applying nursing theory to clinical practice, and who undertake assessment of students to meet programme requirements. They are also supported by preceptors, experienced nurses in practice who oversee nursing student's clinical practice and learning.

The preceptorship model of clinical support involves working with a nominated experienced nurse who assist the student by clinical teaching, and assessment of the undergraduate programme criteria. Some clinical areas support the nursing student within a Dedicated Education Unit (DEU). The DEU is a model of clinical teaching and learning based within clinical areas, and is a partnership between the tertiary education provider and the health facility. The nursing student is supported by the multidisciplinary health team, and has a clinical liaison nurse allocated to them as the key clinical support role, and an academic liaison nurse from the education institution. During clinical placements, undergraduate nursing students are learning to make nursing decisions and to manage the complexities and responsibilities of nursing care within integrated team environments, however they have had 'limited opportunities to demonstrate their competency' (NCNZ, 2014, p. 49) as an undergraduate nursing student.

Since undergraduate nursing education in New Zealand moved from the apprentice model of learning in hospitals, to the student-centred model in the tertiary education sector in the 1980's of there have been efforts to improve transition into practice for the new graduate nurse following registration (Adlam, Dotchin, & Hayward, 2009). Three District Health Boards (DHB) in New Zealand piloted a graduate nurse programme in

2002. As a result, Nurse Entry to Practice (NetP) programmes have since been implemented nationally within New Zealand District Health Boards. New Entry to Specialist Practice (NESP), Mental Health and Addictions, was also implemented for new graduate nurses practising in mental health. In 2015 one private hospital chain in New Zealand commenced a NetP programme. All NetP programmes are aligned to one vision for new graduate nurses, 'New Zealand nursing graduates commence their careers in New Zealand: well supported, safe, skilled and confident in their clinical practice' (Ministry of Health, 2014, p. 1).

When commencing their professional practice new graduate nurses applying for a NetP or NESP position apply via a central recruitment system, Advanced Choice of Employment, which is aligned to the New Zealand Government's Ministry of Health. There are currently new graduate nurses employed in New Zealand who are not enrolled in a NetP or NESP programme, and who commence their practice within clinical areas of some non-Government organisations, for example Aged Residential Care facilities, General Practises, and some hospitals.

Varying models of nursing care, professional responsibilities, patient acuity and clinical staff support the new graduate nurse within the clinical environment. These factors are dependent upon the models of care and ethos existing in clinical practice. New graduate nurses are employed into Aged Residential Care (ARC) positions where they may be one of two registered nurses within a facility on any given duty, with oversight of a team of health care assistants and the care of the residents. After six months of practice, the ARC facility may roster the new graduate nurse as the sole registered nurse on afternoon or night duty. New graduate nurses employed into district nursing positions will be practising on their own after an orientation period, and will have telephone contact with senior colleagues. The new graduate nurse employed into a General Practice may be preceptored by a nurse manager. The majority of new graduate nurses in New Zealand are employed into a District Health Board which has a larger number of nursing colleagues and health teams available for oversight and support.

The majority of new graduate nurses seek a NetP or NESP programme position in New Zealand in their first two years of professional practice. The majority are employed between a 0.8 full time equivalent to full time position, and complete academic and assessment components of their respective transition programme. New graduate nurses have support from another nurse trained in preceptorship whose role is to socialise them into the registered nurse role, assist with assimilation of clinical practice and nursing theory, and academic programme support. Both the preceptor and new graduate nurse are expected to share a clinical load for the first four to six weeks of practice in the clinical environment.

At the successful completion of their programme the new graduate nurse will have attained competent level on the Professional Development Recognition Programme (PDRP). The PDRP is a competence based programme where the nurse achieves a level of practice via the submission of a professional portfolio of their nursing practice. Achieving competent level on the PDRP is a completion criterion for NetP or NESP programmes nationally.

Confidence

Confidence, self-confidence, professional confidence and self-efficacy are used as surrogate terms within the literature (Brown et al., 2003; Holland, Middleton & Uys, 2012a). The Merriam Webster on-line dictionary (2016) defines confidence as 'feelings of one's consciousness of one's powers or of reliance on one's circumstances'. It further defines it as a 'faith or belief that one will act in a right, proper or effective way.' Within nursing literature, confidence is a self-belief in our own ability to achieve something, and is fundamental to nurses' own judgement and thinking (Perry, 2011). Etheridge's (2007) nursing study defined confidence as 'a belief in one's self, in one's judgement and psychomotor skills, and in one's possession of the knowledge and ability to think and draw conclusions' (p. 25).

Confidence is an important attribute of a nurse as it is essential in making decisions in nursing practice to achieve the outcomes they or their patients and families/whānau

families and/or whanau require. It enables new graduate nurses to perform clinically, and to face any challenges in their practice (Perry, 2011).

Theoretical background to confidence

Confidence is related to Albert Bandura's self-efficacy theory. Bandura (2012) associates human functioning, personal influences and environmental factors as influencing a person's behaviour. Robb (2012) defines self-efficacy as the ability to choose a course of action depending on the skills and ability a person believes they have. Having self-efficacy affects a person's thinking, their analytical ability, and their ability to reflect upon their former knowledge to make hypotheses and predictions. Therefore people who believe strongly in their problem-solving capabilities will be efficient in their analytical thinking within decision-making situations (Bandura & Wood, 1989). Self-efficacy therefore is individual to the person, as it is their own belief in their capacity to achieve in a given situation. It influences how people feel, think, behave and motivate themselves to act (Zulkosky, 2009).

In nursing self-efficacy is having the confidence and ability to practice influencing patient care (Willett, Hood & Cross, 2015). Being confident informs self-efficacy and enables a person to perform and achieve at something which then influences learning, influencing confidence further (Perry, 2011). While confidence is therefore linked to self-efficacy, this study will focus primarily on confidence of the new graduate nurse.

The study environment

The participants in this study were current members within a new graduate nurse programme or had recently graduated from such a programme. All had practised in nursing a minimum of six months. Five were employed in hospital settings, three within primary-health non-government organisations, and one within a government organisation which is not a health facility, but employs a health team. As new graduate nurses they are, 'accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards' (Nursing Council of New Zealand, 2015b).

Each participant had experienced a period of orientation within their clinical environment, receiving preceptor support throughout orientation and then intermittently for 10-12 months, which was the duration of the graduate nurse programme. Haggerty, Holloway and Wilson (2012), contend the preceptor relationship between a new graduate nurse and a preceptor is fundamental to successful transition of the new nurse.

Methodology

This study utilises a qualitative approach based on the principles of Appreciative Inquiry (AI). This methodology was chosen because it places an emphasis on the positive aspects within the new graduate nurse's situation, rather than aspects which need to be improved. In using a positive inquiry I aimed to increase self-esteem amongst the study participants by using stories and affirmation.

The challenge of integrating the principles of Appreciative Inquiry into the study design has required reflection upon the study, and on confidence in graduate nurses. In the early stages of this study, I was encouraged by my supervisors to consider my own understanding of confidence to clarify my thoughts about the topic:

I have been thinking that confidence at its most basic level is about knowledge or behaviour, but I'm still not sure, and I guess this dichotomy is about the lens I use to look at it. When I was first searching for the meaning of confidence last year I remember there being a photo of a 'confident little boy' – a lovely photo of a boy who had his arms crossed and was smiling at the camera. I found this interesting that we label someone confident, when it was simply a photo of a boy smiling with his arms crossed. I'm not sure how this defined confidence and I thought about the multiple contexts that we use the word.

I believe confidence includes other traits which are close in definition, like esteem, concept, assertiveness (all prefixed with 'self', i.e. self-esteem, self-concept, self-assertive), and also perseverance, resilience; possibly competence and knowledge or knowing. I also believe confidence is influenced by multiple personal and external factors, numerous factors. Thinking about our cultural

safety education over the years, as nurses we believe in respecting and valuing the individual person as having a unique culture and world view and influences that make us who we are today. This influences our confidence. So our individual culture and world experiences may make us more or less confident / assertive / esteemed / resilient / competent or knowledgeable to follow through or not on something.

Other influences include personality, including extrovert or introvert, although being either of these does not mean we are a certain confidence. I can be an extrovert and not confident at something, and vice versa. Also previous experience in a situation, or a positive / negative outcome previously, or the education we have had about a situation, or practice at a situation, the natural fight or flight instinct of a person, our ethical / value system, religious background, culture of the environment we are practicing in, known limitations / outcomes of a situation, the presence of certain people, male / female stereotypes etc. etc. all can influence why someone may or may not behave a certain way in any given situation.

Another thought over the last year is about over or under-confidence. At what point does one move from confidence to over-confidence, or from under-confidence to confidence? And why do we look negatively at times, on someone who we define as under or over confident? And why do we define some people as over or under confident and not others? I find the part-definition of over-confidence interesting and think it may include it being a person who fails to consider an alternative option.

And then there is the environmental context which may influence confidence, a 'confident' new graduate nurse may not be seen the same as a 'confident' white-water rafter as the two situations differ so much, but again some nurses might also be white water rafters. I've seen a first year RN struggle to speak up in a crowded office at handover, yet during a workplace crisis, she picked up a torch

and checked all the patients, checked on staff, contacted the emergency team to give an update, and lead the ward until some staff were replaced.

So I guess confidence is individual, and possibly we need to emphasise the 'self' in confidence rather than the other words like 'belief / esteem / assertiveness; and concentrate on what the individual defines themselves with regards to confidence. If the individual defines it as standing in a photo with their arms folded smiling, then that is what it is. So I'm looking forward to having conversations with the nurses, and seeing what they define it to be, and how it may / may not influence their practice and patient care. I suspect it could be a 'self-belief' after all. (Personal reflection: 2014)

This early reflection highlighted my assumptions and beliefs about confidence, but also laid the foundation for later reflections which challenged me to articulate explicitly what I was studying.

Organisation of the thesis

This thesis is written in five chapters. In addition to this current chapter which introduces the study, are the following:

Chapter Two: Literature review

Whilst there is a large amount of literature on the new graduate registered nurse, this chapter will identify that there are a limited number of studies which specifically discuss the influences on confidence of the new graduate registered nurse. Those which discuss the New Zealand context are primarily commissioned reports from the Ministry of Health.

Chapter Three: Methodology

Appreciative Inquiry (AI) is the methodology which underpins this study on the influences of new graduate nurses' confidence. This chapter discusses AI and its philosophical background, its positive approach, and the study process. It will identify

the principles and the 'four-D cycle' of AI, and how these are utilised in participant interviews and the study process.

Chapter Four: Findings

This chapter articulates the findings of the new graduate nurses' dialogue on confidence. It is written with reference to the 'Discovery' and 'Dream' philosophy of the AI 'four-D cycle' and identifies the uniqueness of the participants and their stories and views on confidence in their practice.

Chapter Five: Discussion

This chapter discusses the implications of the findings expressed by the participants, the limitations of the study and the recommendations which have evolved from the study. It also discusses the 'Design' and 'Destiny' phases of the 4-D cycle of Appreciative Inquiry.

Chapter Two: Literature Review

The subjective nature of confidence is of a dynamic character and is highly individualised, based on factors such as one's perspective, role, self-esteem, sense of efficacy, sense of self, and experiences related to the context or setting. (Perry, 2011, p. 228)

This chapter provides an overview of the literature relevant to this study. The literature examines the concept of confidence specific to clinical situations, for example confidence in relation to inter-professional collaboration (Pfaff et al., 2014). I could find no one study which investigated the influences on confidence from the perspective of the new graduate nurse in relation to their overall nursing practice.

The following literature review will commence with discussing confidence in the nursing and psychology literature, and then in terms of nursing practice, with some discussion relevant to the new graduate nurse. The themes that emerged from the literature are related to the concept of confidence as it relates to nursing: the meaning of confidence, personal attributes influencing confidence, relationships, and developing learning and experience.

Search term strategies

Literature was gathered from the health specific electronic databases Combined Index of Nursing and Allied Health Literature (CINAHL Complete), ProQuest Nursing and Allied Health, PubMed, Medline and PsychInfo to find studies that related to confidence and the new graduate nurse. The key search terms used included combinations of the words: 'new graduate nurs*', 'novice nurs*', 'new* qualified nurs*', 'new* licensed nurs*', 'new* registered nurs*', 'new nurs*', 'transition', 'residency', 'confidence', 'self-confidence', 'professional confidence' and 'self-efficacy'. The goal was to identify as much information on confidence and the new graduate nurse as possible.

Literature was selected from a broad date range and which was available in English. An on-line search of specific nursing journals, and reference paths from downloaded

articles to procure further studies was then conducted. This search method was deployed at various times throughout the research study to gather any further published studies. Literature was discarded if it was not related to the topic, for example studies which did not identify the opinions of participants, and studies which used the word 'confidence' in the title as an outcome of the study, yet did not discuss confidence.

Journal articles were selected for their definitions or explanations of confidence related to the health field, and which best reflected influences and experiences of confidence and nursing practice.

The meaning of confidence

Confidence is important for nurses to possess (White, 2009), yet it is a complex phenomenon (Halarie, 2006). There are several nursing studies which express the meaning of confidence (Brown et al., 2003; Crooks et al., 2005; Etheridge, 2007; Evans, Bell, Sweeney, Morgan & Kelly, 2010). The definition by Etheridge (2007, p. 25) is articulated in the introduction chapter of this thesis, 'a belief in one's self, in one's judgement and psychomotor skills, and in one's possession of the knowledge and ability to think and draw conclusions'. Evans et al.'s (2010) study did not find a definition within the scientific literature, and the authors offer their own definition of confidence as 'an acquired attribute that provides individuals with the ability to maintain a positive and realistic perception of self and abilities' (p. 335). Both Brown et al. (2003) and Crooks et al. (2005) discussed the meaning of confidence within their studies as 'an internal feeling of self-assurance and comfort' (Crooks et al., 2005, p. 361) and 'feeling good, comfortable', and Duchscher (2008) comments that the graduate nurses relax 'into a more comfortable space' when they realise what it is that they 'do not know' – which coexists with the nurse's confidence in what they 'did know' (Duchscher, 2008, p. 447). Holland, Middleton and Uys consider it to be a 'self-assessed belief' (2012a, p. 216), and in their later study contend confidence is a 'maturing self-belief' (Holland, Middleton & Uys, 2013, p. 105). A study on confidence in critical care nurses described confidence as an 'ability to maintain a positive and realistic perception of oneself and abilities' (Evans et al., 2010, p. 335).

Koriat, Lichtenstein and Fischhoff (1980) maintain there are two reasons for confidence: to assess the knowledge and skill of a situation or task, and secondly to review that evidence and then decide upon a belief-level about how successful a person feels they will be. The reasons for confidence are complex (Chesser-Smyth & Long, 2013; Halarie, 2006) with some authors contending it may be attributed to personal beliefs and achievements (Etheridge, 2007; Evans et al., 2010). Confidence is essential for achieving in a range of areas from personal, professional, social, mental, leadership, sport and combat performance (Johnson & Fowler, 2011; Shipman & Mumford, 2011).

Optimism, self-affirmation and believing in achieving a positive outcome in a situation are attributes of self-confidence (Halarie, 2006; Kissinger, 1998; Perry, 2011; White, 2009). Stajkovic explains this in his discussion on the enabling role of confidence, where those with high confidence may initiate action, pursue it and sustain persistence of the action as 'they feel certain that they can handle what they desire to do or needs to be done' (2006, p. 1209). Stajkovic aligns confidence with performance, surmising highly confident people are more successful performers, and conversely less confident people are less likely to initiate action, pursue it and sustain persistence as they feel uncertain and experience doubt. Confidence, skill and desire are required for an action to progress, and if one of these three components is absent, performance will be inhibited (Stajkovic, 2006). According to Stajkovic (2006), having core confidence is being certain that one can cope with something. Core confidence is working out what and how to do something [hope], believing one can do the task [self-efficacy], having a positive outcome of the task [optimism] and rebounding if things do not go as planned [resilience] (Stajkovic, 2006).

Confidence and nursing

Confidence and self-confidence have been described within the concept analysis literature by a number of authors (Halarie, 2006; Holland et al., 2012a; Perry, 2011; White, 2009). A concept analysis defines and clarifies nursing knowledge on conceptual problems which originate in nursing practice, theory or research (Rogers, 1989). The aim is to further advance nursing theory (Perry, 2011).

Confidence has various meanings within concept analyses. Halarie (2006, p. 3) describes confidence as a 'human quality demonstrated through an efficient act, resulting in a positive outcome'; and White (2009, p. 107) defined self-confidence as a 'personal belief that one can achieve an affirmative outcome in a certain situation'. Within Perry's (2011) concept analysis confidence is discussed in regards to nursing students using simulation education and learning strategies. Perry contends personal attitudes and cognition may affect a person's confidence. Halarie's (2006) concept analysis discussed confidence within a nursing education context also, contending confidence relies on somebody or something, for example 'God, faith, the self, abilities, experiences, knowledge, and skills' (Halarie, 2006, p. 3).

Confidence has been associated with professional roles. In Holland et al. (2012a) concept analysis on professional confidence, the authors consider confidence differs slightly from self-confidence and aligns the concept of confidence to a professional role. The professionally confident person experiences a feeling of self-assurance which is affirmed by colleagues, patients or friends. Being professionally confident also includes having an understanding of the profession a person practices in, their scope of practice, the significance of their profession and the capacity and affirming experiences which enables them to be competent in the profession (Holland et al., 2012a). Having professional confidence therefore enables effective practice and skills of the health practitioner, and effective patient outcomes. Holland et al.'s (2012a) concept analysis on professional confidence studied occupational therapists, and referred to literature from both the occupational therapy and nursing professions.

Confidence is believed to underpin competence in nursing care (Bell, Horsfall & Goodin, 1998). Evans et al. (2010, p. 334) identify 'nurses experience confidence in different ways, to different degrees, at different times, and in different situations'. Confidence is thus transient in the nurse and it takes time to develop (Brown et al., 2003; Holland, 2012a). Holland et al. (2012a) further describe the transient nature of confidence as a 'spiral' (p. 219) where attributes of confidence are influenced by each other, with the person moving in and out of feelings of comfort with their confidence. Therefore moving

in and out of confidence influence the decisions nurses made with regards to 'knowing what was going on' in patient care (Etheridge, 2007, p. 25).

Confidence is further described in the nursing literature in the context of the nurse's workplace or situation (Etheridge, 2007; Evans, et al., 2010; Perry, 2011; White, 2007). Etheridge's (2007) longitudinal phenomenological study from the United States of America used semi-structured interviews to study the perceptions and meaning of new graduate nurses making clinical judgments in their practice. Etheridge identified 'developing confidence'. Participants grew to become confident over the nine month period of the study, learning about responsibility and accountability for their actions. In contrast to a clinically based study, Crooks et al.'s (2005) qualitative study of professional confidence in post diploma baccalaureate nursing students investigated confidence prior to entering a nursing education programme, and the development of confidence following this. The nursing students had previously attained a nursing diploma. Prior to the programme, four themes were identified from the nurses which were related to professional confidence: defining confidence, developing confidence, knowing when you have confidence and outcomes of being confident. They were then interviewed during their degree studies, and described phases of development which identified feeling, doing, knowing and reflecting with regards to confidence and their nursing practice. They had moved from wanting to understand confidence to understanding it further in practice.

Over-confidence in nursing practice was identified within some literature on confidence. Holland et al. (2012a) discussed over-confidence and the negative consequences which impacted upon the health worker's clinical reasoning and patient outcomes. Over-confident people believe they are correct and 'better than they actually are' (Johnson & Fowler, 2011, cited in Shipman & Mumford, 2011, p. 651). Kissinger's concept analysis on overconfidence found that the over-confident nurses' scrutiny of their practice would decrease, and therefore their learning from the experience would decrease, and a false sense of security and errors could develop (Kissinger, 1998). This is explained by a participant in Kissinger's concept analysis who stated, 'one is so sure of himself, that questions are no longer asked' (cited in Kissinger, 1998, p. 19). Kissinger (1998)

contended over-confident people do not consider alternative perspectives in situations, and have an unwarranted certainty in their decision making. Johnson and Fowler (2011) discuss the emergence of over-confidence as a bias in people who have an incorrect belief about their own capability. In balance, Kilkus (1993, cited in Ohlen & Segesten, 1998) contends that assertive nurses believe in themselves and their abilities which influences their personal and professional empowerment. Being over-confident means the nurse's clients may be misled to the true state of clinical opinion and decision making (Kissinger, 1998).

Feigning confidence was a behaviour which emerged within some nursing studies (Brown et al., 2003; Crooks et al., 2005; Holland et al., 2013), although this was not specifically studied within studies on confidence. Crooks et al. (2005, p. 362) termed this 'false confidence'. Andersson and Edberg (2010, p. 190) contended new graduate nurses may exaggerate their competence in their practice to 'hide behind the mask of confidence'. Managing the emotions and therefore the experiences of others' feelings by being confident was originally discussed by Hochschild (1983) in a text describing this phenomenon occurring in flight attendants. Hochschild (1983) asserts that people manage their feelings and their private emotional system to suppress their real feelings as a means of caring for the client. Titled 'emotional labour' (Hochschild, 1983, p. 7), this is expressed within the nursing literature as nurses suppressing their undesirable emotions and therefore communicating emotions which are desired by the patient. This practice displays empathy with the patient (Karimi et al., 2014), with the patients feeling cared for if the nurse is supportive and anticipates their needs, and appears confident in their practice (Riemen, 1986, cited in Rego et al., 2010).

The literature also identified the self-doubt that exists in nurses, often termed under-confidence. Feeling self-doubt within a situation requires a higher motivation to process information (Tormala, Rucker, & Seger, 2008) causing the health professional to act, feel and think differently (Holland et al., 2012a). Self-doubt is identified as dynamic and evolving, and occurs because of intrinsic or extrinsic factors such as the context of the situation, the subject, situation of the environment, or perceptions of efficacy by the nurse (Perry, 2011). This is similar to Duchscher's (2008) discussion of the professional

journey of the nurse transitioning from a student to professional not always being a consistent progression. Duchscher (2008, p. 444) contended nurses can regress because of 'new events, relational circumstances, and unfamiliar or complex practice situations or contexts'. Self-doubt will influence new graduate nurses' practice as the feeling of doubt in practice means the new graduate nurse will be less likely to trust themselves (Perry, 2011), utilising a significant amount of energy to overcome the doubt and to manage their reactions and feelings (Wichman et al., 2010).

Confidence can diminish in new graduate nurses, although studies varied on when this happens. Etheridge (2007) contended new graduate nurses did not feel confident at all when commencing practice yet by six months they were developing confidence in their decisions on the status of the patient. By nine months of practice they were feeling more confident in their clinical decision making, developing the ability to make more complex decisions and independently acting on their decisions. Duchscher's (2009) study also found new graduate nurses experienced a lack of confidence, but it was between their first and fourth months in practice when the nurses felt physically and psychologically debilitated and at times powerless.

Duchscher's (2009) 10-year longitudinal study investigated the experiences of new graduate nurses adapting to their registered nurse role, utilising four qualitative studies and an extensive literature review throughout the study. According to Duchscher, participants appeared unprepared for the effect the transition would have on them. Four months after orientation the new nurses felt exhausted, isolated and confused (Duchscher, 2009). Confidence began developing after this time and by twelve months of practice they were feeling an increased confidence.

Further to this, confidence may predict a person's success (Chesser-Smyth & Long, 2013; Perry, 2011; White, 2009). Being successful in achieving something in practice influences confidence and if success does not happen, feeling confident may be delayed (White, 2009). Chesser-Smyth and Long's (2013) study on the influences on self-confidence among first-year undergraduate nursing students in Ireland, found

having academic success resulted in an increased confidence, although it was not stated if the increased confidence transferred to clinical practice.

Chesser-Smyth and Long's (2013) mixed methods study utilised a pre-test and a post-test measurement of self-confidence, and focus group interviews followed by student self-evaluation questionnaires and curriculum analysis. While this study identified students' responses about confidence, the outcomes identified that self-confidence is complex and dependent upon multiple factors, similar to the findings of White (2009) and Perry (2011). Positive influences on confidence were articulated in the findings of Chesser-Smyth and Long (2013) for example self-confidence changed over time, and among age groups and genders; and with having undertaken previous study. Feeling a part of the team and having the support of peers were all positively influencing attributes on confidence. The negative influences which diminished participants' confidence were anxiety in the clinical environment, feeling unable to challenge a dominant nursing culture and having to conform to workplace requirements (Chesser-Smyth & Long, 2013).

Personal attributes influencing confidence

Confidence is a part of an individual's personality (Holland, Middleton, Uys, 2012b). Central to self-confidence is having a belief in oneself that an affirmative outcome will be achieved in a situation (Holland et al., 2012a; White, 2009). The personal characteristics of being optimistic and self-affirming (Chesser-Smyth & Long, 2013; White, 2009) and taking personal responsibility for self-confidence is influential on a person professionally. Equally, being anxious will also influence confidence (Chesser-Smyth & Long, 2013; White, 2007) and being self-aware and self-regulating can allay this anxiety (White, 2007).

Nurses know what it is to feel confident (Brown et al., 2003; Crooks et al., 2005). Within Crooks et al.'s (2005, p. 362) qualitative study of diploma nurses, participants discussed 'knowing' when they felt confident. They contended the participants knew they had confidence in their practice from the patients and other colleagues seeking the nurse's knowledge, or trusting their judgement. When the participants acquired knowledge they

reflected, and critical thinking developed which enabled the participants to further self-question their practice. This encouraged them to seek further education and learning.

In contrast Newton and McKenna's study (2009) contends that aesthetic knowing, the interpretive knowing in a situation, is not always evident in a graduate nurse's first year of practice. McKenna and Green (2004) studied the experiences and learning of nurses during a graduate nurse programme. This study undertook focus group interviews with participants at six months and the end of the 12 month programme. Although this was not a study on confidence in the new graduate nurse, the study found participants at six months into the programme focused on surviving. By the end of the programme they were focusing on others and on extending their learning and developing a degree of assertiveness.

Self-awareness and management of one's own behaviour impacted upon confidence in studies by Holland et al. (2012a) and White (2007). When nurses experienced periods of change they experience unrealistic expectations, uncertainty, anxiety and stress which may impact upon their ability to cope. Having self-awareness of these factors which influence coping also decreased anxiety (White, 2009) and may lead to an internal feeling of success (Evans et al., 2010). Nurses who felt successful in practice experienced raised self-efficacy, and raised their ability to perform specific tasks to meet diverse challenges (White, 2007). Evans et al. (2010) qualitative descriptive study investigated confidence in registered nurses in a critical care unit in Canada, primarily studying the cultural, social and environmental factors related to the nurses' confidence. This study, while not specific to new graduate nurses, discussed the sub-culture of critical care nursing and utilised a theory of culture care to guide the study. Participants described confidence within the context of their workplace, reporting they did not feel prepared for the reality of nursing amid the chaos and demands of the environment. The nurses sought supportive colleagues which helped increase their confidence in practice.

Further to satisfaction in nursing practice, Perry's (2011) concept analysis identified being emotionally intelligent enabled the nurse to self-monitor themselves which empowered performance of the nurse. Equally, being emotionally competent assisted

the nurse to make adjustments to learning and their success in situations. Being both emotionally intelligent and emotionally competent are considered positive attributes influencing confidence. Perry's (2011) concept analysis further identified resilience, attitude, cognitive ability, trust and intuition as positive attributes of self-confidence; identifying the negative attributes of self-confidence as narcissism, depression, doubt, uncertainty and negativity as adversely affecting confidence.

The literature also identified reflective practice as an element of practice which aided confidence. Crooks et al. (2005) referred to reflection-on-practice as key in self-awareness and in developing professional confidence. Participants within Crooks et al.'s study who understood their learning and were able to self-evaluate, became more assertive in their practice. This finding in support of confidence, is similar to a study by Brown et al. (2003). Brown et al. indicated reflection supports confidence, having investigated two time periods influencing confidence in nurses, namely a time before nursing education and a time after this. The study discussed the themes of feeling, knowing, believing, accepting, doing, looking, becoming, and evolving professional confidence. These stages occurred as participants moved through a four year undergraduate programme (Brown et al., 2003). Prior to nursing, participants' confidence was influenced by their personality and their life experiences. In contrast, during their nursing studies participants' confidence was influenced by other factors, namely the curriculum, their tutors and their own experiences which positively impacted upon them. Also their own perceptions of nursing and some nursing tutors brought a negative influence which therefore impacted upon confidence.

Of the literature on nursing studies from clinical practice, the following studies identified individual or personal factors as influencing confidence of participants. In Brown et al. (2003) study, the authors explored attributes which began in childhood, for example the personality characteristics of participants, their self-discovery, or the ability to take initiative which aided participants' professional confidence. Similarly Holland et al. (2012a) identified this within their concept analysis of occupational health students who

had an internal ability to take the initiative from a young age which influenced their professional confidence. Chesser-Smyth and Long (2013) also discussed personal factors such as age and gender which influenced the self-confidence of the nursing students in their study.

Having a professional identity or professional awareness was an influencing factor for confidence in some of the literature. Professional awareness is discussed by Crooks et al. (2005). Participants initially had a fear of their knowledge or actions being challenged and after internalising the values and knowledge required for the role, they gained confidence. As a result of their evolving confidence they were able to voice their views and values, define nursing and confidently articulate their practice. Defined by Crooks et al. (2005, p. 363) as 'finding a voice of my own', this finding was not just articulating their practice in the classroom, but being able to transfer this to their clinical practice aiding their confidence in the clinical environment.

Relationships

Professional relationships were a key factor in supporting a nurse in practice and influencing their confidence. One study recognised the benefit of having the support and encouragement of student peers to feel confident (Holland et al., 2012b). While Holland et al. researched nursing students' experiences of confidence, other authors acknowledged the importance of peer relationships for nurses in practice. Evans et al. (2010), found participants deliberately developed supportive relationships. For some participants it was the fostering of these relationships more as friendships which aided their confidence. Duchscher (2007) also explains that new graduate nurses will look to nurse colleagues they depend upon for their experience and knowledge. Difficulties in professional relationships could therefore result in miscommunication with nurse colleagues, which can inhibit the professional communication that is required for patient care. Collegial nursing relationships were significant for the participants to manage their self-doubt and to integrate into the workplace. Seeking assistance in their practice and experiencing collegial relationships increased confidence in practice situations.

Preceptors were important as providing primary role modelling and mentoring in several studies; (Evans et al., 2010; Haggerty, McEldowney, Wilson & Holloway, 2010; Holland et al., 2012a; Holland et al., 2012b). Developing relationships with senior colleagues enabled the new graduate nurse to be less concerned about not knowing everything (Etheridge, 2007), and having the experience of the senior colleagues further encouraged participants to trust their decision making and understand their responsibility in the role. Etheridge (2007) also discussed peer relationships as significant in a study on new nursing graduates and clinical nursing judgement. Etheridge's longitudinal phenomenological study found new graduate nurses initially looked up to and questioned their preceptor, but later preferred to seek out experienced nurses and colleagues to support and enhance their confidence (Etheridge, 2007).

Colleagues other than nurse preceptors were also identified as significant in influencing confidence in the nurse. Pfaff et al.'s (2014) study explored the relationships with others in their study on new graduate nurses' confidence in inter-professional collaboration. This mixed method study surveyed 514 new graduate nurses from acute, community and long term care explaining the factors which facilitated and challenged their confidence to engage in inter-professional collaboration. Study findings showed that supportive relationships of the team, the organisational leaders and other health professionals were significant in enabling confidence of the new graduate nurse. This was also identified in other studies, where professional relationships from colleagues who portray a mutual respect and acceptance was also significant for the new graduate nurse in experiencing confidence (Brown et al, 2003; Davidhizar, 1993). Experiencing collegiality within health teams enhanced confidence by promoting critical thinking skills and decision making, and therefore confidence (Kaddoura, 2010).

Confidence is also influenced by feedback from colleagues (Davidhizar, 1993; Duchscher, 2009; Haavardsholm & Naden, 2009; Haggerty, McEldowney, Wilson, & Holloway, 2010; Holland, 2012a). The new graduate nurse will seek validation, affirmation, role modelling and feedback from colleagues (Duchscher, 2009; Evans et al., 2010). One study identified that the new graduate nurse may not always receive quality feedback nor have the time to assimilate it into their practice (Phillips, Esterman,

Smith, & Kenny, 2013). Duchscher and Cowin (2004) contend that new graduate nurses appreciate both affirmative feedback and that which improves their practice. This is also identified in a study by Crooks et al. (2005) who identify the importance of constructive feedback about nurses' strengths, and feedback for improvement.

In contrast to having supportive relationships, Duchscher (2009) wrote of dominant nurses in the workplaces who challenged the new graduate nurses' education which was then perceived as diminishing the new nurses' confidence. The literature identified the struggle of new graduate nurses in interacting and communicating with senior nurses and medical staff, leading to the new graduate nurses' experiencing difficulty in professional communication (Duchscher, 2009; Dyess & Sherman, 2009).

Influencing confidence

Developing knowledge was an influencing factor in studies on confidence. Davidhizar's (1993) study on self-confidence in critical care nurses emphasised the intrinsic factors of knowledge and experience as influencing self-confidence in the nurse. Several other studies also found the nurse's knowledge influenced confidence (Holland et al., 2012a; Pfaff et al., 2014; White, 2009). The graduate nurses gained their knowledge informally from colleagues, and this enabled the nurse to exchange information more confidently within the team, especially when the nurse felt less confident in communicating due to limited knowledge. Even when knowledge was lacking however, participants still required self-confidence to feel success in their practice (Davidhizar, 1993). Davidhizar (1993) uses the example of the critical care nurse who is subsequently practising in a medical/surgical environment - they can still feel confident in their skills in the new environment, even if they need further information or resources to assist them.

Critical thinking and decision making of the new graduate nurse is also identified within the literature on confidence (Etheridge, 2007; Evans et al., 2010; Hoffman & Elwin, 2004; Kaddoura, 2010). Baumann, Deber and Thompson (1991) suggest being uncertain is an inevitable trait of clinical decision making and the new graduate nurse is therefore less confident in critical thinking and their ability to make decisions, which are dependent upon their clinical knowledge. Etheridge (2007, p. 27) explains this further

stating, 'critical thinking occurs continuously, expands with experience, and eventually becomes second nature'. Etheridge, (2007) contends that new graduate nurses' transition from a student to registered nurse when they learn to make clinical nursing judgements.

Similarly, Hoffman and Elwin's (2004) correlational study of 82 graduate nurses in Australia used the 'CI=confidence in decision-making scale' (p. 10) to measure new graduate nurses' perceptions of confidence in decision making. The authors found that although confidence in decision making is thought to be important in practice, new graduate nurses who were good critical thinkers take more time to search for answers to a problem and hesitate to achieve a decision; and over-confident nurses may be detrimental to decision making by coming to conclusions too quickly, and may negatively affect clinical practice (Hoffman & Elwin, 2004). The authors concluded that there was no relationship between critical thinking and confidence in the decision making of new graduate nurses.

Clinical simulation is an area of growth within the international nursing literature, with some studies discussing the influence on nurses' confidence in their decision making and critical thinking abilities. Kaddoura's (2010) descriptive study of new graduate nurses' simulation experiences and how this influenced their critical thinking, learning and confidence provided three findings significant to their study. Findings indicated the nurses experienced cognitive and psychomotor skills, critical thinking and leadership skills, and awareness of safety after their simulation training. Of the nine sub themes in the study, the new graduate nurses gained confidence in decision making and for one nurse, increased confidence in their critical thinking. The authors surmised that clinical competency and confidence were enhanced, as was the nurses' ability to critically analyse their holistic patient care.

New graduate nurses' experience or time in practice influenced confidence (Duchscher, 2009; Etheridge, 2007; Kaddoura, 2010; Ulrich et al., 2010). Etheridge (2007) discussed how participants were growing and developing within six months of commencing their nursing practice, and at nine months the new graduate nurses had gained the ability to

make more complex decisions and act independently upon those decisions. In comparison, Duchscher's (2009) study stated new graduate nurses reach a 'crisis of confidence' between 5-7 months practice when they experience insecurity regarding their competence, and a fear of failing (p. 446). This resolved by 12 months of practice when the nurses felt relatively confident in their practice (Duchscher, 2009). McKenna & Green (2004) found that the graduate nurse's confidence was increasing at six months but they still required an increased knowledge and skill to maintain their confidence.

The amount of exposure to practice is related to the development of self-confidence experienced by the nurse. This was a finding from Ulrich et al.'s (2010) longitudinal study on retention, confidence and competence of new graduate nurses who had completed a residency programme. Their 10 year longitudinal database study on 6000 graduate nurses was prompted by a high graduate nurse attrition rate in the first and second year of practice. The study used self-reporting and observation instruments, in particular the Skills Competency Self-Confidence Survey at two weeks into practice and at intervals until completion at 60 months. The results of the graduate nurses improved over time with their self-confidence growing over this 60 month period. The more exposure the participants had to situations produced better outcomes for themselves, their colleagues and the patient (Ulrich et al., 2010). This is contradicted in Pfaff et al. (2014) however, which found that it is not the length of experience that is most influential to confidence, but the nurse's maturity and relational experience which is linked to their increasing knowledge acquisition.

Having the support of a transition to practice programme is important for nurses' confidence (Ulrich et al., 2010) which indicated participants who were supported by a residency programme experienced an increase in competence and confidence at the completion of the programme. Dyess and Sherman (2009) studied nurse transition also, but within a community transition programme with participants commencing their programme feeling both fearful and confident in their abilities. Participants moved through the stages that are identified within Duchscher's (2009) study, of doing, knowing and being in their first 12 months of practice. New graduate nurses require further support after their orientation and preceptorship support programme (Dyess &

Sherman, 2009). Cleary, Matheson and Happel (2009) also evaluated the transition to practice of mental health nurses in Australia, finding the support of the programme encouraged the nurses to remain in mental health positions. Having support in practice enhanced skill, knowledge, self-awareness and professional development, with an increase in confidence following the completion of the programme.

The New Zealand context

The Ministerial Taskforce on Nursing (Ministry of Health, 2004) commissioned an evaluation report on three District Health Board pilot graduate nurse programmes which had commenced in 2002. Of the 162 new graduate nurses surveyed, 87% rated their confidence as good or excellent at the end of the pilot programme. The remaining 13% felt their confidence was average at the end of the programme (Ministry of Health, 2004, p. 28). At that time, one third of these respondents had felt confident when commencing the programme. The study concluded the participants' confidence was enhanced because of the support and guidance they received during the programme.

A mixed method study also commissioned by the Ministry of Health (Haggarty, McEldowney, Wilson & Holloway, 2009), later reviewed the 21 Nursing Entry to Practice (NetP) programmes in New Zealand and concluded the NetP programmes supported the development of confidence and competence in the new graduate nurse. Using a mixed method design, the study's findings indicated the nurses had increased confidence by the end of their first year of practice. The report linked the positive feedback to the quality preceptorship provided by senior registered nurses who had been educated in preceptorship. Confidence was an outcome deliberately sought by the development and implementation of the NetP programmes and was therefore surveyed to ensure the programmes were meeting the aim of the national specifications.

The above study has outcomes similar to a New Zealand study by Lennox, Jutel and Foureur (2012) who examined new graduate midwives' confidence in their first year of professional practice. This mixed methods study gathered data from the new graduate midwives and their mentors at three periods within the first year of practice, and identified mentoring of the graduate midwives aided the transition to a confident

midwife. The new graduate midwives' ability to choose their mentor and negotiate their support, which is a different process to their new graduate nursing colleagues, increased the midwives practice confidence.

Conclusion

This literature review has placed the study enquiry within the literature on confidence. The concept of confidence has varying meanings and is influenced at varying times throughout nursing practice dependent on factors which are individual to the participants of the studies, or the situation at the time. New graduate nurses experience a degree of confidence, under-confidence and over-confidence in practice which is influenced by self-awareness, reflection, critical-thinking and knowledge, collegial support and environmental factors such as time in practice and workplace culture. Nurses feign their confidence as a means to advocate for the patient or to support the patient, decision-making and patient care.

We know little of the current situation of New Zealand graduate nurses regarding their confidence. There are a small number of New Zealand studies, with the key nursing studies commissioned by the Ministry of Health as an evaluation of nationally funded Nursing Entry to Practice programmes.

While some study's discussed the positive aspects influencing confidence of new nurses, the majority of international literature with regards to the new graduate nurse is studied from a deficit perspective identifying and studying the problems within nurses' practice. This research study has therefore been undertaken to understand the positive influences on confidence of the new graduate nurse by using positive language, encouraging positive affirmation and discussion with the participants. By doing so, this study will seek to transform nursing's thinking towards positive or affirmative learning (Cooperrider et al. 2008). The following chapter identifies the principles of Appreciative Inquiry and the design process of the research study.

Chapter Three: Methodology

Clarity of purpose is essential to successful AI work.

(Cooperrider, Whitney & Stavros, 2008, p. 54)

Introduction

This chapter will examine quantitative and qualitative methodologies, and the rationale for utilising a qualitative approach for the current study. In particular it will discuss Appreciative Inquiry as an emerging research methodology and how the principles of this methodology support a nursing study. The study design will be discussed identifying ethical considerations, the recruitment of participants, data collection, the study interview, analysis of the data, reflexivity and bias, and rigour.

Quantitative and qualitative methodologies

Before I commenced this study, it was important to determine the research approach which would best meet the aims of the study question. I initially considered and discarded a quantitative methodology as this tests an objective theory and the relationship between variables in a study (Leedy & Ormrod 2013; Polit & Beck, 2012). This method of research utilises a systematic and logical process to progress through a study to statistically analyse the results (Polit & Beck, 2012). This differs from a qualitative methodology which uses a naturalistic and inductive approach that is more subjective and highlights the holistic and individual characteristics of human experiences (Polit & Beck, 2012). As Sandelowski, Trimble, Woodard and Barroso (2006) note, qualitative research is now seen as supporting evidence based research and improvement in health care. The knowledge nursing needs as a practice discipline, is about knowing 'how, when, why, whether and for whom' (Sandelowski, 2004, p. 1367). Qualitative methodology is exploratory and open-ended producing detailed, rich and in-depth data (Braun & Clarke, 2013).

Appreciative Inquiry (AI) is one such methodology which gathers and analyses information from a qualitative paradigm (Carter, 2006). AI is based on the 1986 work of Cooperrider and the theory of social constructionism which is the idea of finding meaning and interpretation in knowledge. An Appreciative Inquiry philosophy considers the knowledge we gain by interacting with, and in, social systems. A social system creates its own reality (Reed, 2007; Cooperrider et al., 2008). AI originates in the study of organisational change and is a holistic, flexible and context-specific method of investigation which challenges traditional research methodologies by using a positive approach (Trajkovski, Schmied, Vickers, & Jackson, 2013).

Appreciative Inquiry (AI)

Appreciative Inquiry is distinctive as a methodology in that it seeks out what is working well (Carter, 2006; Cooperrider et al, 2008; Reed, 2007), focusing on the positive rather than 'what is wrong' within an inquiry (Reed, 2007, p. 74). AI does not overlook the problems within a study but reframes the problem positively (Cooperrider et al., 2008).

Appreciative Inquiry uses dialogue and storytelling, affirmation and appreciation to empower people and to enhance organisational growth and change processes (Reed, 2007; Trajkovski et al., 2013). By using an Appreciative Inquiry approach the aim was to positively value and appreciate the new graduate nurses' current and future role while questioning them on influences on confidence. It was an appropriate methodology to support a nursing study as AI is mindful of the individual within the complex environment of health and their individual values, rules and interpretations of nursing practice. Incorporating the principles of Appreciative Inquiry enabled me to support participants to reflect upon and identify their strengths and future direction in practice. AI therefore was a methodology which resonated closely with my philosophy and desire to support new graduate nurses' and their practice development.

With regard to this study, Appreciative Inquiry's method therefore, was to investigate the affirmative topic of influences on confidence in new graduate nurses. This is an affirmative topic because it is stated in the 'positive' and it is a 'desirable' objective for the participants (Cooperrider et al., 2008, p. 41). I am aware that this topic is desirable

for new graduate nurses because of previous discussions held with nurses, and their indications that this is the direction they wish to pursue in their practice. This was therefore, an explicit and positive topic. The 'AI process truly begins when a conscious choice is made to focus on the affirmative' (Cooperrider et al. 2008, p. 42). It was important during the study that the principles of Appreciative Inquiry were adhered to during the design and the implementation of this study.

The Principles of Appreciative Inquiry

The principles of Appreciative Inquiry which shaped the study approach were the Constructionist Principle, the Principle of Simultaneity, the Poetic Principle, the Anticipatory Principle and the Positive Principle (Cooperrider et al. 2008).

The Constructionist Principle involves understanding how individuals shape their knowledge, what controls ways of knowing and knowledge, and how this is shared. Postmodern knowledge acquisition involves being collaborative, inquiring and finding options, sharing of knowledge, and questioning (or inquiry) of all that has been. The world is constructed through language and relationships (Cooperrider, 2000). Understanding that the participants shaped their knowledge and ways of knowing was important for the study, as I needed to ensure the study valued and affirmed the participants own knowledge of their nursing practice, by being collaborative with them during interviews and any interactions. To do this, I ensured I appreciated and affirmed participants' own knowledge, engaged in dialogue, co-constructed the design of the future by enquiring of the future with positively framed questions and prompting reflection. I sustained the design and destiny phases of Appreciative Inquiry by ensuring their dialogue was heard through writing the research thesis and making recommendations, translating their vision for nursing practice, education, policy and research (Cooperrider et al., 2008). The phases of Appreciative Inquiry are identified later within this chapter.

The Principle of Simultaneity is described by Cooperrider (2000) as the individual processes of inquiry and change which occurs concurrently. Participants thought about, discussed and learnt from the moment the first question was discussed with them,

stimulating images or changes of the future. The questions that were used were not necessarily seeking answers, but generating thinking and dialogue, and a way forward for the future of the new graduate nurses. During the interviews participants were encouraged to think about, discuss and learn from the questions and discussion. To achieve this they were asked questions to explain or clarify their discussion and meaning of their dialogue. During these moments, positively framed questions were used to elicit further reflection and discussion about their nursing practice or confidence.

The Poetic Principle describes the participants' practice as constantly evolving including acknowledging the past, moving forward to the present, and onto the future. All the situations they discussed were multiple sources of learning (Cooperrider, 2000). The premise of this principle is that we create our world by what we explore to generate our learning and its interpretation.

The Anticipatory Principle uncovers positive images of the future, which further develops the existing performance of the new graduate nurse (Cooperrider, 2000, p 19). How we imagine our future will inform how we achieve it. This is implemented in the interviews by the question asked of participants about their future practice and what they envision this to be. This principle is also indicated in the actions undertaken to foster confidence in new graduates, in the learnings generated from this study.

Finally the Positive Principle creates and sustains a positive environment or inquiry which creates a positive and sustained change, 'the major thing we do that makes the difference is to craft the unconditional positive question' (Cooperrider, 2000, p 20). Positive questioning was utilised throughout the interviews, with a guide of questions available to assist during the discussions.

In following an Appreciative Inquiry design, I utilised the phases known as the '4-D' cycle.

Implementing the Four-D (4-D) cycle

The first phase of the 4-D cycle *discovered* and appreciated what 'gave life' and was at its 'best' in the current practice of new graduate nurses (Cooperrider et al., 2008, p. 5).

This phase was commenced at the moment of meeting participants for interview by the introduction and opening statements, and the initial questioning and discussion with each participant. It was an important time in the interview as this time was aimed to relax both interviewee and interviewer, and to generate affirmative stories throughout the interviews and discussion. The aim was to increase participants' feelings of affirmation about nursing practice and confidence, and for them to commence reflecting upon their perceptions of confidence and/or initiating change in practice. The process was purposefully supportive with the questions being framed positively (Appendix 4). In this phase the dialogue and sharing of stories on what was valued by the individuals was achieved by a reflective process of 'looking around, looking backwards and looking within' (Carter, 2006, p. 54). There was little guidance on how to look 'differently' during the *discovery* phase as it was dependent on the direction I took as the researcher and my own interpersonal skills (Carter, 2006), which supports the flexibility of AI as a research design.

The *dream* phase envisioned and imagined what the aspirations and potential of the future could be by the new graduate nurse. This phase challenged the status quo using conversation, identifying their past strengths and their envisioning of their future practice (Cooperrider et al., 2008). During this phase of the interviews the participants were encouraged to think of the future position they visualised themselves in, in relationship to confidence. Cooperrider et al. believe this process is 'personally invigorating' (2008, p. 45).

The *design* phase plans what the future could be for the participants. The opportunities for the participants are articulated to determine what their future could be, and to plan the support for the new future (Cooperrider et al, 2008, p 45.). The design phase was incorporated by articulating the findings of this study, what it was that influenced new graduate confidence and where they saw their future opportunities. This included reflection on their practice to plan future endeavours in their nursing careers.

Finally the *destiny* phase was when the plan was implemented to create a desired future which is organisation wide (Hennessy & Hughes, 2014), or for this study for

nursing. This phase of the 4-D cycle was incorporated in the discussion chapter of this study, in understanding and linking the findings to nursing, and by discussing the limitations and recommendations for future nursing practice, policy, education or research. The cycle had the potential to circle back to the *discovery* phase during this time or at any phase of the 4-D cycle with the development of new affirmative topics (Cooperrider et al., 2008, p. 47) for the participants, or for the researcher.

Relevance of Appreciative Inquiry to this study

Appreciative Inquiry has been used to investigate many contexts of societal groups, for example the evaluation of human performance technology (Dunlap, 2008); a clinical chair-side teaching scenario of dental therapists (Sweet, Wilson, Pugsley & Schofield, 2008); information technology degree programme changes (Bush & Korrapati, 2004); academic nursing culture transformation (Moody, Horton-Deutsch & Pesut, 2007); and a study on applying Appreciative Inquiry to mental health services (Hennessy & Hughes, 2014).

Reed, Pearson, Douglas, Swinburne and Wilding's (2002) undertook a study utilising AI to create improvement in their multi-service discharge processes for older patients. Reed et al. discussed the benefits and the potential and difficulties of Appreciative Inquiry as a change process for health and research. They discussed the collaborative outcomes of the organisations who contributed to the study, namely enhanced communication and participation. Reed's later work in 2007 considered where Appreciative Inquiry is developing as a research approach. Reed debated how aspects of Appreciative Inquiry are exhibited in other methodologies and contexts which support change or growth, giving the example of narrative methodology as a research perspective which influences change or growth, and how studies using this methodology explore the world through stories, an element of Appreciative Inquiry. In another example, Reed discusses how narrative methodology and Appreciative Inquiry are similar in that they both write of the 'perceived chronology' of events (2007, p. 62). Other comparisons by Reed include ethnography, the study of everyday occurrences in social relationships, as being similar to Appreciative Inquiry by emphasising how people

make sense of their world. Case study methodology is also similar as it develops as the study develops, as in Appreciative Inquiry (Reed, 2007).

There have been further critiques of Appreciative Inquiry within the health literature other than Reed's (2007). Trajkovski, Schmied, Vickers and Jackson's (2013) methodological literature review of the four phases of Appreciative Inquiry in health care, concluded that it is significant in facilitating change by engaging with people across all boundaries and groups. Their review also highlighted their limitations in utilising Appreciative Inquiry, for example raising false hope if the new Appreciative Inquiry visions were not embedded within an organisation.

The value and impact of this methodology upon the new graduate nurse during this study is an important consideration. The philosophy of utilising reflection, dialogue, appreciation and empowerment which underpins Appreciative Inquiry is positioned within my nursing philosophy on nursing practice. Nurses are educated to reflect in and on nursing practice. Reflection is utilised by thinking about practice and to implement or change practice if required (Taylor, 2000). Nurses are also educated in communication and utilise dialogue to reflect upon practice, communicate with colleagues and the patient and the family and/or the whanau and other health professionals; and also learn about power imbalance and empowerment to support the patient in their care.

On balance an outcome of this study was not just for myself to learn about research and the influences on confidence of the new graduate nurse, but to augment or support the nurses' awareness of their own growth and influences on their confidence for their future nursing practice. Whilst other studies have identified some limitations, AI's affirming approach and its inclusiveness (Reed, 2007) are concepts which align with the nursing philosophy of partnership and empowerment. It was also an approach which I felt suited both the question and the participants as new graduate nurses. It was therefore important to my own values that the participants could speak of their confidence and practice in a positive environment, identifying what they do well in their practice.

Ethical considerations

The study has been guided by the ethical principles of beneficence, justice and respect for human dignity (New Zealand Nurses Organisation [NZNO], 2010; Polit & Beck, 2012). Ethical approval was granted from the Victoria University of Wellington (VUW) Human Ethics Committee prior to recruitment of study participants (Appendix 1 & 2). The approval process involved considering the research process, the respect and protection of participants and their knowledge and information. It also included understanding the role the Treaty of Waitangi has in education and nursing research, and honouring the Treaty of Waitangi for participants.

The principle of beneficence

The principle of beneficence involves the responsibility of protection from physical, psychological, social or economic harm (NZNO, 2010; Polit & Beck, 2012). Considerations were made as to where, when and how the research was conducted (Braun & Clarke, 2013) to lessen any impact on, or risks to each participant. Participants were assured their information would not be used in any way which may be harmful to them.

The principle of justice

This principle includes the right to fair treatment and the right to privacy (NZNO, 2010; Polit & Beck, 2012). To protect the participants, and ensure they and their personal information and research data was protected, their identities have remained confidential and are not identifiable in the body of the thesis. The research data is secured on a laptop which is password protected.

The principle of respect for human dignity

This principle includes the right to self-determination and full-disclosure (NZNO, 2010). The participants were assured of their right to participate in the study, or to withdraw from the study without any consequences. They were invited to opt in through an invitation distributed via either the new graduate nurse team leader, nurse manager, or educator. Potential participants were given an information sheet that outlined the process for maintaining their anonymity and confidentiality, their right to withdraw at any

time, the process of data collection and analysis, and the means through which they may learn about the results. Each participant was asked to sign a consent form before data collection began. Transcripts were checked by the participants for accuracy of data. Feedback will be given to participants at the conclusion of the study. The thesis reporting on the study will be lodged in the Victoria University of Wellington library and the researcher and study supervisors will prepare one or more publications at the completion of the study.

Power imbalance during data collection

Reed (2007) discusses the power imbalance between the researcher and the participant. Traditional information gathering processes have a power imbalance between the researcher and participant because of a perceived difference in research knowledge or demographic factors. Appreciative Inquiry strives to equalise this imbalance. Within the research process the collegial and collaborative context attempts to connect across boundaries of power where participants are 'free to be heard; dream and contribute' (Cooperrider, et al., 2008, p. 27-28). I have been conscious of the power inherent within the researcher-participant relationship within this study. While I work with new graduate nurses within my professional role, the participants within this study were not my responsibility within the new graduate programmes they attended.

I was conscious to respect the views and knowledge of the participants prior to and during the interviews (Cooperrider et al., 2008; Reed, 2007). Each participant decided on the venue and timing of their interview to be held in a situation where they felt most comfortable, with an emphasis on exploring the participants' values, experiences and visions. The participant was encouraged to 'share and create' (Cooperrider, et al., 2008, p. 104).

The Treaty of Waitangi

The Treaty of Waitangi (NCNZ, 2011b) principles of protection, partnership and participation are recognised as significant to this study. Maori sovereignty is recognised with regards to ensuring the participants are respectfully acknowledged, and their safety in the research process is an open and negotiated process. Information was protected

via passwords for electronic storage, or stored in locked cupboards. Minimal information was shared with the study supervisors only.

Cultural Safety and the Code of Conduct

I reflected upon my own culture and was aware of the power imbalance between myself as a senior nurse and each participant as a new graduate nurse. My understanding of cultural safety (NCNZ, 2011b) ensured I was mindful and respectful of others as individuals with their own uniqueness.

The Nursing Council of New Zealand Code of Conduct (2012) was acknowledged as a resource to support myself in maintaining a professional relationship with individual participants, ensuring the participant and their information was treated respectfully, with confidentiality, and with safety.

Sampling

Qualitative studies can use small non-random groups of participants which reflect the group of people representative of the study and the methodology (Bernard & Ryan, 2009; Higginbottom, 2004). This study required participants who specifically reflected the question and context under study (Reed, 2007).

Purposive sampling was utilised to enrol participants in this study to intentionally invite participants who were current or recent new graduate nurses, representing a specific group providing 'information rich' data for analysis (Patton, 2002, p. 230). In keeping with the philosophy of Appreciative Inquiry, it was anticipated that purposive sampling would bring as many views, experiences and perspectives as possible from the participants (Cooperrider et al., 2008), thus new graduate nurses from any nursing speciality who wanted to participate were invited to do so. Participants who were new graduate nurses within the last two years were identified as generating the greatest information about the subject under study (Bernard & Ryan, 2009).

Recruitment of participants

Senior nurse leaders of District Health Boards, Public Health Organisations and non-government organisations in urban and rural areas within New Zealand, were contacted by telephone and then followed up by e-mail with study information. I contacted the senior nursing groups as a courtesy informing them of the research study and to generate lists of potential participants who met the study criteria. The research proposal or ethics approval confirmation was emailed to two organisations which requested them, and one returned an email with interest and advice on using Appreciative Inquiry.

Invitations and study information (Appendix 3) was distributed to registered nurses who were practising within their first two years of professional practice. Although all participants had completed a Nursing Entry to Practice programme, there was no requirement to have participated within a programme. Following this an information sheet and consent form was forwarded to 12 participants who registered their interest in the study. Weller and Romney (1998, cited in Bernard & Ryan, 2009, p. 360) maintain that only 10 'knowledgeable informants' are required to appreciate the subject of a culture. Whilst 12 participants originally agreed to participate in this study, two withdrew because of family reasons and one because of work commitments. Nine participants were recruited. Participants were seven to 18 months post nursing registration having completed a three year Bachelor's degree in nursing at the time. Participants were aged between 23 and 54 years old and practised in primary, secondary and tertiary health facilities. One nurse practised in a non-health facility and one nurse had previously practised as an enrolled nurse. One nurse had resided in New Zealand less than five years and three identified as Maori. Interview times and venues were arranged at a time and place identified by the participants.

Data collection

A semi-structured interview was the data collection method utilised in this study (Gill, Stewart, Treasure, & Chadwick, 2008). This format was flexible and enabled further discovery of material that would be important to the participants (Gill et al., 2008) and therefore aligned appropriately with the Discovery phase of Appreciative Inquiry where

the participants identified their 'thoughts, emotions, behaviour and environmental' factors which influenced them (Bernard & Ryan, 2009, p. 5). Demographic data were also obtained at the time of interviews.

The interview and dialogue

Throughout the interviews and the data collection phase, I had to keep to the forefront of my thinking the importance of the AI principles, and integrating the 4-D cycle in the planning and interviews. To integrate an AI philosophy it was important to gain an understanding of how other studies had utilised this. This was a challenge as there is limited detail of AI in published studies to give me an indication of the research process they utilised. AI processes are learnt and may change as the study progresses (Cooperrider, et al. 2008).

Positively-framed questions were used to enable participants to tell their story and to encourage them to envision where they see their future nursing practice. Affirmative vocabulary was used to 'move' the individual forward in the study (Cooperrider et al., 2008, p. 19) and to appreciate the individual's response and their activities (Reed, 2007). This process is 'fluid' and although some semi-structured interview questions were pre-determined, questions were also used to 'find' the information (Reed, 2007, p. 111). Questions are identified within the Interview Plan (Appendix 4). Interviews took between 60-90 minutes with each participant.

Cooperrider et al. (2008, p. 104) explain this process as not about collecting objective data but participants' sharing 'their values, experience and history' and their future wishes. This would identify any strengths and successes in the new graduate nurses' practice and their confidence (Preskill & Catsambas, 2006, p. 19). Using storytelling, data reveals which high points and successes remind the participants of their positive experiences (Preskill & Catsambas, 2006, p. 18).

Interview questions

In semi-structured interviews the researcher asks similar questions of each participant (Bernard & Ryan, 2009). Questions were open-ended and planned (Donalek, 2005) which enabled either the participant or the researcher to pursue an understanding of a particular discussion (Gill et al., 2008). As with the intent of AI and the 4-D cycle, I used a variety of questions to discuss confidence with, and of, the participants, identified in an Interview Plan which was developed for the purpose of clarifying the 4-D cycle and the interview questions (Appendix 4).

The opening and exploratory questions supported the Discovery phase of Appreciative Inquiry by generating reflection and dialogue for the participant. During the interviews an interview guide was at hand as a guide for questioning. The questions focused on the influences on confidence of the new graduate nurse, and were framed positively to meet the aims of the study. These questions sought to collect data which was meaningful and future focused. I also used questions to assist further reflection upon the participant's practice and to follow an idea in more detail (Gill et al., 2008).

Participants were subsequently asked to reflect upon and envision their nursing practice of the future. This enabled the participant to construct their positive future building upon their current practice (Preskill & Catsambas, 2006, p. 20), and supported the 'Dream' phase of the 4-D cycle.

Transcription

The interviews were audio-taped, and transcribed verbatim as soon as possible after each interview. I transcribed the tapes to absorb myself in the data (Sandelowski, 2004) and to commence the analysis. This process required the audio tapes to be played repeatedly to ensure each word was recorded accurately. The data collected contained stories and practices, exemplars and illustrations of nursing practice by the new graduate nurse.

When reading each transcript back immediately after transcribing, I realised that transcribing the spoken words did not capture the entire meaning or significance of each

sentence as the nuances of speech were not immediately appreciated. The written message was not as clear as the verbal articulation conveyed by the participant. I was transcribing what I maintained was the verbal message in print. It is almost impossible to represent the features of speech such as pitch, volume, stress, and rate of the participant. To correct this I listened fully to each interview after transcription up to four, and in some cases eight times to ensure the words were captured accurately, and then to ensure the diction was captured by my best use of punctuation to try and express the sense of what was being conveyed. Being sensitive to the language and dialogue of the communication was important for accurately transcribing its meaning (Yardley, 2000). I included punctuation in the transcribed sentences to endeavour to emphasise the language of the interviews in the analysis of the data, and wrote notes on my interview questions during the interviews to try and convey any emotions which may not have been captured by audiotape.

Each completed transcript was emailed to the respective participant for any further input or discussion they may have wished to include. Two participants had already emailed me offering further information prior to this. Five participants replied to their emails mainly thanking me and offering comments about how they felt their interviews read to them. No one offered any further information or addition to their transcribed interview.

In hindsight and reflecting upon the interviews and data collection, I missed the opportunity possibly at this point, to pursue how the participants felt about the interview process and if they felt any differently regarding their confidence as a result of the AI framed questions, as the following reflection indicates:

I became absorbed in the information they were talking about and concentrated on this than always on my next positive response, with the occasional question asking about the negative experience they may have just talked about...rather than enquiring in the positive. Reading back I somewhere missed the opportunity to ask further how this whole experience was for them and their confidence.

(Personal reflection: 2015)

As Gilgun (2006. P. 439) writes, 'researchers gain expertise through experience as researchers... typically researchers apply only a portion of what they know to the planning of particular studies'.

Analysis

Thematic analysis was utilised to analyse the interview data. It is flexible and therefore fits well with Appreciative Inquiry for this study. Thematic analysis 'describes and interprets the participant's views' (Smith & Firth, 2011, p. 54), it is widely used but I found there is a scarcity of information on its application and evaluation. I was guided by what literature I did find on thematic analysis and discussions with my supervisors.

Thematic analysis seeks patterns across the whole of the data (Braun & Clarke, 2006) capturing what is important in data related to the research question. There is no rule on the proportion of the data set that needs to be displayed or to be reflected as a theme. A theme may appear as a large proportion of data in one interview, and a small proportion of data in another. It may not be quantifiable in the interviews, but it may be something which is important in relation to the research question (Braun & Clarke, 2006).

Data were generated from the dialogue within the verbatim transcripts. The findings were within the stories which were told in everyday language (Polit & Beck, 2014) and which were mainly expressed in the positive. There was also some participant dialogue which discussed stories expressing self-doubt.

The purpose of analysis was to find meaning from the data, by summarising the 'content of the data' (Braun & Clarke, 2013, p. 207). Data were then themed to identify meanings within. These are assumptions and frameworks supporting what the participants have discussed. I needed to be sensitive to the data by not enforcing my own meanings on it, but being open to other interpretations and complexities within the data (Yardley 2000, 2008, cited in Braun & Clarke, 2013).

After transcribing and reading the data I needed to access the data from one document, so I bound all into one book with reference to participants. Each line of data was

numbered for reference. I analysed the data line by line reading it closely and re-reading it, looking for details that appeared as key or essential and which linked to the 4-D phases. Similar items were labelled or colour coded, and then placed into groups of broad themes. As each new label was established, previous labels on data were reviewed to ensure it matched any previous data. This process required lists, reflection, and constant review to refine, looking for relationships between themes and sub-themes.

However, I uncovered problems with the complexity of analysing the data. I felt that many of the stories and their meaning were becoming lost in the line-by-line breaking down into themes, even though they were being linked to similar items. I felt the overall intent of AI which included the dialogue and the meaning of the story, was being lost by breaking the stories down to numerous lines or small excerpts of information. I was having difficulty writing my findings, because some messages in a short line of dialogue were not always reflective of the more in-depth theme the participant was actually conveying. I realised when breaking down the data and trying to keep to a 4-D cycle process for analysis, that some themes did not sit well with 'discover', 'dream', 'design' or 'destiny'. Where some lines of stories could have sat together well explaining a meaning of a story, they were separated into different 4-D phases and some broader themes were becoming lost. This was discussed with the supervisors and I began again with analysis and themed the stories and nurse's verbal expressions back under themed headings as with thematic analysis for qualitative research, without using the 4-D phases. I then re-read the findings and linked the themes with nursing literature on confidence (Braun & Clarke, 2013).

Reflexivity and bias

Reflexivity is a process of reflection upon the influence the researcher brings to the study, and the impact the researcher may have on the data being collected (Polit & Beck, 2012). The researcher brings their own culture and assumptions into the research (Braun & Clarke, 2013), and can be identified in the information that is created.

Acknowledging reflexivity is essential for qualitative research (Braun & Clarke, 2013).

To accomplish this I kept a reflective diary during the study. This enabled me to write and reflect upon the study, my thoughts and what I was learning, and my perceived impact upon the study.

Investigating a research question using the principles of Appreciative Inquiry exposes a deliberate bias. Seeking positive stories and not problems is deliberately being selective in what is studied, and utilising this methodology may not have disclosed the issues that originally uncovered the study question. Therefore using a positive framework is a bias which has enabled myself as a researcher, to deliberately choose to look at confidence, and the new graduate nurse this way. If participants did uncover problems within interviews, these stories were analysed the same as all of the findings within this study, and discussed within Chapter Five, the discussion chapter of this thesis.

When reflecting upon the interviews and my impact as a researcher, I noticed that I had a more relaxed rapport with some participants than others. Two interviews were memorable because of the relaxed and easy conversation prior to the interviews, yet when both interviews commenced I had difficulty drawing out the participant. They were both shorter interviews. At the time of these interviews, it was a time I had been busy with extra work and extended family commitments, and had continued finishing the interviews and transcribing during this period. This may have affected the outcome, as my reflection indicates:

...and I didn't see it at the time. I was at the dementia unit when I remembered the interview. I got there just in time, when [participant] rang and cancelled. We rescheduled. Looking back I should have just rescheduled it all for a few months later... I think this may have affected how I interviewed two participants, their data wasn't as detailed, with more short answers than conversations. (Personal reflection: 2015)

Rigour

Rigour, or the credibility of the research, is dependent on the skill and competence of the researcher (Tuckett, 2005). Cooperrider et al. (2000, p. 104) claim that the aim of the AI process is not to collect objective data but for the researcher to 'stimulate

excitement and delight as they [the participants] share their values, experience, and history, and their wishes for the future'. In the AI interviews I became engrossed in the conversations and was an active listener. The sharing and creating of the AI dialogue was individual to each person and research question, and how the participants responded may have been influenced by my role in exploring their dialogue.

Mays and Pope (1995) believe that rigour in qualitative research should be creating an account of the method and data to produce an explanation of the phenomenon under scrutiny. The data collection, analysis and reporting of this research study will be as thorough as my skill and competence as a novice researcher. The reliability of the research will also be reflective of the AI process, which is always a fluid and flexible progression. My aim was to collect, analyse, interpret and report the data as completely as possible with the oversight of my supervisors. For this study I reflected and read many qualitative and quantitative studies, literature and information on Appreciative Inquiry before feeling sufficiently confident to proceed with this relatively unknown methodology. I conferred early on with my supervisors. Alongside the research study I have worked with the participants by ensuring they checked the transcripts giving them options to change or correct information, and by being available for further information if they wished to speak further. I have ensured the dialogue of the participants is recorded as valid, and ensured a diversity of analysis, in keeping with Appreciative Inquiry 'sense-making' from the data (Cooperrider et al., 2008, p. 116).

Conclusion

This chapter has identified the principles and phases of Appreciative Inquiry which have been used in this research study. Appreciative Inquiry is fluid and flexible and is applied to research studies by utilising positive questioning and dialogue. Less positive data may also be incorporated into the study if it is uncovered during the data collection. When this occurs a positive framework is utilised to draw out the positive lessons from the story.

Chapter Four: Findings

Insights are our greatest asset
(Oliver Sellen, 'AI Commons' website)

Introduction

This chapter presents the findings from the interviews of the nine new graduate nurses, identified in the methodology chapter. In keeping with the principles and phases of Appreciative Inquiry the participants were asked to explain what confidence meant to them. This is 'where the story telling begins' (Cooperrider, Whitney & Stavros, p. 43) and where the new graduate nurses' discover what they do best in their practice. Each topic heading in this chapter indicates a theme identified in the dialogue which has been raised as an important issue by the participants, with regards to their understanding of confidence and the influences on their confidence. Subthemes are identified under each main theme.

The following section begins with participants discussing their understanding of confidence. This includes how they have a self-awareness of confidence personally and professionally and reflect upon this and nursing practice, including their moments of self-doubt, over-confidence and when they feign confidence. They also identify an understanding of their resilience.

As the chapter continues, participants tell us that colleagues and patients influence their confidence, as well as those colleagues they identify as a challenge in their clinical environments. Participants have recognised how their previous knowledge from their undergraduate programmes and their current learning and experience influences their confidence, and how they trust themselves and others in practice.

Finally participants have identified their dream for their future practice and how they look to achieve this, thus designing their practice of the future. Their responses to the final questions and therefore their responses to the 4-D phases of dream and design, were deliberately sought from participants in keeping with Appreciative Inquiry 4-D cycle

(Discover, Dream, Design and Destiny). The phase of Destiny is identified in the discussion chapter. Deliberately questioning the participants on their future has identified that they continue to place importance on their future learning and nursing experience, including the support they require in practice and their plans to achieve this.

Participants expressed their meanings through stories from practice, with some stories recorded here in their entirety. Their dialogue identifies the reflective thinking of the practice moment and the construction of their professional knowledge which 'resides in the stories' (Cooperrider et al., 2008, p. 15).

To maintain confidentiality of the participants, pseudonyms have been used in the following dialogue examples, and data are identified by a number next to the name which resembles the location of the dialogue within the transcribed interviews.

Understanding confidence

The meaning of confidence was individual for each participant. In answering the topic question to explain confidence, participants *discovered* what confidence meant to them and their practice and how it made them feel. They defined confidence by expressing a story from practice or by a phrase to explain the concept:

Confidence is going in there and going in to see and work with the client, and being able to do the practice and be confident at what I've done, and I've walked out and I felt great actually, and I felt like I was on top of things. (Anne: 11)

It was things starting to come together and I felt like I was doing a really good job and I was able to anticipate things. (Sam: 14)

The emotions produced when the participants felt confident included being happy or feeling great about the way they were practising, or feeling strong, proud or good about a situation. This example expresses how confidence is for one participant:

Confidence is feeling like you've got what it takes to achieve what you're asked to achieve and to feel not pressured but to feel strong in your choices, to feel like the decisions you're making are right, and the reason you know it's right is

because you've got the knowledge behind you, both for pathophysiology, as well as the theory behind what you're doing. You actually know, 'this is why I'm doing it, and it is the right thing to do', and you don't have to second guess or question yourself. So I guess confidence is about not being scared and not being questioning of yourself. (Therese: 14)

I'm pretty good at going 'oh that was really good', but not getting way excited. It's nice because every time it does build your confidence I guess, a little bit more and it just relaxes you a little bit too, and so you can have a little giggle. It's like you have a little bit of space to go 'ok I'm feeling good' and I can make other people feel good too. (Rachel: 166)

Reflecting back upon when they commenced their nursing career, participants expressed how they felt in the beginning, explaining their self-doubt as a new graduate nurse:

Right at the start you don't feel confident at all. I didn't feel confident in the least actually. I realised very quickly that I didn't know a lot. I knew from my degree and things like that and all that study, but I just kind of struggled to have something to hang that off and just being able to feel like I was on top of things, and to not be nervous. Stops you in the first part, just being nervous (Rachel: 11)

You know your first couple of weeks on the ward you're going, 'I don't know, am I right? Am I wrong?' (Therese: 60)

This 'stopping' that Rachel explains in the first example above is an example of participants' experiencing the lows of confidence occurring in practice. The transient nature of confidence has occurred throughout clinical practice since commencing their career. The following two stories demonstrate how the participants don't always recognise their becoming confident, but they have multiple realisations of their evolving confidence, its fluidity, and some of the reasons for confidence changing:

See I can't put it down to, there's no really one specific moment for me that nailed it, where I went 'yeah that's it'. It was more the fact of building up this gradualness of then realising that I had, I did have skills and everything but I

could use them. Like I could understand medications and I guess as well that also comes from me when moments when you're teaching other students and when you have students or young nurses, and they ask you questions and you actually go 'oh I know the answer to that', and it makes you go in yourself 'oh I actually know quite a bit'. It's a realisation that comes, I think it comes multiple times as well, the more you gain the more that confidence grows. And I mean confidence I think is a quite a fluid thing, it ebbs and it flows, there's some days when you don't feel confident at all or something shakes that confidence and it goes right back down, and then other days where you come out of a shift and you've had a really good patient interaction or a really good experience, where you've had a clinical emergency and you've known what to do. And so for me I can't really say there is one specific moment where I went and had a kind of light bulb moment. (Louise: 53)

When you get your registration you know, and go 'oh my God now I'm really responsible for my own practice, and all the things they've taught us' and, 'oh I've got to be safe' and you know, it's quite heavy, it's so heavy and I'm nervous. Like I said with the x-rays, I felt confident yesterday about doing my stuff but I get a bit nervous sometimes when I'm sitting there going 'oh I've got x-ray again' and I go over my book quick before I get into work, you know, so it's not like I'm 'yeah I own it now, sweet', not at all. So I guess it kind of wanes and waxes you know, with the day and how you're feeling. (Rachel: 130)

When participants felt confident, they had a self-belief or a certainty in themselves. Some participants could give a time in their new graduate year of when they felt confident in their practice, stating this occurred at four months, or nine months into their first year of nursing. Others could not expressly state when they became confident as it continued to evolve in differing situations, it may have been how they were feeling on the day, or how the duty was progressing, or how they assimilated patient information:

See this is the hard thing, I don't know. It slowly just, oh I don't know. It's a hard thing to, it just came I guess, because of our role we do so many different things.

Like my knowledge around wound care came a lot sooner than my knowledge around palliative. I don't know. I don't know everything, but I know a bit more about certain things that could go wrong. (Anne: 192)

But confidence I guess, is just saying 'yep, I can see that my decisions for this particular person for now is this'. And it might change, but at the moment it is this until I have some other information, and I might get that from anywhere. (Rachel: 40)

Confidence was an evolving entity building upon itself as each situation was experienced. It continued to evolve with subsequent experiences. The following example expresses the evolving and building of confidence. Here Therese reflects on her practice, discovers a trust in her practice, and realises a growing confidence:

Within the new grad year you're building up those experiences of realising you know what's going wrong, making those changes to fix it, and then seeing their outcome of it, and if you can see the outcome was good, and that you made the right choice, and you had the right rationale, and you did the right thing, then you can look back on that and that builds and builds and builds, and then after a few times of that your confidence is quite strong, because you trust yourself. It's almost like a trust thing really within yourself. Whereas, I think yeah, when you first start you're second guessing, you're constantly questioning yourself. I think it's a combination because it's the amount of situations that add up over time. You start having those experiences where things went right, you made the right choices you saw the outcome change, and then that was your first bit of growing, your first bit of confidence building, and then over the next couple of months you've had more and more experiences of that. (Therese: 69)

Self-awareness

As each participant talked about their confidence, they expressed an absolute knowing of what confidence was. Participants knew when they felt their evolving confidence or doubt, and how it was portrayed in a variety of ways for each of them. This self-awareness permeates the discussions and examples of the participants. The following

examples explain how participants drew on personal attributes, and *knew* what to do in a clinical situation as a new nurse:

It's knowing what you're doing, and knowing that the decisions you're making are the right ones. (Lillian: 10)

I just knew what to do with the presentation. And where I work is a whole lot of acute cases coming in, we get a lot of lacerations, a lot of people coming in in respiratory distress and a lot of people with anaphylactic or allergic reactions and so we just need to know how to handle these cases quickly to improve people's vital signs as quickly as possible. (Jenny: 23)

And further from Jenny when she was experiencing not knowing in practice:

I've always asked many questions which nurses must have thought 'what an idiot', because when I've heard the answer I've thought 'but you already knew that, why didn't I think of that yourself?' (Jenny: 76)

In expressing their *knowing* in practice the majority of participants had a knowledge of their limitations in practice situations. The following account identifies how participants have a confidence in their knowledge in a situation, and an awareness of the urgency required, yet they are also aware of their limitations and how they look for support from nursing colleagues to assist them:

...a patient came in with stridor, struggling to breathe, they were brought around to the acute area and given to me to help, and I first of all took a set of vital signs, and found that it was a young girl who was only 11 and she only had oxygen saturations which were 89% so she was put in a wheelchair and taken straight round to our emergency room and given oxygen; and on the way past I called a doctor in, and the doctor prescribed adrenaline nebulizer and hydrocortisone IV and I put a line in gave, took some bloods, gave the adrenaline nebulizer and gave the hydrocortisone and her saturations came up very, very quickly with the medication. And I called another nurse to help as we needed to call an

ambulance and get her away to A&E quickly, but it just worked really well, because I just knew what to do. (Jenny: 23)

Although participants were aware of their new graduate status, and their limitations in practice, they had an awareness of their professional identity as a registered nurse and the responsibility this entailed. The majority expressed an understanding of responsibility in their registered nurse role and their own expectation of being a registered nurse. They were learning their professional role:

There's a moment where you just have to say, 'ok I've got to own this now, I'm not a student now, I'm a proper nurse now. Let's just get over that nervousness and just get down to the nitty gritty of doing the job properly, and the best that I can do'. And I know that if something goes wrong or something goes right then I've got everyone behind me. (Rachel: 100)

Participants were aware of their personal attributes which influenced their confidence, discussing their own personal qualities, for example their age, or emotional maturity, or an individual's personality:

I would say, my age. I've communicated a lot so I've found that communication [undergraduate education] quite basic, but that's not to say for a younger student coming straight out of school... (Josephine: 45)

Being able to manage my stress, and knowing when I'm getting stressed, so that's just from years of working probably. So knowing how to manage that and knowing that I actually don't need to feel that way, which I can do these things and I don't feel stress anymore. So that's not going to impact on how I am at work. I guess just knowing yourself, you know being able to go 'I'm not feeling good today', or 'I feel good today'. I guess we forget about those self-management things, and self-regulating things too that impact on how we are in our job, and how clear minded we are, so being able to manage things at home or things that happen, because things are going to happen in your life and you've still got to go to work. You still have to give your best to your patient. (Jenny: 619)

Participants' life experience, or an ability to engage with people of differing ages and backgrounds, or their years of work experience, were instrumental in influencing confidence. These attributes influenced their confidence in meeting the needs of their patients:

I guess he [the client] did listen in the end. It was my confidence with the patient and knowing him, if [security] hadn't have been there I think I would have got the same result, I had to come across as confident as well, that I knew what I was talking about and I think that he knew that at the end of the day, with my calm demeanour. (Josephine: 69)

The new graduate nurse is aware of the importance of being confident for the patient to feel confidence and trust in the nurse. It gave the patient a belief that their own situation was not hopeless, and that they would gain the best health outcome. Reflect upon Josephine's thoughts on this:

...if a nurse is confident then they [the clients] are happy. They are getting the best care. If you appear wishy-washy and don't know what you're talking about, you and I both know as a person, that there must be a different answer here. So giving the patient confidence, then they feel they're getting the best treatment. (Josephine: 163)

Reflection

Participants understood the positive impact reflection had on their practice. They talked about reflecting on patient care, how they were feeling about their practice, their knowledge and learning, and the impact on the patient and family and/or whanau. When they expressed their moments of anxiety or doubt in their practice, they reflected upon the learning involved and how to improve practice. Some wrote reflections on practice issues to gain an understanding of another person's perspective:

And thought, 'Oh was I too abrupt in my speaking up?', or 'was I appropriate in the way that I approached [it]?' I didn't want to come across aggressive or demeaning, or anything like that. But once I had written it and I did reflect on the situation, I didn't feel that I had come across that way and the fact that I had

decided to write a reflection about it obviously meant that I did feel confident about the situation. (Mabel: 95)

Participants used reflection to step away and re-evaluate practice, by looking at the situation from differing perspectives. One participant reflected upon their role and made the decision to decrease practice hours to provide more rest, and time for further clinical reading and reflection. Subsequently she was aware her nursing practice had improved. This enabled her decision making in practice and therefore her responsibility to the patient:

Yep, it's the only way I think. It's the only way. You can't make a good decision if you can't back it up. Not at all. For me if I really have evidence then I can support myself and I can get help that they need quickly or not so quickly if that's the case, I don't feel nervous about it in the end. I don't feel as nervous about it because you have to support yourself. It's like going to court, you have to make a good court case to move people up the line, because there are another 40 people out there waiting, who are all unwell. They didn't come in for nothing. So I'm responsible for that too. (Rachel: 268)

Reflection also assists the participant in the following example, when the participant experiences self-doubt. She analyses her reflection on her confidence in two ways: reflections on clinical factors which are structured and policy driven, and secondly reflections on interactions with people. She reflects on the administration of medications as an example of how she rationalises why she feels confident in predictable situations, and feels less confident when situations are more unknown:

It's a little bit more structured in medications like in medications there's definite answers there in the end. You follow these set of rules and you get this answer. Humans don't do that, and following patient interactions like that, you couldn't do it. It has so many unknowns. And there's so many ways that things can be taken, and there's so many more possibilities of options of going wrong. But at the same time, options of going right. Like in medications it's a yes or no answer. So that's one thing for me. I feel quite confident in doing them because there's a set of rules to finding it, and I can go, "yep, I'm doing it right, and I'm following the

procedure and I'm doing all of these things right." Whereas in a patient interaction, like you could say one word wrong and it throws everything. (Louise: 190)

Reflection was used to bridge gaps in knowledge or learning, and to support decision-making in practice:

I learnt from that. I learnt I should have done it then. Like when you say 'what would you have done differently?' I reflected on it and I should have stood up right then and said 'it's not ok'. So I had made a decision that next time that's what I was going to do, and that's what I did. It was really, really, hard to do. (Therese: 662)

Self-doubt

Amongst these moments of increasing confidence which was evolving and building, participants experienced moments of self-doubt, a lack of confidence in their practice. One participant said that this was her natural persona, yet she told a story of advocacy when she was challenged by a senior nurse. Her story finishes by telling us why she did this when feeling unconfident:

...and standing up for my own knowledge and the students' knowledge, and reiterating that having a negative student experience such as that one, where a student had been called out can affect a person's career path. (Mabel: 15)

Participants shared stories of adverse events in practice even when positively framed questioning was used to elicit what was the best of the nurses' practice. Several interviews commenced with an adverse clinical event or a story on an issue with a colleague, and appeared to be moments of self-doubt:

Personally I find if it's an area that I haven't had a lot of exposure too, or I haven't got all that much knowledge with. You may come away feeling as though maybe you haven't done the best job. I mean in district nursing now there's such a push from everywhere that you can't be a specialist in every area. And so I have had a situation where someone came out with a perc [percutaneous] drain that I've really had little exposure too. I chatted with the manager before I went out there.

But I didn't feel, you know the patient was asking me questions, they had a partner who were asking me questions and I didn't feel as though I really was able to answer it. I had the basic understanding of how to manage it, and there were some complications over the weekend which was, through no fault of what we'd done, but you know I just felt like I had done a crappy job to be honest.

(Sam: 138)

However as the stories progressed, and participants reflected further these were expressed as moments of learning. Participants described how they reflected and turned the moments into learning and for some a growth in their confidence as a result. One participant took a balanced approach to self-doubt with the following comment. Here the participant expresses an understanding that self-doubt exists yet finds a pragmatic middle-road to manage this in her practice:

So it's that self-doubting all the time you waste so much energy on. But you're wanting to do your best all the time, and you know, you're at work now and it's my responsibility if something happens, or you know, it's my responsibility if something good happens too, you know? You have to take a focus of balance.

(Rachel: 35)

Participants' confidence was shaken with unpredictable events that occurred in relationships with others. These events affected confidence more frequently than those events which were planned and predictable. To express how a nurse's confidence was adversely affected, the following exemplar is provided here in its entirety. This piece of dialogue highlights a dichotomy in the nurse's clinical practice, where it is not the knowledge of the nurse being tested in the situation, but the competence of other nursing skills which have unpredictable outcomes – the 'unknowns' as the nurse names them in her dialogue. The following highlights the 'unknowns' of communication, partnership and professional boundaries, and how the nurse discovers a way forward from this moment:

And all I gave them was information that you could've found on Google about that surgery in general. And the next, I don't know if it was the next shift or later on in that shift, the patients husband came up to me and started yelling at me

and telling me off and telling me that I was going to be in trouble because I had shared information with the family that I shouldn't have. And that I was a bad person and that I was going to suffer and I was going to pay, because I had given out all this information that wasn't mine to give. I was particularly astounded because it happened right outside the nurses' station. I was sitting down with him, my Charge Nurse walked past cos she was going home, and everyone could see it, and I think, that was also quite embarrassing, is the fact that it happened so publically, and so I tried to calm him down and show him all the information but at that point he was not in any position to listen or to talk, and there was... English was a big barrier as well, the language. And so I literally went out the back and said 'ok I'll go and get someone else to sort this'. And went out the back and cried. One of the senior nurses came out and asked me the situation and so she kind of calmed me down a little bit but I was still panicking on the inside. And I went straight to the Nursing Council website and I was looking up everything, making sure I hadn't breached any confidentiality, massive confidentially things and was looking up my legal rights and freaking. Probably freaking myself out and I got the nurse-in-charge to talk to the family. And then also, it just happened that the IV tech was their translator as well so that was handy. She came up and they all talked about it. And then the daughter who spoke English came in and I discussed it with them, and I explained everything and showed them what I had given and showed them that I had never given them any of their personal details and then they actually sat down and explained a little bit more about the family. Which for us was a really good thing because it hadn't been clarified at all. I mean, the husband wasn't even on the green sheet [next of kin]. And I asked the nurse-in-charge to ask them if they wanted me to continue being their nurse, because I don't want to be in the situation where I'm with someone who doesn't want to be with me. And they said now that they knew the issue and now that they knew that I hadn't told them anything, they were quite happy. And I think the hardest thing was going back in and nursing that patient. She was fine, it was the husband who had the massive issue, and once I clarified that with them, the family were really lovely... Man it

was the biggest scare of my life, I've, I've not felt that scared in a situation, and un-confident in my own, because you start second guessing yourself, did I give away anything? Is there anything that was considered breaking confidentiality? It all comes back to it, and really hits home. I think for a while after that I did kind of second guess and, I think I went to a different extreme of being so confidential about everything that it was almost to the other extreme. But once I kind of stopped and looked at it from another perspective, and I had to spend a little bit of time reflecting back on it and thinking about the situation, from not just my perspective but from the family's perspective, and from like the nurse-in-charge and everyone. And so from my confidence it did take a bit of a hit. And I guess actually working with the family after that, it was hard. But that did help my confidence as well knowing that I could repair that, and knowing that even though this massive thing had happened and the breakdown of communication, we actually did work through it and ended up working for the better, for the patient. So it, it did help working with them on it but it wasn't at the same level. So my confidence was ninety-percent up until that event. It probably got knocked back, oh I'd say probably 45-50. Like quite a big hit. And by the end of the week I might have been back up to like 65, maybe coming up 70. (Louise: 117)

In navigating through situations of under-confidence such as this, participants relied on colleagues for support and advice. This was instrumental in assisting participants to manage difficulties. In an interesting conclusion to this situation the nurse discussed the problems with a senior nurse on duty at the time, but was not comfortable discussing this event with her charge nurse manager. This second example describes the importance of collegial support in a moment of self-doubt and how this support and the nurse's familiarity with the situation, and reflection, assisted in overcoming this:

I did the visit and then I walked out and I was kind of like, 'woo-ah, why am I doing this? Oh, I don't know this, this is too hard, and I don't ever want to go back in there'. I was afraid that my knowledge wasn't good enough for the patient and that I wasn't actually helping them in any way. And so I had then said to my coordinator that I didn't want to go back into that house, because I felt that patient's health condition was too complex for me and I didn't feel that I had the

experience to deal with the patient. So after that I had the opportunity to go out with other people, and then I was asked if I could actually go back into that house. And so it was maybe two or three weeks later, and I said ‘oh, oh well I’ve got to put myself in those situations as long as there’s someone there that I can contact if I feel uncomfortable’. And it was quite good knowing that I had that support going in there, but I went in. The questions they were asking me, I knew what they were. I was able to then answer them, and I was able to then say, ‘well actually I’m not sure about this, but I’ll follow it up for you and get back to you’ and I actually felt like I was doing what I was supposed to be doing, and was beneficial for that patient. I felt great actually. You really feel like you’re doing good, I really felt like it was really rewarding going in there, and then walking out and thinking, “I’ve done something”. I [had] walked away from the situation, I reflected on it, and then I had that time to process it, and then actually go in.
(Anne: 33)

The above exemplar gives a picture of what changed for the nurse, how she took time away to work with other colleagues for support, reflect and return to the patient. Her discovery of her knowledge and professional communication increasing confidence.

Some participants self-depreciated themselves when discussing their lack of confidence, or when working with experienced nurse colleagues. At times participants’ self-doubt was all consuming. The following example identifies self-depreciation and the participant subsequently discovering their awareness:

I think I’m a slow, methodical learner. I’m not as intuitive as I want to be, and when I haven’t caught onto things quickly enough I’m quite critical of myself and I always want to be able to go faster than I can and so there’s always that feeling afterwards. I know I’ve always asked many questions which nurses must have thought “what an idiot” because when I’ve heard the answer I’ve thought “but you already knew that, why didn’t I think of that yourself?” So just being more intuitive and just using my own common sense more... (Jenny: 93)

As this participant became exposed to further clinical practice and more aware that she did have the knowledge in situations, her confidence increased over the new graduate year.

Over-confidence

Over-confidence was discussed by some participants'. One acknowledged they felt over-confident, and another stated they were conscious to not portray over confidence:

...you don't want to be over-confident either. People can take that as arrogant or looking arrogant or that they've been dominated. And also sometimes with colleagues, being over confident they feel threatened...and I think I'm more conscious of doing that, especially having already been a nurse and doing the raining. (Sam: 220)

Sam had worked in the same specialty previously under another scope of practice. As he was working with the same colleagues he wanted to maintain his collegial relationships and not portray over-confidence in his new role. It was important for participants to be seen as contributing to the health care team.

This differs from Louise who discusses feeling self-doubt and over-confidence within the same situation. The participant's awareness of her over-confidence had become apparent to both herself and her preceptors as a nursing student, and again in her new graduate year. In Louise's practice discussions about confidence she discussed feelings of self-doubt and how she overcame this to feel confident, yet in other areas of practice she comments upon her natural tendency to be over-confident. Here she explains how other new graduate colleagues were anxious about aspects of their practice but these situations did not affect her in the same way. Each time Louise experienced self-doubt she retreated to solitude to reflect and to calm herself. When she feels over-confident and situations do not go as planned, she retreats to solitude also. Here Louise is talking about how she felt after describing her moments of feeling over-confident and how her reactions differed from her new graduate nursing colleagues:

There were a lot of things that I just never got freaked out about, it never bothered me, like people [new graduate colleagues] worrying about giving

injections, or IV stuff, or people worrying about talking to a family. Like even though I've had situations which have been bad, and I have had horrible ones, going up and talking to a family for me is not the scariest thing in the world, it's just the unknowns. As I was saying prior to the interview having my first patient die, I was quite shook up by it I actually was shaking, and I had to go and leave the room which is something that I'm not used to experiencing. For me, being shocked by something for me, is a very rare occurrence. And so having to go back and calm myself down from that, and then deal with calling the family and making the very first family call, it was the very first time I had to do that, and it was scary, but I knew I could get through it. I still get nervous about that but they're not like the be-all and end-all and I'm freaking out for days about it.

(Louise: 259)

While Louise does not describe at what point she changes from feeling self-doubt to confident, to overconfident, she knows that she had varying degrees of confidence over time, particularly when coming out of moments of self-doubt. This change from self-doubt to confidence and over-confidence was not expressed by any other participant in the study.

Feigning confidence

Five of the nine participants discussed how they feigned confidence in practice. When explaining these moments, they laughed gently at the situation. The humour was not malicious but a knowing laughter that what they did was in support of the patient/client. Consider the following where participants discuss feigning their confidence, portraying confidence to appear competent in practice:

...I guess if you look confident, the patient's (laughs) not scared you're going to hurt them (laughs). If you look like you're fumbling around and (laughs), then they'll probably think 'oh is she competent enough to be caring for me?' I try and look confident when I'm, like when we had this emergency situation last week. She was having something to do with her heart in the end. But when I came in she was fitting, and she went blue and I was "whoa" on the inside. Her family was

panicking, because I knew they were panicking. I couldn't be panicked so I tried to make sure I looked confident and I helped out with the emergency situation. And everyone said afterwards how well I did, but inside I was going 'what the hell do I do? I'm so scared' (laughs), and I felt like a mess (laughs), but apparently I outwardly showed I was confident, which helped. (Lillian: 249)

In the following example, participants are providing nursing care in which they felt unsure about. They were aware however, of practising safely so that if the skill was an unknown one they would seek out colleagues to assist them. In the nurse's view, feigning confidence was not for the benefit of themselves, but for the benefit of others:

I know that as soon as, if I was to walk in there and be a nervous wreck, 'Aww I don't know what I'm doing', that patient would be scared. I know that, and I know that for a fact. Because when I started doing catheter changes and I went in, and they knew I was a new graduate nurse, they would go to me 'have you done this before?' (Laughs). And I was like 'I've done heaps before' which I'd probably done about 5-6 before then (laughs). But, 'yep I've done it'. You know I had too I think. If I was to say, 'Oh, it'll be ok', sort of thing, I think they would be petrified. And I know that, I know that. I think your confidence can rub off on anyone around you. If I go in there and I'm confident in regards to what I am doing, they have more hope. And they have more confidence in themselves to think that their wound is going to heal and everything's going to get better and I think building that whole therapeutic relationship gives them the opportunity to accept what you're saying and they take your rationales into consideration. (Anne: 206)

...nurses are pretty good at pretending to know what they are doing before they do it, you always act confident, and you never let them know you don't know it's the first time of doing something. (Therese: 256)

Resilience

Participants expressed resilience in practice, or persistence to achieve in practice when they felt varying degrees of confidence. Resilience further aided confidence for decision making or confidence in their practice:

Just finding that I could do it, actually finding that it wasn't impossible [venepuncture]. (Jenny: 95)

Participants used strategies such as developing their own learning resources, or perseverance in learning nursing processes or concepts, as expressions of resilience in their nursing practice. In the following excerpt Rachel identifies her changing and developing knowledge in her health assessment which strengthened her confidence and her ability to determine which injuries warranted an x-ray:

I've got those books right beside me, so I've set myself up to be successful in that moment. So like yesterday I had people in with broken ankles and sprained ankles, you never know if it's broken or not, so I did all my assessments and I've written all my x-ray forms [and] the lady from radiology said 'oh they're getting better aren't they' [radiology requests]. You're feeling a little bit good like that, and then like you're like 'ok I'm finally getting it right', and um, being able to explain to a patient 'look' you know, 'it was this kind of injury wasn't it?' and she's like 'oh yeah, you're right'. And you're like 'oh I got it right'. It's just the little things, but it all adds up to feeling more confident like 'oh yes I finally cracked that. (Rachel: 80)

Relationships

Central to each nurse's story on confidence was another person. This was a common theme within the dialogue of each participant, where a relationship with a person was at the heart of the situation which influenced their varying confidence. It would be easy to consider that every story was about the nurse's practice, but each story was about their relationship with other people, either their colleagues or a patient, or a family and/or whanau.

Collegial Relationships

When speaking about colleagues in general, the participants spoke mainly of nurses other than their preceptors, as key support people in practice.

At the start I was only going out with one nurse, my preceptor, to these palliative patients. So I was seeing how she approached these situations and then I had other experiences with different nurses after that and I was able to see how they interacted and their approach to things. And somehow, it's hard to explain, but somehow I just went back in there and it was fine, and from then on I was confident. (Anne: 42)

Having a nursing team that I can access all the time that I can continually ask questions, they give their time. (Josephine: 111)

Nursing colleagues were frequently observed in practice by the participants as role models:

When I looked at them I'd say 'well, how are they managing themselves?', and it just seemed so easy for other folk, you know like 'oh, yep they're a 3' [triage code], or 'they look terrible' or 'they're fine they can wait' whereas it's taken me quite a while to get those antennas and those feelers. (Rachel: 52)

Participants compared their own practice with that of these nurses, observing their nursing care, how they communicated and approached situations, and how they managed patient conditions. The nurse colleagues encouraged the participants to ask questions. One participant noted how focused their colleagues were when she discussed the nurses who had recently completed the new graduate programme:

...they were like me just the other day, nervous and new and now they are awesome and go and do anything and they are really open about, 'Oh no I used to do that too', or 'no I do it like this'. They are awesome to go to when you're feeling like 'oh gosh, am I doing this right?' They don't feel possibly as judgmental maybe as someone else, but they explain things in the same way that we've been learning it because they've just come off their degree too. [It] makes me know now that I can get to be like that, because they are quite focused. It's just really good role modelling. If I keep doing the things that I'm doing I'll be on the right path to be as good as they are. (Rachel: 526)

Four of the nine participants however, did discuss preceptors as influencing their confidence. Preceptorship is the formal support relationship new graduate nurses have with a more senior nurse in practice. Two participants spoke in more depth about their relationship with allocated preceptors, describing their preceptors as having a 'parental' role, and being a key guide and support for the graduate programme and their practice:

She's lovely, she's like a mum. She's quite straight up. (Lillian: 190)

Some participants also appreciated the role of the preceptor as their guide and mentor, their go-to person when they were finding their feet and learning their new role. Their preceptors were experienced, engaging, and positive to the new graduate nurse:

And the two preceptors I had were a terrific help in my first year, they were great. They were both really positive encouraging type nurses that kept telling me I was doing well, even if I felt I was a bumbling idiot. (Jenny: 69)

Preceptor/nurse discussions were an influencing factor for two of the participants, even when these occurred as small moments:

Just wee little hallway catch ups for two minutes and it's just 'right, where are we at in your practice?' And she'll tell me what she's noted that I've been doing well and what things she thinks I need to work on, not in a bad way just what will help me focus on this for the next month or so. I think that's quite good. I think that's helped quite a lot in the fact that she can see since I've arrived, my growth from six months to now, I think that help.' (Lillian: 188)

One participant took the opportunity to discuss her own preceptoring of a nursing student. She explained how she advocated for the student when a senior nurse had questioned the student's ability to obtain an accurate blood sugar level. This was her story of feeling confident in practice:

I saw that she [student] had the correct technique of cleaning the finger first, and wearing gloves and not contaminating the blood sugar level; and standing up for my own knowledge and the students' knowledge. You know reiterating that,

having a negative student experience such as that one, where a student had been called out can affect a person's career-path. It made me feel confident in the fact that I wanted to stick up for my practice and what I knew, and it's also given an example to the student of the 'speak up', [to] defend my own practice and what I had known and was confident in. (Mabel: 30)

This was a challenging moment for the participant as it was the first occasion that she had been critiqued in her new role as a registered nurse. Mabel was the only participant to give examples of advocating for colleagues and gave further examples of this occurring within her dialogue. Although several participants discussed self-doubt or a lack of confidence, Mabel was also the only participant who identified and declared that she had always lacked confidence in her life. In the example with the nursing student, Mabel was able to have the senior nurse *'come around in the end to understand that what I did was correct'* (Mabel: 58). Other than articulating her practice and coaching the senior nurse to understand her decision making, Mabel also understood the need to support the student by her own role modelling:

I suppose being a role model at the time for the student that was, that was buddied with me. Knowing that, knowing that we've now sort of come through a generation where it's ok to say, you know, 'stop, you're making me feel uncomfortable', or 'this isn't appropriate' rather than that matronly sort of way that some people may have been trained through... I think having the student there did make me more confident... to help myself to become confident, to speak up on my behalf and her behalf. (Mabel: 71)

Participants who practised in primary health spoke of their nursing colleagues as being engaging and helpful. The majority of the primary health participants were mature new graduate nurses with well-established team relationships working with some independence in practice. One participant had previously worked in health, and enjoyed the semi-autonomy, yet still valued the support from senior nurses. As a nursing student Sam had received extra clinical time with community nurse specialists and felt this assisted in the transition to the registered nurse role within that same specialty. This

extra time with senior nurses also helped with building upon current collegial relationships:

I think they've been very supportive and the lines of communication are very open with them. And I think that if you show interest, and it was the same during the training, then you'll find that people will respond and show interest in what you're doing, and so I guess that support was one of the biggest things and I learnt a lot. Well I still learn a lot from people...I think if you show interest then people will show interest in what you're doing and be really helpful. (Sam: 103)

Participants who worked within hospital environments spoke of nursing colleagues as being helpful and supportive also, but some participants had to look for their support from colleagues, seeking moments for feedback and affirmation of their practice.

Collegial support was also instrumental in assisting participants who were anxious and doubtful about specific practice skills. The support of colleagues assisted further learning and development of skills in practice. Some participants felt that taking the time to work with other experienced nurses who were not their allocated preceptor exposed them to other ways of practising and other experiences:

...and observation of other staff, watching what the experienced nurses, how they handled those acute presentations, and also observing and discussing with the doctors where I work, and just watching how they approached their assessments and patients. I've learnt a lot through watching them, and talking to them too, especially in the first three months I was there, I probably asked endless questions. (Jenny: 56)

Later in their first year of practice, participants felt an increased comfort with their nursing colleagues to ask them to step back from offering support so that they could practice with more independence. They believed their colleagues support was becoming more protective than supportive, seeking an increased self-responsibility in their practice:

I don't know if this is a positive or a negative, but being able to have the confidence to tell another nurse to step back when my confidence is good in something. We have some great senior nurses on our ward and a lot of them are quite protective and so they'll come and try and do something. And so sometimes it's about asking them, saying to them before you get into that situation, saying 'I feel quite confident in doing this, do you mind just watching?' Setting these boundaries and it's communicating with them. (Louise: 411)

The culture of the environment

It was important for participants to feel included in the wider health team. Participants discussed various relationships with nursing colleagues, and also the administration, medical, and allied health team members. Participants who practiced in primary and community organisations discussed team relationships as being engaging and supportive, compared to those who practised in hospital environments. These participants felt fully integrated within the team and spoke consistently with their colleagues, seeking advice from medical and allied health. They knew with absolute certainty that they would be supported and listened to:

I have no problem asking questions at any time. They encourage it because it tests their knowledge as well. (Josephine: 125)

Participants from hospital environments spoke more of their senior nurses or managers and the medical officers as having an influence on their practice and their confidence, and spoke sparingly about their preceptors and day to day nursing colleagues. One primary workplace employed a large and diverse group of medical and nursing staff from practices across the boundaries of a city. Participants were rostered with different staff each day, yet they felt supported and confident in communicating and talking with their colleagues. This positive and collegial team atmosphere, and the sharing of the work amongst nurse colleagues, was a significant factor for the participants to feel safe in their practice and to practice with confidence. Jenny explains this here:

The team work certainly helps confidence. And even the way the nurses relate to each other makes a huge difference with confidence because you walk in and

people great you, they seem pleased, there's a real feeling of support in each shift. That just makes such a huge difference to how you feel about your part of being in the team. (Jenny: 213)

Some participants felt anxious when communicating with colleagues, in particular the medical officers. It took time or experience to overcome this. Having the responsibility to advocate on behalf of the patient, was a driving force to overcome this anxiety:

...even at the start, I used to dread phoning another health professional, I felt like an idiot, but the good thing about community is it's all over the phone, makes it easier. But the first few times I was just so scared, now I just get on the phone. I feel like I've got the knowledge to know what I'm actually talking about, whereas I think at the start, I felt like I knew nothing and the person on the other end of the phone knew everything. I guess I just cared too much, but the main thing is making sure that I do my part to pass on the message. (Anne: 187)

One participant who had been rebuffed by a doctor in a hospital ward later spoke with the doctor to talk about her communication:

I really appreciated that. So it was all negative initially but she was like, 'No that's not how you do it', you know and I was like 'oh God, aww'. I would have then been too scared in that situation again had she probably not actually come and sat me down and said 'and this is how you do it for next time. (Lillian: 93)

Participants noted how their role in the team changed when they became more comfortable in the team. This occurred at three months into practice for some participants, for others this change occurred around eight-nine months. Some participants required ongoing self-reminders that they were no longer nursing students with a tutor but a professional member of their team. This has changed their awareness on their overall responsibility as a registered nurse, as confidence evolved over the new graduate year:

...I know that when I first started, I was still in that mind-set of asking my preceptor like 'can you please sign my notes?' And thinking 'oh no, you don't

have to do that'. Or you know, when you're checking out tablets and being like 'oh? No don't, I can get my own Panadol'. And that sort of change. And then realising that you didn't have someone checking over your shoulder which you had been sort of used to for three years prior. I think that sort of, when you realised you didn't have to sort of impress someone constantly, that's when that change happened. (Mabel: 156)

Some participants noted how their communication with team members, both verbal and written, changed over time. Participants believed they were trusting their own knowledge more by understanding patient conditions and care more. This influenced the way they interacted with team members. The following is an example of increasing confidence with communication in the first year of practice. In the beginning Therese would be hesitant and hint at what she required from her colleagues and as she gained in experience and knowledge her language changed to be more assertive and directive:

When I was a very first new grad speaking to the RMOs [registered medical officers] about something, maybe asking for fluids to be stopped, because I thought maybe somebody was overloaded or whatever, I might have been a bit hesitant to say 'aw maybe you might look at this?', or 'have you considered...?'. Whereas now I think if I listen to somebody's lung sounds, I've done all my bits and pieces and I knew that that patient was overloaded, I would probably 'strongly suggest', and I would probably say to them 'I'm pretty confident that this patient has, you know, dot, dot, dot, what would it be like if we stopped these fluids and started them on just sips? (Therese: 124)

Two participants talked of the bullying culture that existed in the workplace. One participant talked at length of the intolerance from colleagues that she had experienced as a new graduate nurse. Hence she rostered herself to work with people who provided affirmative feedback to her. Her colleague's strong personalities affected her confidence, and the workplace culture, commenting that the behaviour was ignored by other colleagues. Here is a short excerpt of her story:

That bullying or whatever, affects your confidence. And I think again it's about naming something. A lot of people won't name it. They'll know it's there, and they know it affects them, they know it affects how they work and how they feel.
(Therese: 752)

There were moments where participants experienced little support from their nurse colleagues. One participant was previously working as an enrolled nurse, and experienced difficulties when returning as a bachelor of nursing student, and then later as a registered nurse:

[Senior nurse] really laid down the law from the first day. I remember she said '[is there] anybody here who's worked in health' and I didn't say anything. And then she said 'you do, don't you?' and she said 'you're not working here as a nurse', and I didn't want to go back. I didn't know if I was cut out for it, and there were other situations she was bullying people... (Sam: 224)

Eighteen months following registration, one participant spoke of how she recognised and accepted the difficulties in a colleague's forthright personality. In the following, the participant was having difficulty working with a colleague but was able to appreciate the importance of the colleague's nursing care. She overlooked the issues and professionally trusted her colleague's decision making, even when the colleague was making time at work difficult for her:

I think because of my life experience, I can look at them... and I can separate. And I can say 'this is their personality, this is how they are, but actually she's a good nurse'. Or 'actually, she actually makes good decisions, and she provides good care. (Therese: 598)

The patient's influence

Participants' confidence was influenced by interactions with patients. These person-centred relationships with positive outcomes or where they helped and benefited a patient were a significant influence on participants' feeling confident:

I thought I'd done a really good job. I felt as though I was quite competent in what I was doing and able to answer the questions and provide education. I felt that the patient and the family were more at ease. (Sam: 67)

I was ecstatic, not more for me that what I did worked, but more for him [the patient]. It wasn't about me, it was about him. (Josephine: 89)

Patients provided indicators of what was working well in the participants' clinical nursing, as the following identifies:

She had delirium and she came over and she was very suspicious, very paranoid, and thought all the staff was talking about her, and thought that everyone's actions were against her. And someone put the sterilizer on in the sluice room and that noise really upset her. Because it was across from her, and she thought that we were deliberately banging pots and, deliberately making all this noise to hurt her because she had post-shingles pain that went up through her scalp, and so that any loud noise had set off the shingles pain. And I came into her room and she was crying and screaming and literally trying to tear her hair out, and she'd already pulled out a clump. And I don't know why I felt confident then as such, but I just sat with her and just talked. And I knew that what I was doing was actually what I was supposed to be doing. And we talked for about 45 minutes, and by the end of it she felt really calm, and I never once felt in that situation felt I was doing the wrong thing by just sitting and talking to her, cos I knew that was what, she didn't need like empty words or didn't need like a medical intervention she just wanted someone, she was scared. She just wanted someone to talk to her. And I think that I knew I wasn't going to make anything worse. We'd made quite a good relationship earlier on in the week, and I think just from her personality and our previous discussions I knew that it was not, it was, more for her which was just feeling scared and I knew I could help her with that. And she really was just lonely and scared and the whole situation was scary and she thought everyone was against her. I wanted to show her that I was on her team, like we weren't against her and I don't know, I just felt confident that

I was doing the right thing, I can't really explain why. It just seemed it would work, and it did. (Lillian: 37)

This example from Lillian demonstrates the importance of the therapeutic relationship between the participant and the patient/client. Participants felt that patient communication, establishing rapport, and patient education were important factors of nursing practice influencing the relationship with the patient. This gave confidence to some nurses who looked for the patient's response, and the patient's trust, as a result of nursing interactions. This following exemplar identifies how Rachel recognises the importance of rapport and trust between herself and the patient:

But if you go 'Hi, I'm the nurse for today', they don't know that you've only just started yesterday. You've just told them that you're a nurse. So I've been a nurse for only a day and a half. So you're nervous and then you're doing your bits and pieces and you drop things and oh, it's just horrible. So yes. Once you get your confidence up, and you get a bit of a banter too. I think everyone has standard questions like, 'is it still raining outside?' or whatever. And you're like 'pew' cos you're nervous. It's kind of like getting a few key things to say under your belt at the start, just to manage certain situations that happen all the time. So they know when you're nervous. So when you're not nervous, I think that you've calmed down and so they'll calm down too. You get a much better response and the rapport improves and then you're off and running really. It's very, very, very few times would you trip over after you've got a good rapport going. (Rachel: 845)

Seeing the outcomes of their interventions impacting positively upon the patient was also significant for the participants' confidence. The following example explains how the nurse feels after being confronted with a respiratory crisis:

I guess I have to admit that I'm still a wee bit panicky with acute cases, especially with a life threatening situation...turning someone around from that point to a point where they're stabilised and relaxed, well reasonably relaxed, it's just a great feeling, you're doing something to help people. (Jenny: 65)

Feedback

Feedback from both colleagues and patients influenced participants' confidence. Patients' feedback was particularly influential. When patients appreciated the care they received and commented positively upon this, the nurse initiated that same intervention for another patient knowing that it had been previously successful, for example:

They've really liked a certain thing about what you did for them and you think 'oh ok, I might try that next time with somebody else', if they really appreciated it. With the lady, she was near being discharged and she was just really thankful, I don't know, I got through that really scary moment, it actually gave me really positive feedback. (Lillian: 170)

Critical feedback was often sought by participants to learn and improve practice. It was not always offered by colleagues and participants asked for feedback to develop their practice further:

I prefer feedback verbally, and whether it be positive or negative, because I need to take that feedback. I need to process that feedback. It's up to me how I process that positive or negative feedback to make me a better nurse. (Josephine: 170)

My preceptor in particular she's very nice and friendly and she tells me that I'm doing good. She hasn't told me that I haven't done anything bad, but I have to get it out of her what she thinks I should change. (Anne: 149)

As participants progressed through their first year and discussed practice with colleagues, participants' language developed to be more professional with colleagues. This also changed how their colleagues viewed the participants. Colleagues would listen to the participant's views and take action on the suggestions. The feedback became reciprocal further affirming the participant's knowledge and influencing their confidence.

At times participants were sought out by senior nurses to complete procedures that senior staff were having difficulty with. This impacted positively on participants'

confidence as colleagues trusted the skills or decision making of the participants. The following example identifies an instance where Rachel discovers the meaning of 'normal' practice in the nursing team and being trusted by her colleagues:

Every time it's different, and sometimes I ask other nurses about that [cannulation] and they say 'oh sometimes I'm fine cannulating and sometimes I just can't get it right'. So not everyone's happy-snappy every day and not everyone gets it right every time. And when I saw other experienced nurses going 'Oh, I just can't get any blood out of this guy, your turn' you know? 'We've already poked him 3-4 times'. And then 'You're asking me? oh God'. And then you go in and it works and you're like, 'sweet'. That also makes you feel like 'actually we're all in this together' and it didn't work for you that day and I've had days like that [when] it didn't work for me either, so that's normal then. (Rachel: 153)

The majority of participants appreciated positive feedback from colleagues but some valued feedback for improvement. Participants particularly sought out senior nurses for affirmation and support in practice. Rachel explains what this means for being a safe nurse:

I'll definitely go to a shift leader or whoever else is around to say 'Look, I need help with that'. And if they weren't so accessible or so happy to go 'yep, what?', then that would be a problem probably. That would mean then, that I was feeling unsafe in my practice actually. (Rachel: 208)

When participants were having moments of doubt or anxiety, receiving positive affirmation and reassurance from colleagues assisted them to reflect upon the situation. One participant was advised to refocus away from a moment of self-doubt and to refocus on positive outcomes of the situation.

Trust

Having trust in their own decision making and being trusted by the patient and by colleagues influenced confidence in practice. In the situation where a nurse had a miscommunication with a family, the nurse identified how difficult this situation was to

discuss with her manager. Upon reflection Louise understands the trust relationship with her colleagues may influence confidence:

It's coming back to what I think they think of me, and you do think about whether or not a senior nurse would trust you to do something and I think that admitting that you make a mistake and being in a situation like that, makes you think 'oh God, nobody's going to trust me with anything again'. And in a way that shakes up your confidence as well. So much [is] based on trust and confidence. (Louise: 145)

Having other nurses watching practice like this created inner turmoil for some participants. Participants discussed how they felt when their colleagues were watching:

If it's a new skill or something where I've not got a lot of confidence in it, then having that person watching me is good, because it's like a security net. But if I felt my skills were ok and I was feeling quite confident in it, it works negatively against you. And having someone watch those skills makes you doubt yourself, and pulls back on your confidence. So it's such a weird line because in some way it can be a real build up but in other ways it can kind of pull back a bit. (Louise: 152)

Trusting themselves in their decision making, and taking responsibility for these decisions was also important for participants:

[I was] critiquing the student and myself. Myself for trusting the students. (Mabel: 18)

Again it makes you feel proud that you made the right choice. It again helps build that building block of confidence of knowing that you spoke out, you said what you thought. Maybe they gave you a hard time about it at that moment but in actual fact it was the right decision to make and so you feel like, 'oh yeah I can trust that I've made the right choice'. (Therese: 150)

Developing learning and experience

Learning and knowledge

Undergraduate education had an impact on participants' ability to make decisions in practice as a registered nurse. The majority of participants talked of this being the foundation to their current knowledge as a new graduate nurse:

Education is a huge influence on confidence. Because the more I felt educated about something. If you're studying something and then you're seeing it in practice, you feel 'oh yeah I know about this, I've read about that. I know what the latest research is about something". (Therese: 207)

My initiation through doing bachelor of nursing was probably the first that was my foundation, and then building on that with further study. (Jenny: 49)

Well I was starting to look just beyond. I worked as [previous health role] and there was a lot of things like care and comfort. I was [now] able to put other knowledge into the mix like pharmacology. (Sam: 30)

However, most participants felt that they struggled initially in their first year of practice to remember what they had learned and to put this knowledge into practice. When this became easier to achieve, participants' confidence increased. A small number of participants felt that applying their undergraduate learning into their practice came quicker once they were practising as a registered nurse:

Post my orientation period where I was out on my own working as a district nurse, it's a little bit more autonomous and I did an admission on a palliative care patient and then followed through that care. And it was a time when I felt when all the theory and the practice and that sort of thing was all sort of coming together for me personally. (Sam: 14)

Other participants' confidence developed after attending an education paper. They had knowledge from their undergraduate education, yet had struggled to use this in practice until they later attended education, which reaffirmed what they had learnt as a nursing

student. The following exemplar from practice comes from a story when a participant had felt most confident in practice. In this extract Rachel talks about health assessment and looking for the 'red flags':

It's about red flags and just going through things quite systematically and I think that at the start I kind of, well I should already know what's wrong, I should already know what I have to do, but I didn't. I had to work through things. So, even when I learnt 'top-to-toe' and 'PQRST'¹, it actually takes a little while to bed that into practice. So once I had some of those tools really straight in my mind, those assessment tools, then I could feel a little bit of confidence. But it's not until maybe now that I feel a bit more confident in my practice. (Rachel: 19)

When participants attended professional development in the workplace specific to their speciality this built on previous undergraduate education. All participants contended their workplace professional development gave them more understanding of their clinical area and individual practice. This influenced their nursing practice in various ways, for example the way they verbally communicated with colleagues, the education they offered their patient/clients, their knowledge about assessment skills and evaluating this, or changes in their health terminology and documentation. Increasing knowledge and skills improved confidence to make decisions in practice:

When you start something new you're much focused and quite into it. And then once you can build and see some of the knowledge that you've learnt then it can become second nature, and I've definitely noticed that sometimes, in note writing. Initially I'd be doing quite extensive note writing and maybe 'patient being seen', you know, 'reacting to unseen stimuli', and then later on, [it] becomes more short-hand and saying 'no delusions or hallucinations were evident'.

(Mabel: 143)

I think, as long as I've been given the education then my confidence in that area has been increased tremendously. The times when it's not increased is when I

¹PQRST is a pain assessment method. P: provocation/palliation; Q: quality/quantity; R: region/radiation; S: severity scale; T: timing; D: documentation. (Lippincott Nursing Centre, 2016)

haven't had any education around it and I feel quite inadequate and quite unconfident. (Therese: 243)

Professional development within the clinical environment was influential on confidence. A participant gave the example of the impact upon the nursing team when they had been unable to attend an in-service education. In the following the participant had not attended education on restraint minimisation as a registered nurse:

...so you couldn't be useful in an emergency situation for restraint, and for seclusion, that was needed. At times you felt you were letting your colleagues down because you couldn't help them. (Mabel: 181)

Some participants were anxious and less than confident about unknown clinical situations, and attended professional development to prepare themselves if the event should happen. Until they had been exposed to the situations that were causing anxiety, participants would continue to attend education and prepare themselves:

I've been a bit scared of my very first cardiac arrest. I haven't had one which is amazing, I work in an [acute specialty] ward and you would think we would have them all the time. But I am scared of them. However I do like the fact I know I'm about to go through the CPR² course again and get those skills back up to date. (Louise: 350)

The formal education within participants' new graduate year built on their undergraduate education. Attending an advanced health assessment paper reaffirmed and recapped on their previous education. Participants felt this was applicable to their current practice as its application was immediate. Reaffirming knowledge from their undergraduate education gave them confidence in their practice as the learning fell into place for them in the first year of practice. Participants commented that they had forgotten some of what they had learnt by the time they commenced their nursing practice:

² CPR: Cardio Pulmonary Resuscitation: chest compressions and rescue breathing (New Zealand Resuscitation Council, 2016)

Everything in your head just disappears, I'm pleased we did that actually [new graduate programme paper] it's a really, really good course, because it made me remember everything. (Lillian: 113;

... [I] had a more understanding of the actual action of the medication and then I felt a more confident in ringing the doctor to have that reviewed. I think I'm more confident now than I was probably at the beginning, so I'm learning new things all the time. I've done two papers, two post grad papers so that's also helped. (Sam: 49)

Self-directed reading and learning was undertaken by a large number of participants prior to commencing the formal component of their new graduate education. This continued throughout the duration of the first year of practice. Some nurses made their own resources, or utilised a number of formal resources available to them to support their knowledge and practice, such as anatomy and physiology texts:

[I] read and read - we got a leaflet which was about 40 pages which I read about three times that had about the anatomy of veins and arms and various techniques of ways of finding veins. (Jenny: 98)

Participants were self-directed in seeking further learning. Being aware of the limitations of their knowledge and skills, participants would seek information and knowledge from colleagues and text books. They were also aware of how their limitations impacted upon the patient/client:

If it's not a skill I feel confident it, I generally will seek help and seek advice. I think that's one of my good attributes that I have to realise when I don't have the confidence or I don't have the skills in a situation and I need to get that help. I think that's the best thing for the patient, and I think that's how it will probably affect my patient. If it's something I'm unsure of I will always get a second opinion. (Louise: 389)

The majority of participants indicated they gained confidence from the patient by discussing health education with them. They also spent time educating the families on understanding disease progression or health expectations.

Participants' knowledge from the undergraduate degree, their professional development and the graduate education paper was identified as important for gaining confidence in nursing practice. Participants who were practice nurses had experienced an orientation process which taught them systematic processes for health assessment and triage.

Participants discussed learning health assessment in their practice:

And so she [preceptor] is very methodical and systematic in how she delivers her assessments which is wonderful, so lately I've been working on that side and I was initially very nervous, and now I feel like I know better what I'm doing and that's based on being able to do it more often and regularly. But also at the start when you're left on your own your kind of fumbling a little bit, and then suddenly you get this nice sweet spot, where you're actually like, 'I know what I have to do' and I've done some extra study about this, and I've got those books right beside me, so I've set myself up to be successful in that moment. (Rachel: 71)

Most of my patients have got depression because you know, the long term chronic illness they're suddenly not as independent as they were, and maybe they're had sick partners or their partners have passed away. And so for a lot of them they're quite, for a lot of them I do end up using that [mental health assessment]. (Lillian: 64)

Experience

The exposure to experiences and success in their practice was important for participants in gaining confidence, as constant exposure built further confidence in the nurse. Consider these examples on the amount of experience in situations which developed confidence for future nursing practice:

At the start I was really nervous and concerned about my practice, 'Am I making the right decision? Am I, being ok? Am I being safe? Am I remembering everything?' To now going, 'ok I'm more experienced now and I've got some things down pat'. Taking bloods for example. At the start you go 'oh my God, did I swipe it? Did I put my gloves on? Have I got all the bits, got the tubes?' It's a much more mental process at the start going round and around and around. Whereas now it's like 'hang on a minute I need this, and I need this and I need

this, and this might happen, or that might happen, and I've got what I need'. I'm more focused in that way. (Rachel: 575)

Some participants were required to change clinical practice areas half way through their first year of practice. Participants who experienced two clinical rotations felt a decrease in confidence at the time of the placement change. They were conscious of this and also aware of their confidence returning quicker in the second placement, compared to when they commenced their practice six months earlier. The time in practice, or experiences, influenced the rebuilding of their confidence:

It's not just about time in nursing, it's about how many patients you've been in contact with, how many different types of things have you experienced. And that's why I have mixed feelings about the whole switching around and doing different things during your new grad year. I think you're so much better benefitted if you do move around and see different skills, because it's about numbers, that's just my personal experience, it's about numbers. It's about how many people you've laid hands on, how many people you have touched and cared for, because every single one of them has a different story to tell, everyone single one of them has a different experience, a different presentation. (Therese: 298)

...so I think the main thing that helped build my confidence was having that time to decide what I wanted to gain, and I was able to use time to do that. (Anne: 174)

Looking to the future

Participants were asked for a vision of their future practice. This question meets the Dream phase of the 4-D cycle of Appreciative Inquiry, and has influenced this theme 'Looking to the future'. The following dialogue from Anne expresses what is possible in her practice and how she realises her strengths (Cooperrider, 2008) as she contemplates her future nursing practice. As she talks Anne envisions her thoughts about her knowledge and the potential of her practice:

There were so many things that they [senior nurses] didn't know. There was a couple of occasions I went out and I was to show them how to do things, and that made me feel I had the experience, and it made me realise no matter how many years' experience they have in their nursing, they still don't, you know, no one knows everything. And it made me, just little situations where I was able to teach someone how to do something made me realise I know this. And there was other occasions, the two days I took the student nurse out [and] she was asking me things that I never would ask myself, but I was able to answer them, and that made me realise, oh my gosh [where] I've come from. I remember sitting in that situation asking the same questions. So, those occasions like that. And even our enrolled nurses coming to me and asking me something, [who] have been here for years but they have a question about something, and it's knowing that they have the confidence in me as well. And we have a really experienced health care assistant and she would ring me and ask me something about wound care product selection, and these sort of things, or what should I do, or could you follow this up for me, and it just made me realise others have confidence in me.
(Anne: 264)

Anne was happy to remain practicing in her current placement, her vision was to support the client in their own environment:

Ideally I enjoy where I am now, I'm hoping I can continue somewhere in the community sector. I want to. I know I have gained so much since day one, to this year to where I am now, and I know that it is going to continue to increase; and I would like to continue doing what I am doing. But there's so many things I would like to do, some more education based on the area I'm in... I would like to do more mentoring, preceptoring. (Anne: 239)

In envisioning her future, Jenny was looking to specialise, aware of how she needs to get there. It will take a dual focus of gaining more education:

Just keep learning more skills, and getting better at what I do, getting quicker. I still feel that I'm too slow. Just been able to integrate my treatment, coordinate

myself more quickly so that I can deal with things more quickly and knowing what to leave out. Because I think, as a new nurse, you're going by theoretical knowledge because you haven't got the practical experience. (Jenny: 257)

Therese envisioned new possibilities for her future practice. She wished to continue building her confidence as she now recognises when she is confident and what this feels like. She commences a mental health position on the next Nursing Entry to Specialist Practice (Mental Health and Addictions) programme:

...I'm going to go through this getting completely shot down, completely at the very bottom again and building myself back up, so I'll be starting a whole new area that I don't really have the confidence in yet. But again I think it'll come quicker this time around, the third time around it's going to come even quicker because I've got more skills than what I started with. So eventually each place that I go, whether I stay in this next field or whether I move onto something else, because nursing you can constantly be gaining different skills, it's going to be the same way when you start something new. You start [with] a little bit lesser confidence and then you build it and you build it and you build it. So I think that's how I see my career I see that it's going to be constant changing and building and learning. (Therese: 361)

Being an inpatient as a nursing student influenced Mabel's view on nursing and how she practised. She was aware of the 'little things' that impacted upon a person, and feels her hospitalisation has influenced her future vision of her nursing:

...just being mindful of people's dignity in four bedded or two bedded rooms, remembering it's the little things. Smiling or just remembering family members' names. I think if you can make someone's stay in hospital a little bit brighter for a small thing, they weren't going away saying that's a negative experience for them. And that makes me feel better about nursing. (Mabel: 267)

Another participant visualised the future every day of her practice. As she explained her plans of how she saw her future she uncovered how she is already building the knowledge and experience to get to where she wants to be:

Well I have a little thing that I say. I say it every day, 'a highly skilled, resourceful, and intuitive nurse and I want to contribute those skills positively to my community'. And so when I think about those things, highly skilled that means I have to study, it means I have to practice. Otherwise I'll never be highly skilled will I? I have to be resourceful, and intuitive, [which] is just experience, just sitting with folks and looking hard at people. That was a skill that I didn't have before, we never really looked at people. We were always taught not to, that it was rude actually. So that's something I've had to learn. And I've noticed now I'm much better at picking up on different cues. So verbally they might be saying one thing but physically they're saying something else. (Rachel: 896)

In realising this vision, Rachel who was in her second year of practice realised that she should be practising with more independence, and should perhaps foster more 'nursing friends' as a networking group. Her ultimate goal was to gain experience and to work in the Pacific Islands or South America through Volunteer Service Abroad, utilising her language and her nursing skills. Other participants were content to remain in practice where they currently were:

I really enjoy it. I don't know why. I never, never, ever thought I'd end up in aged or older adult care. And my first ever placement was on a rehab ward and I absolutely loved it, I didn't really want to do anything else. I did all the placements, [and] I've loved everywhere I've worked but I've always known this is where I'll want to come back to. (Lillian: 299)

Sam's vision for the future was to become a Clinical Nurse Specialist in Diabetes and was aiming for an internship which is available in another facility, in preparation for this role:

This internship, it came with the education as well, and that's very rare. (Sam: 199)

Gaining further education and learning was important for participants and their future career pathway. One participant was particularly focused on completing a pharmacology paper to gain a better understanding on educating patients about

medications. Participants had an awareness of when it would be the most appropriate time to undertake education in the future.

Conclusion

Participants identified an understanding of confidence, and how this made them feel personally. They discussed how they had a self-awareness of their confidence, and utilised reflective practice when discussing confidence in their practice. Participants experienced self-doubt, and some experienced over-confidence. They feigned their confidence to support the patient, and had a resilience to persist in their practice as they continued to learn and their confidence evolved. Confidence was influenced by relationships with colleagues and patients, the feedback they received, and the trust they experienced in collegial relationships, and trust in themselves. They continued to learn and seek knowledge formally and informally, continued to develop their critical thinking and decision making, and sought further experiences to develop confidence. Participants envisioned their professional future and sought to develop their practice and confidence further.

Chapter Five: Discussion

...she always comes back to 'well the research I've done, or the best practice that I've seen', she always brings it back to stuff like that, which I think is one of the best ways of communicating because she always brings it back to knowledge; and I go, 'oh yeah, I get that'. (Participant, 2014)

Introduction

This chapter discusses the findings of this study in the context of the participants' nursing practice, the research aim, and the literature. The purpose of this qualitative study was to gain an understanding of the influences on new graduate nurses' confidence. This was achieved by interviewing participants with at least six months nursing practice and then reporting on the findings in Chapter Four of this thesis.

I have described the design process utilised based on the principles of Appreciative Inquiry. Appreciative Inquiry is a methodology which seeks in this thesis, to uncover aspects that are successfully influencing new graduate nurses' confidence. This was achieved through dialogue, stories, appreciation and affirmation of a time in their nursing practice when they felt most confident. The first three stages of the 4-D cycle – discovering, dreaming and designing – have been uncovered by participants' interviews and discussion on confidence which provided data for analysis. The fourth stage of Appreciative Inquiry, destiny, is employed within this chapter by way of understanding and discussing the findings and relating them to nursing practice and the literature. The study findings are discussed ensuring the diversity and differences of the participants' views are respected and communicated which is representative of Appreciative Inquiry (Reed, 2007).

The themes identified in this study include *understanding confidence, developing a professional identity, relationships, developing learning and experience, and looking to the future*. The first theme *understanding confidence* is an overarching theme which permeates the participants' stories. Participants were asked to define confidence and were prompted further by the use of positive and affirming questioning to elaborate on

their stories. The data showed participants had a self-awareness about what they understood confidence to mean. They expressed when and how they felt confident or doubt, and what influenced this. Participants had a strong reflective component underpinning their confidence, their nursing practice, and their stories in this thesis. The themes reflected the dialogue generated from the questions which were employed during the interviews.

At the conclusion of this chapter, recommendations for future nursing practice, education and research are made and the limitations of the study are discussed. The chapter concludes with a post-script reflection.

Understanding confidence

The theme of *understanding confidence* identified the participant's self-awareness and knowledge as central to knowing themselves and their own practice. This theme evolved as the participants were asked to define confidence and its meaning specific to them. *Understanding confidence* includes the subthemes of *self-awareness, knowing, the meaning of confidence, reflection, self-doubt, over-confidence, and feigning confidence*.

Self-awareness

Participants were cognisant of themselves as individuals and as nurses. Self-awareness was a conscious and continuing process which supported participants understanding of how confidence was influenced and how nursing practice developed over the first year of practice. This finding corresponds with the studies of White (2009), and Middleton and Uys (2012) which revealed self-awareness as moments where nurses self-regulate their practice behaviour to become more aware in nursing situations, self-regulating their personal selves and their nursing performance to meet other's needs, particularly those of the patient and family and/or whanau. Examples of self-awareness in practice pervade the findings chapter with stories involving interactions with others, for example on page 57 Louise talks of the unpredictability of nursing and what she has to consider when interacting with others, and in another excerpt Therese (p. 58) has an awareness of her decision-making. Further in the findings chapter Sam (p. 59) has an awareness of

his nursing knowledge and how he feels at not being able to do more in a situation. Being self-aware therefore enabled participants to examine their behaviour and what they did or thought, how they felt in a situation, and how they functioned in practice.

Participants expressed self-awareness of their personal attributes or life experiences that influenced confidence in their nursing role. This finding relates to Crooks et al. (2005) who found individual's life experiences or personality influenced confidence. Personal attributes influenced engagement with the patient and colleagues, and when seeking education and support to meet practice needs. Their understanding of themselves influenced nursing care enabling participants to recognise personal values, interests and biases which were individual to them and which they brought to their practice which is a finding identified by Eckroth-Bucher (2010). Life experience influenced participant's ability to establish rapport with the patient and to engage within the therapeutic relationship, or to have an increased comfort in collegial relationships.

Participants were aware of the impact that they had upon their relationships with patients and family and/or whanau, and colleagues. This is a finding found in the concept analysis by Eckroth-Bucher (2010). Participants were aware of the importance of the communication required in relationships to gain feedback and support from others which influenced nursing practice. This instilled in them an awareness of the importance of what they needed to make nursing decisions in the future. This was particularly identified when more complex decision making was required and nursing interactions or behaviours were adjusted to manage situations which were unknown or were difficult for participants. Sam discusses how he self-regulates his practice when he becomes concerned at his limited knowledge, and attempts to control or pre-empt this by talking with the manager before visiting the patient. His concern and awareness that his performance was not the best that he wanted indicates his responsiveness to the patient, and an understanding of his practice limitations and knowledge which he would need to regulate or control further to be effective. Being cognisant of themselves in their relationships with others was therefore expressed by participants' feelings of either satisfaction, or in some cases their distress, at their level of confidence and their practice interventions.

However, until participants had developed their knowledge and familiarity with nursing situations, they did not always have an awareness of the complexity of the nursing knowledge that was required of them in their decision making. This affected an ability to provide person centred care in some situations. Louise identifies this (p. 60-61) with her moment of awareness at her struggle to meet the needs of the patient's family, and her solution to seek colleagues' assistance. This finding of decreased awareness of complex knowledge was not specifically found within the new graduate nursing literature on confidence and self-awareness. The concept of having self-doubt and limited knowledge and skills in situations was constraining for participants as new registered nurses. This limited participants' ability to immediately offer the best advice or intervention to the patient at the moment of care. Being exposed to further experiences and learning, and therefore recognising the nursing issues that they were encountering in practice would resolve participants not knowing in practice. However, during these moments of less awareness in complex situations, participants continued to be self-aware enough, and professionally responsible, to seek assistance from colleagues.

Participants were aware of feeling successful in practice, which empowered their decision making and influenced patient outcomes as they come to realise what worked well for patients. Self-affirming, positive and encouraging feelings for participants are evident as participants used the words 'strong', 'right', 'ecstatic' or 'good' to describe feeling confident. This finding is consistent with Brown et al. (2003) who identified feeling positive in practice is a key component of professional confidence. Perry's (2011) concept analysis revealed the cognitive abilities of confidence may predict success, and Cooperrider et al. (2008) equally contend that moments of success are a core component of an Appreciative Inquiry philosophy. Successful nursing moments encouraged participants' self-regard and self-esteem in practice and their awareness of how this affected confidence. The importance of this cannot be underestimated for nursing and for mentor support as enhancing nurses' self-image influenced decision making processes.

Consequently, being self-aware of changing and evolving confidence had an impact upon individual nurses and their practice. This is important for participants in their role

as registered nurses and for nursing itself. Self-awareness enabled an understanding of when and how to consciously act in situations, how to provide person-centred nursing care, and how it made them feel when they experienced success.

Knowing

Participants expressed 'knowing' what confidence was, when confidence occurred, to what degree they felt confident, self-doubt or over-confidence, and what influenced confidence. They also expressed a knowledge of how confidence impacted upon nursing practice. This finding of knowing confidence relates to the results of Brown et al. (2003) and Crooks et al. (2005) who discuss how new nurses develop knowledge in practice.

Aesthetic knowing, the interpretative form of knowledge, influenced participants' evolving practice. Lillian (p. 54) talks about her intuition, her subjective knowledge and her empathy in understanding the patient. Participants acquired an understanding of the patient as an individual and were therefore able to engage holistically and provide person-centred care. This finding of being aware of and dependent upon context, intuition and subjective knowledge is identified by Carper (1978), who discussed the aesthetic knowledge required by nurses. Aesthetic knowing influenced participants' reflection upon their practice, seeking patterns in practice, sensing what they knew and being interpretative, and development of nursing knowledge. At times assistance from colleagues was gained in understanding how to do this. Having aesthetic knowledge therefore informed participants' decision making and influenced confidence when the outcomes were positive and supportive for the patient. This finding is significant for nursing education and practice in identifying the importance of the therapeutic moment between the nurse and patient, and in identifying the context that the patient and family and/or whanau responds to.

Empirical knowing in practice follows laws and theories (Carper, 1978), and reflects Benner's (1984) view of advanced beginners who develop practice from principles and standards. Examples of empirical knowing identified the nursing knowledge that participants acquired during their first year of practice, expressed by Jenny (pp. 55-56),

who talks of her knowing how to initiate care and treatment for a patient. In Louise's example (p. 60-61) Nursing Council guidelines were referred to, while other participants utilised reference material and nursing and allied health colleagues for information and knowledge to support clinical judgement and decision making. Thus, empirical nursing knowledge was being constructed which was unique to each participant and dependant on influencing factors, for example collegial support which promoted knowledge and learning, and uptake of professional development or formal education opportunities. Empirical knowledge therefore influenced confidence in participants by developing individual knowledge which was service specific and patient-centred to support decision making in practice.

There was a shift in awareness when participant's articulated that they did not have the knowledge or awareness of what to do in some situations. This finding is revealed by Brown et al. (2003) claiming that nurses have times of not knowing in practice. Not knowing influenced participants' self-doubt where they questioned their practice decisions and at times withdrew from situations. This is expressed by Therese, (p. 51), Anne (p. 53) and Jenny (p. 54). However when experiencing a lack of knowing in practice participants had strategies to manage the situation by seeking support or further learning.

The meaning of confidence

The meaning of confidence reflected participants' awareness of themselves and their nursing practice. The use of positive language, for example *achieving*, *strong*, *right*, *growing* and *believing*, revealed in Chapter Four is similar to confidence studies discussed in the literature review (Chapter Three). This finding is congruent with White (2009, p. 107) who contends the use of affirming language is an 'overwhelming feature' in confidence studies. This language is also a feature of an Appreciative Inquiry study, and explained by Watkins, Mohr, and Kelly (2011) as participant's creating the reality of what is happening for them. Affirming language encouraged feelings of optimism and a self-belief in practice. This is an interesting feature for nursing practice identifying a simple strategy of being affirmative in our nursing language with colleagues will influence a self-belief in nursing ability.

Participants discussed examples of their confidence coming and going and building upon itself. Evidence to support the changing and evolving nature of participants' confidence is identified where Rachel talks of the fluid nature of confidence, and Therese discusses how it can build upon itself (p. 52). This finding of a changing and building confidence is acknowledged within the nursing literature, for example the 'cycle of confidence' (Perry, 2011, p. 219). Evans et al. (2010) also express confidence as occurring at differing times and situations in critical care nurses. Confidence would continue to ebb and flow for the participants for reasons individual to them, or it would build and then diminish, yet at no time did participants state that they felt confident and then remained so in their practice.

The majority of participants expressed how they did not feel confident when they commenced nursing practice. An example of this is found by Rachel (p. 51) which reflects participants who talked of their self-doubt as a new registered nurse. This finding is identified in Duchscher (2009) who concluded new nurses experience anxiety in their first months of practice. Crooks et al. (2005) discussed how participants practise applying what they have learnt in theory, into the practice area. Therefore initially in their practice, participants focussed on the routines of being a nurse with an awareness of their limited knowledge, skill and experience. This influenced participants to seek new experiences and learning. This has implications for practice and for nursing education and how the profession can find ways to further support nurses to gain knowledge in practice with the appropriate support and discussion on theory and nursing practice. This finding is also important for undergraduate nursing education and how to influence the confidence of nursing students applying what they have learnt into practice.

Reflection

Participants reflected upon nursing practice in regard to this study's aim and their nursing practice highlighting learning and self-awareness moments. Examples of reflection are evidenced throughout the findings. Reflection is identified in the writing of Taylor (2000) who considers reflection is important in making sense of thoughts to validate or change practice if required. Participants were able to look at learning and new knowledge as influencing their confidence, as reflection highlighted the gaps

between learning and practice, and situations in practice where patient interventions were required.

Participants' reflections identified how confidence made them feel. This is evident when Therese (p. 58) reflects about how her confidence was influenced when supporting a colleague in practice. Many examples identified practice and critical thinking and how the outcomes made them feel over time. Reflexive thinking, the continuous reflective experience over time (Johns, 1995) is further explained in Duffy's (2007) concept analysis when past experiences impact upon the present. Reflexive thinking was evident when participants discussed their engagement with the patient. They utilised assessment skills to engage in the therapeutic moment with the patient, reflecting upon their nursing care, their growth in confidence, their learning and patient outcomes. Reflexive thinking upon practice was a continuous learning process which changed and evolved as experiences changed and practice developed. This enabled participants to build on experiences and develop confidence. Reflexive thinking is identified when Louise (p. 79) explains her confidence over time and as a result of exposure to experiences. Participants continued to experienced reflective experiences over their first year of practice, and reflexive thinking influenced their confidence as time and their nursing experience had progressed.

Self-doubt

Participants identified they moved from moments of confidence to moments of being doubtful or uncertain in practice during unpredictable or new situations. This occurred particularly at the commencement of their nursing career and led to feelings of being nervous or scared. This finding is congruent with Dyess and Sherman (2009) who discuss new graduate nurses as being both confident and fearful in their practice; and Etheridge's (2007) study which claims new graduate nurses lack confidence when commencing their nursing career. Being able to trust in decision making with some certainty and not becoming nervous was a challenge for participants, who described how they reacted to these feelings. Similar to the literature of Duchscher (2008), Louise (p. 59) explains how she regressed when situations were too complex. For others, being unsure led to second-guessing themselves which reflects Holland et al. (2013) study

identifying that self-doubt is grounded in participants not trusting their decisions in practice. However, participants had strategies to manage self-doubt and were able to act proactively and question colleagues, or to seek avenues of further information to rescue the situation. Bandura (2012) noted that people who have a belief that they can succeed, and prevent negative results by their actions, will succeed in difficult times. This is an important finding as varying confidence meant that the new graduate nurse could still succeed to safely manage a situation by seeking other avenues of support.

The challenges of new or unpredictable situations impacted upon participant's confidence. When returning to situations a second time participants were expecting to feel similar to the first experience, for example self-doubt. Most participants had put strategies in place to diminish this occurring for example, working with more senior nurses or developing their own clinical resource material. This changed the way they experienced their confidence the second time. Being able to manage the situation with a higher degree of confidence such as in Anne's exemplar (pp. 61-62), was influential to her feeling confident as having support either from colleagues or resources pre-empted these challenging feelings. The support requested by participants was significant in decreasing self-doubt and in increasing confidence for the future. This is a significant finding in understanding new graduate nurse practice as it identifies the responsibility that the new graduate has for self-directed learning and development in practice. They have recognised their self-doubt, sought to improve their confidence by education or experience to improve patient care.

Over-confidence

In the findings, Louise (p. 64) discusses herself as a person who is naturally over-confident. What we also uncover is her awareness of how she managed herself in situations that were challenging, stressful, or unpredictable. Kissinger's (1998) concept analysis of over-confidence contends that over-confident people fail to consider alternative perspectives in situations, and have an unwarranted certainty in their decision making. Participants who experienced over-confidence and had difficulties were influenced by their ability to critically consider other alternatives at the time. Although they had not been able to resolve the issues themselves participants that

experienced over-confidence looked to colleagues for support to resolve the situation. This is interesting in that participants who naturally felt over-confident experienced self-doubt to a greater degree and consistently sought experienced colleagues to assist. Situations such as Louise experiencing doubt when feeling naturally over confident, reveal participants were having difficulty believing that they were managing their nursing practice, which a situation identified in Kissinger's (1998) concept analysis. Kissinger identified participants do not consider alternative interventions in their nursing practice when they feel over-confident. The dichotomy of being over-confident and progressing through Duchscher's (2008) development stages of a new graduate role was a challenging situation for participants when practice decisions did not have the desired outcome.

Feigning confidence

The nursing literature confirms that nurses feign or fake confidence although research studies identifying this were not found explicitly in new graduate nurse studies. The literature that comments on feigning confidence finds nurses do this to appear certain in a situation (Holland, 2013). Anne for example (Chapter Four, p. 65), identified she appeared more confident to protect the expectations of the patient, offering hope and anticipation of a positive outcome. This deception was identified by participants as meeting the needs of the patient (Burston & Tuckett, 2015). There was also a degree of altruism from Anne who felt that displaying optimism and confidence would generate this in the patient. This uncovers how feigning their practice brought empathy to the nurse/patient relationship and supported the therapeutic relationship between the patient and nurse. This influenced beneficence within the nurse/patient relationship.

Participants who feigned confidence to enable and support the therapeutic relationship laughed gently at the subterfuge of this behaviour. Participants saw this as unwritten and accepted practice which made them feel in control of the situation and in control of their self-doubt, yet they kept this behaviour silent within the practice environment. It is an interesting finding that participants had learnt early in their practice to keep their self-control invisible to support the patient. This finding is identified by Hochschild (1983)

who asserts nurses hide their emotions as a way of caring for the patient. The majority of participants valued the control this gave to an unknown or unexpected situation.

Participants controlled themselves and their reactions to the patient's emotions (Meyer et al., 2008, cited in Karimi et al., 2014, p. 178) during interactions with them. This is illustrated in practice where participants managed their stress in unknown situations which assisted their own emotional intelligence and emerging experience and comfort in situations. An example of displaying emotional intelligence is identified in Chapter Four (p. 55) where Rachel comments on being able to manage herself during moments of stress. Rachel's emotional intelligence and self-awareness enabled her to adjust her practice to meet her own and her patient's needs (Perry, 2011). However, this wasn't always evident for all participants where some felt unable to manage situations and withdrew to re-evaluate their practice. I believe new graduate nurses' level of confidence affects emotional intelligence and their ability to make decisions independent of others for the benefit of the patient's emotional outcomes.

Developing a professional identity

The experience of being a new graduate nurse developed specific nursing knowledge and qualities for participants. Participants identified with the practice norms of their workplace and the nursing profession, for example they pursued the knowledge, skills, values, norms and culture of what it meant to practice as a nurse by seeking further education, developing supportive relationships, engaging in reflection, initiating practice discussions and developing resources, and seeking feedback and affirmation from colleagues and patients to inform practice. Ohlen and Segesten (1998) maintain nurses have a personal and professional identity to practice nursing with skill and responsibility, identified by Rachel's (p. 57) expression of using reflection to make decisions and Jenny (p. 55) self-managing her stressors. Therefore having a professional identity, developing knowledge and supportive relationships and being supported into the profession influenced feelings of engagement developing confidence. Professional identity was a key feature to feeling comfortable in practice, and influenced the ability to confidently make decisions if collegial support was available.

The increasing use of professional language by participants developed awareness of how they interacted with others and felt within the clinical workplace. Participants noticed changes in their practice behaviour, exemplified by Therese (p. 73) who gained more credibility with medical officers by developing her assessment and being more assertive in her communication. Behavioural changes in practice and displaying an increasing assertiveness in practice influenced credibility within the clinical teams who began interacting with participants on a more equal level. This finding is found in a study by Apker, Propp, Ford and Hofmeister (2006), who note the four communication skill sets that nurses utilise to convey their professionalism in the team: collaboration, credibility, compassion and coordination. Displaying a higher degree of professionalism in discussions with health colleagues increased professional respect from colleagues, and their comfort with decision making, responsibility and place in the team. As Crooks et al. (2005) reveal nurses seek self-assurance and comfort and support in practice.

Autonomy in practice was a feature for some participants. From a competence perspective autonomy does not appear in the Nursing Council of New Zealand (2007) registered nurse competencies, nonetheless some participants used the word autonomy to identify they were making their own decisions and following through on care independently (Sam, p. 80). Autonomous practice has not been found explicitly within the new graduate nurse literature. In this study participants who had previous career experiences, and for Sam who had nursed previously in another scope of practice, felt confident in practising more independently albeit knowing support was available from senior nurses. Similarly other participants practising in clinical areas with direct support from colleagues also articulated how they increased responsibility in practice and although these participants did not use the word autonomy, their practice was developing with similar independence in decision making to those working in semi-isolated areas.

Resilience

Frequent disruptions to evolving and building confidence elicited personal or professional responses in participants. It became a realisation that no two situations were alike in practice and participants relied on their standards, policies and for some

their own resources, to manage and control the unknowns in their practice (Perry, 2011). Having a resilience and an ability to bounce back to what participants felt was normal practice was identified by most participants, yet some were affected by their ability to cope in trying situations. In Jenny's dialogue (p. 66) she reveals her optimism when she was not feeling confident with venepuncture. It was a revelation to participants that they could manage what they previously thought were difficulties in practice. To support these moments in practice, and influencing their resilience, participants self-initiated their learning, education and resources to assist them. Resilience influenced and built confidence as participants became aware of their abilities to self-manage changes in practice. They persevered in moments that were difficult for them, used reflection and learning, and developed their ability to cope with adversity.

Being enabling to colleagues and instilling hope in others is grounded in confidence. This created resilience (Hart, Brannan, & De Chesnay, 2014) for participants. Mabel (p. 69) advocates for and instils hope in a student by role modelling to the student the importance of rebounding from difficulties, redirecting an adverse moment into a positive experience. This instilled a sense of control for Mabel and influenced her confidence by way of supporting the student. This was an influential moment for her practice and for the nurse/student learning moment as it demonstrated assertiveness, advocacy, communication, the importance of collegial relationships and professional respect.

Relationships

Participants expected professional relationships to be supportive and engaging. Participants experienced varying degrees of support from colleagues, which was somewhat dependent upon how services practised. Models of nursing care practised by participants differed from one participant to another. Two participants practised in community roles, one worked in a non-health environment, two worked in general practice, one in a rural hospital and three within a tertiary hospital. Having positive collegial relationships was important for participants as they realised the value of team

relationships, information sharing and collegial support. Additionally the liaison role between participants, the patient and other team members was crucial to their practice (Apker et al., 2006).

Collegial relationships

Collegial relationships were understood as providing a support network within health teams. Etheridge's (2007, p. 65) study contends new relationships with others is important to the new graduate nurse. Using their interpersonal skills to build relationships and develop communication with colleagues improved participants' satisfaction and their sense of belonging in the team, giving them a sense of control to their practice. Positive collegial relationships helped with participants' self-esteem, affirmed practice, enabled exchange of information, and supported participants in unfamiliar situations. This increased their competence in practice and their place as a contributing team member.

There was some admiration expressed by participants when they recognised the ease that other nurse colleagues performed in practice, particularly when they observed the most recent new graduate nurses going about day to day practice with expertise. This finding is similar to Pfaff et al.'s (2014) study, which states new graduate nurses gain confidence from senior nurses who enhance the new graduate nurse's practice. Being watchful of others practice is articulated by Rachel (pp. 67-68) who looked to professional engagement with nurse colleagues for support and for comparison of her practice. Comparing nursing practice with that of nurse colleagues' who were seen as more experienced nurses, was considered a benchmarking of practice by participants, particularly in clinical decision making or communication skills.

While the literature has identified that the preceptorship relationship between an experienced nurse and a new graduate nurse is valuable, this study's findings indicate there was no significant value placed on the preceptorship relationship by seven of the nine participants. The daily experience of four participants illustrated the preceptor was of some support to participants, with two participants inferring they perceived their preceptor in a parental role. Only two participants appreciated the preceptor as being

responsive and influential to their evolving knowledge and skill acquisition, and socialisation to the registered nurse role. Five participants offered no comment at all regarding preceptorship. This is an interesting finding and identified a gap in nursing's current thinking and understanding on preceptorship for new graduate nurses. The main feature here is that although some spoke of preceptors as providing graduate nurse programme support, participants indicated other nursing colleagues were key support people in day to day clinical practice. Segesten (1994, cited in Haavardsholm & Naden, 2009, p. 489) identified nurses feel confident with others in the team if they are able to 'lean on others'. Etheridge (2007) also contends new graduate nurses prefer senior nurses due to their greater experience as opposed to preceptors supporting them in practice. The most recent new graduate nurses were important for understanding them as graduate nurses, and the more senior nurses were important because of their larger body of clinical knowledge and experience. This finding indicates how far new graduate practice has evolved over the last one to two decades, in that new graduate nurses are placing less significance on the preceptor role and feel comfortable in seeking support from a variety of mentors in the health care team.

Culture of the environment

Practising in a supportive environment was important for participants' nursing practice. Value was placed on communication, team work, working with colleagues, and being trusted and supported to implement nursing care. Josephine's measure of feeling comfortable in the team was being able to ask questions of colleagues at any time (p. 71). Such environments appreciated the participants' value to the team and enabled participants to question and engage collegially. In another example Jenny comments upon her value to the team and her satisfaction she feels when she is welcomed to work each shift (p. 72). Positive feelings about teams were influenced by the team cohesiveness and communication, and inclusiveness to participants, encouraging confidence in participants' critical thinking, expressing of opinions, accepting responsibility and learning to make decisions. As a result, participants noted how colleagues would look to them for the knowledge that they brought to nursing practice.

However, the workplace culture and some collegial relationships were constraining and stressful for the new graduate nurse, particularly when working with colleagues who were negative and intimidating in some clinical environments (Therese and Sam, p. 74). This finding aligns to the studies of Andersson and Edberg (2010) and Ohlen and Segesten, (1998) who found relationships were key to participants feeling comfort and engagement in the team. Those that felt intimidated or bullied elected to practice in other clinical environments where they enjoyed friendships and collegial support, although one participant elected to remain in their workplace because of its speciality practice. However, participants would continue to engage with their colleagues who were causing them distress when they became aware that those colleagues were providing safe and appropriate patient care (Therese, p. 74). This identified the value participants placed on respect, beneficence and nursing care over their own feelings of comfort in the professional relationship.

There was a nervousness in speaking with other health professionals, particularly with medical officers at the commencement of the new graduate year. This is expressed by Anne (p. 72) when she spoke of her relationships with others. This is a finding experienced within other nursing studies (Dyess & Sherman, 2009; Andersson & Edberg, 2010). Having difficulty in communication disadvantages participants in that they will not engage and advocate effectively for patient care or when urgent assistance may be required. Professional communication may not succeed if relationships are ineffective. Lillian (p. 72) identified this issue having being rebuffed by a medical officer, yet the situation was able to be resolved through engaging in a discussion on interprofessional communication which influenced professional communication strategies. This aided in transitioning from thinking like a student to moving into the registered nurse role, and created a learning moment of the communication required of a new nurse. The degree of support within the workplace environment was particularly influencing on the exchange of information, interprofessional relationships and therefore confidence to influence patient care outcomes.

The patients' influence

Establishing a rapport and a therapeutic relationship with the patient and their family and/or whanau enhanced confidence in participants' critical thinking in nursing care, and confidence to make practice decisions. Participants involvement with the patient, observing them, reflecting upon theory, and understanding how the patient responded to health interventions influenced further patient interventions, particularly health assessment and communication. Tanner (2006) revealed knowing the patient and engaging with them is central to the new graduate nurses' clinical judgement. Lillian highlights this (pp. 75-76) and talked of knowing the patient; and page 88 Rachel talks of how she has further evolved her practice to now being more intuitive to the patients' needs. Both these ways of knowing the patient, personally and knowing their health status developed the participant's confidence to nurse the patient holistically. This finding is identified by Tanner (2006, p. 206) as the 'daily discourse' of knowing the patient, it is more than clinical assessment, but knowing the individual's responses that enables clinical judgement to occur, developing experience and time in practice, and linking previous learning to current practice. Rachel's account indicates her practice has evolved to now looking more at options in nursing care for individuals. Confidence in clinical judgement has evolved as experience has evolved. Participants were being guided by achieving what the patient had set out to achieve, creating a feeling of satisfaction for participants.

Feedback

Nursing involves giving and receiving feedback on practice to improve patient care. Feedback influenced knowledge in practice, self-awareness, and self-responsibility in decision making for participants in this study. These factors combined with the complexity of care and the stressors of a new role created anxiety in participants if feedback on their practice was not provided. Josephine (p. 77) discussed her need for feedback explaining she requires both positive and negative feedback to improve practice. Preceptors were the nominated person for providing feedback to participants, with other nursing colleagues providing minimal or none at all. Crooks (2005) indicated the importance of feedback for the developing nurse, and in particular the way feedback is delivered. Affirmative feedback was appreciated, but for some the constructive

feedback on what they needed to improve in their practice was more important, indicated by Anne (p.77). The implications of not receiving quality feedback and not being guided adequately in their decision making, was influential on patient care. Participants would not benefit from nursing knowledge and experience from colleagues, nor would they acquire responsibility in future practice if they did not have exposure to practice discussions and collegial support.

There was an awareness of the need for consistent feedback by participants. Participants placed a high value on needing this yet the feedback that was provided was inconsistent particularly from preceptors. This sparing feedback indicated preceptors were largely not providing what was required of their role, and is perhaps linked to participants need to seek and foster relationships with a team of nursing colleagues to provide them with a variety of information and feedback for practice.

Trust

Before participants discussed their relationships with others in the study interviews, they talked of relying on themselves and trusting their own critical thinking and decisions in practice. Trust is both a process and an outcome (Johns, 1996). Participants expressed how they second-guessed decisions, doubted their thinking and questioned themselves. This impacted upon how they perceived their practice at the time and how they managed nursing situations. An example identifying personal trust is in Chapter Four (p. 53) where Therese equates her building confidence and second-guessing her decisions to being able to trust in herself. This finding is present in Perry's (2011) concept analysis of self-confidence, identifying trust as an attribute of confidence. Trusting themselves was influenced by varying attributes, either knowledge or experience, or personal confidence. Participants required trust in themselves to experience confidence, and conversely required confidence in some situations to trust in their decisions in practice. Each appeared to influence the other depending on the situation and how the participant was experiencing confidence at that time.

The trust relationship between participants, the patient and/or their nursing colleagues had an impact upon participants' ability to make confident decisions in patient care.

Trust impacts upon a person's ability to form relationships (Rutherford, 2014) and is centred on empowerment in those relationships, for example the nurse/patient relationship, or nurse/nurse relationship (Johns, 1996). Participants felt vulnerable as new nurses and perceived their nursing colleagues as having more knowledge and experience than they had. They therefore needed their colleagues to trust in their nursing care. Louise (p.79) places an importance on being trusted by her nursing colleagues which enables collegiality within the team and collaboration in future practice. Establishing collegial relationships would therefore foster trust and guide the new graduate nurses in decision making. Having this support for clinical decision making and learning in practice impacted upon the patient and health outcomes.

Equally, seeking a trusting and professional relationship with patients was important for similar reasons, to enable trust and confidence in the relationship for nursing practice to occur. This finding is identified by Haavardsholm and Naden (2009), who contend the nurse will need to take into account the skills, knowledge and role expectations of themselves, and the patient's values in a trust relationship. Although participants did not use the word 'trust' within their stories of patient care, their dialogue was infiltrated with trust in nurse-patient moments. An example sits within Lillian's story (pp. 75-76) identifying the ongoing therapeutic relationship and trust in Lillian's quiet intervention, and Lillian trusting her intuition in that moment. Trust enabled patients to accept treatment from participants and cultivated future relationships between the patients for future health care, a finding in Johns (1996) study. As a result of experiencing trust from patients and within collegial relationships, participants gained confidence in judgement and decision making skills, and experienced moments of feeling success in the situation.

Developing learning and experience

Learning and experience were key influences on confidence for participants. This section discusses how the learning and knowledge obtained from education and experience as a new graduate nurse influenced confidence to make practice decisions.

Learning and knowledge

Participants believed having a nursing knowledge and being able to apply learning to nursing practice were key features to support confidence in nursing practice. Decision making was dependant on clinical knowledge. This is similar to a study by Duffy (2007) who contends knowledge, education and reflection is influential to confidence. These identified the importance of education in a statement in Chapter Four (p. 80).

As is expected by the nursing profession, participants' undergraduate nursing education was significant for their new registered nurse practice, but the findings provide evidence that this gained more significance when it was applied to practice situations as a registered nurse. However until they had experienced nursing care situations in practice, some participants' had doubts about how to apply some undergraduate learning to practice, identified by Rachel (p. 51). This highlights how undergraduate education was not always able to be applied to registered nurse practice. Participants were prompted by more advanced education in the new graduate programme which triggered a memory and awareness of the prior learning. This prompted participants and an immediate awareness of what this meant for patient care. The NetP specifications (Ministry of Health, 2014) state that programmes should not repeat undergraduate education, drawing to their attention the value of nursing education. However, recapping on already learnt knowledge was important for participants' awareness of applying nursing knowledge which was learnt as an undergraduate student, to practice as a registered nurse.

Participants sought professional development opportunities as new graduate nurses, and gained new learning in practice when they worked with their colleagues and observed their practice, or attended professional development education. The self-responsibility of directing their own learning and professional development, a finding found in McKenna and Green (2004), informs nursing knowledge and practice and resulted in participants contributing to patient interventions and nursing discussion. This was important for participants' credibility in team discussions as it lessened the burden on their nursing colleagues. It also affirmed the new graduate nurse's knowledge and influenced feelings of self-esteem and satisfaction. This finding is also identified in

McKenna and Green (2004) who assert new graduate nurses feel an increased esteem when they contribute with knowledge and experience to the team. The further knowledge and learning experienced by participants were important in enabling increased contribution to team discussions, patient education and in discussions with patients regarding their care. Increased engagement in practice, as a result of increased knowledge and learning, influenced confidence in patient interactions and the ability to engage further with patients in sharing information.

Over the last decade in New Zealand, there has been an emphasis on new registered nurses gaining their first year of nursing experience in a transition to practice programme. The participants did not discuss the graduate nurse programme as having any influence on their practice. They did however discuss the content of graduate nurse programmes for example education, preceptorship and colleagues as being supportive to confidence in practice. My assumption going into this study was that NetP programmes may have had some influence on confidence in new graduate nurse practice.

Experience

Participants were regarded competent to practice as a registered nurse. Their anxiety at the responsibility and knowledge they required when commencing practice remained until they had gained experience and time in nursing. Practice experience saw a change in their critical thinking and practice interventions. Rachel and Therese (pp. 86-87) describe how their focus and confidence built as a result of experience. Participant's particularly valued the varied experiences in practice knowing that colleagues were available for support. Crooks et al. (2005) and Etheridge (2007) revealed that experience changes and evolves over time and with practice. Participants gained experience in practice to develop learning and critical thinking skills. However, some participants did not make some practice decisions until they had conferred with colleagues, or taken time out, or referred to resources. These early practice moments influenced confidence. During moments of doubt they felt nervous, less confident and sought assistance or further education; and in moments of increased confidence they felt good, proud and on top of their practice, yet with a knowledge they were still

learning and developing and that confidence could change at any moment. Examples of varied experiences are throughout the findings chapter and amongst patient related stories. Therefore experience in practice is not only about time in practice, but developing learning in practice situations.

Critical thinking and decision making

Critical thinking was a key factor in participants' decision making in patient care. Developing analytical and assessment skills in a situation, participants used the knowledge gained to make decisions, to change practice and to evaluate the changes further. This finding is identified by Crooks et al. (2005) who surmise critical thinking encourages reflection in the new graduate nurse, which increases an awareness of theory based practice. Discussions with senior nurses, further education and self-directed learning informed the participants' thinking and application of their learning to nursing practice, and to seek answers to questions.

In making decisions in practice, participants have utilised their critical thinking, nursing theory, experiences from practice, education and peer learning in applying this to decision making. This finding is identified in Holland et al. (2012a) who contend new graduate nurses think critically in practice and use the learning from this to make decisions. Therese explained the overwhelming amount of knowledge that is needed to make clinical decisions. This is similar to Evans et al. (2010) who reveal new graduate nurses have difficulty making clinical decisions. However, Hoffman and Elwin (2004) equally contend new graduate nurses often miss important cues when making clinical decisions, a point which was not identified in the findings of this study. It is possible, as discussed previously, that participants did not know what knowledge they needed in some critical situations due to a lack of experience. What is evident within this study context is that participants became aware of their limitations in knowledge and experience and sought support when situations became unpredictable or unfamiliar.

Looking to the future

Participants saw education, new learning and mentoring as important to future practice, with some looking to senior nursing and specialist nursing roles. Participants within this

study were prompted to envision their future practice, and to articulate the possibilities of getting there. This met the aims of designing or planning their future; and destiny, achieving where they want their future to be. The Nursing Council of New Zealand states 'registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice' (NCNZ, 2007, p. 3). The current state of population growth and demand, and the aging nursing workforce (NCNZ, 2013) indicates the importance of the nursing profession to take into account the career progression of new nurses. The diversity of knowledge and learning that participants brought to practice influenced patient care. Enabling new nurses to contribute to caring for a diverse population means nursing as a profession requires new nurses to be educated to levels to meet the needs of the population.

Recognition and Celebration of study findings:

This study recognises and celebrates the positive aspects related to new graduate nurses confidence. The principles of Appreciative Inquiry make it possible to pursue and recognise positive and encouraging consequences and effects within the findings of this study, and to value the nurse's degree of confidence they experience in nursing practice.

Participants had an understanding and self-awareness of confidence, and what this meant for patient care. Their discussions on the impact confidence has on developing nursing practice going into the future, further identified influences on their developing knowledge and experience to support the decision making expected of them. Discovering self-awareness of how confidence made them feel, feelings of 'good', 'great', 'happy' and experiencing success in practice, highlighted how they consistently looked for further positive outcomes to achieve practice goals. The benefit of feeling successful is to achieve personal learning and desirable outcomes for the patient, and to then apply the new knowledge to future situations. Being successful in practice is a positive experience therefore, and influences the new graduate nurse's engagement in nursing, engagement in practice, and contributes to further positive patient experiences.

It also influenced the new nurse to strive for further goal setting and challenges, stimulating them to act and feel further success.

Feeling self-doubt and over-confidence influenced success also. The feelings of having to develop confidence or to reflect upon over-confidence highlighted moments of self-awareness in which participants considered alternatives as to how they could achieve their practice goals. These learning moments were positive for new graduate nurses, and identified how they never lost sight of their aim to provide the patient care they desired to achieve. As they sought strategies to mitigate self-doubt or over-confidence, they continued to develop personally and professionally. They learnt to seek feedback, and to develop nursing practice by reflection and critical analysis of their practice. They were also learning the importance of collegial support and advice in their practice, and how these relationships impacted upon wider team relationships. This identifies a quiet leadership in seeking to progress their professional pathway. It is worthy to celebrate the nurse who discovers their ability to succeed and to feel positive about this. The profession is discovering a nurse who will drive for further success and learning in patient care.

This study also recognises and celebrates the value of relationships between the participant and their colleagues and patients. The value of life, people and ideas (Cooperrider et al. 2008) centres the new graduate nurse's practice within a therapeutic partnership philosophy. The new graduate nurses placed the patient as central to their decision making, and as a result gained collegial respect and further confidence within these interpersonal relationships. Although they often felt challenged in their communication with the patient, they were always cognisant of the patient's health needs. Their focus on patient care and safety, and finding a voice to speak up and advocate on behalf of others continued to challenge the new graduate nurse, yet these moments initiated new learning opportunities and a self-awareness of what is possible. This 'positive inter-dependence' (Cooperrider et al. 2008) on doing the best for the patient, or their colleagues, stimulated the new graduate nurse to innovate, learn and cooperate with others. The development of trust and support from colleagues and

patients further resulted in, and was also a result of, developing confidence in relationships.

Seeking self-improvement and achievement in learning has developed a new graduate nurse who believes in supporting nursing practice with knowledge and best practice. This further develops a nursing profession which practises above the level of a competent nurse and stimulates the profession to develop new knowledge and new ways of working. It becomes possible to transform practice with knowledge and experience, and to develop new roles for nurses and patient care in the future, because a nurse has developed a philosophy of learning and seeking new knowledge.

Implications for practice and education

New graduate nurses work in complex health environments and require support during their transition time in practice. The new graduate nurse has an awareness of their nursing practice, their limitations, and the confidence they experience. While the preceptor is a key person to support the new graduate nurse, other colleagues are also important and in particular nurses in senior positions within the clinical workplace. The senior nurses are considered by the new graduate nurse to have expertise and knowledge to share with the new nurse. Clinical practice areas may need to consider how they collegially support the new nurse by seeking engagement from the health care team. Supporting the new graduate nurse from a team perspective, and providing mentors rather than purely the preceptorship model, has merit in supporting the new nurse in practice.

Further to this, nursing education would benefit from understanding moral courage in new graduate nurses, and the relationship between this and confidence and if this is linked to the stages of transition described by Duchscher (2008).

Strategies in practice that offer positive affirmation, identifying what they do best and how to improve that which needs further education or support, are one aspect to pursue in clinical practice. Supporting the use of the principles of Appreciative Inquiry by

providing affirmation in the workplace will encourage team collaboration and feelings of belonging, and empowerment in practice.

Implications for research

There is an opportunity to understand further the implications of utilising a preceptorship model, a team model of support or a mentorship model, or a combination of support models, to guide and support new graduate nurses in practice. I would recommend research be undertaken to explore the issues around preceptorship, including the concept of feedback which is important for new graduate nurses.

Although the new graduate nurses identified that they feign confidence to support the patient and their reasons for this, it would be beneficial to further explore the emotional labour strategies utilised in new graduate practice and if this has any impact upon confidence. This may identify the extent to which emotional labour is associated with confidence.

The environmental culture of organisations has an impact on new graduate nurses' feeling confident within the health team. Exploring the culture of the workplace and its impact on the new graduate nurse will identify issues and the level of support required for the new graduate nurse to be a confident team member.

Limitations

There are limitations to this research study. The aim of Appreciative Inquiry is to seek what works well in nursing practice, to respect participants' views and work affirmatively with the participants in conveying their stories and dialogue as true as possible. Utilising the principles of Appreciative Inquiry methodology has enabled this research to investigate confidence from a positive perspective. This is identified in the methodology chapter as a deliberate bias, and therefore the focus has been on positive aspects of new graduate nurse practice and not on seeking nursing stories on aspects that are not working well in practice. This is a limitation in the data that have been generated in this study.

The participants also practice within two neighbouring geographical areas, and attend education in their new graduate programme, which is at graduate level, level 7 of the New Zealand Qualifications Authority (NZQA). It is unknown if attending NZQA level 8 post graduate education, as happens in other areas in New Zealand, would have different outcomes or influences on confidence of the new graduate nurse. Therefore the experiences of the participants within this study may vary, and these conclusions can not necessarily be extended to nurses in other areas of New Zealand or other countries. However, since many of the findings of this study echo those previously reported in the literature, it is likely that the themes reported herein are broadly applicable.

Conclusion

This thesis has highlighted graduate nurses' views on their confidence and the influences on confidence in nursing practice. I have used the principles of Appreciative Inquiry to understand confidence from a positive paradigm and to affirm participants practice as new graduate nurses. Appreciative Inquiry has been traditionally about change in organisations, and utilising its principles has highlighted how working within a positive framework can make a change by using positive words and phrases when speaking with someone, identified in the post script below.

The study has highlighted that confidence for new nurses is transient, evolving and never static. It changes with situations because of varying factors individual to each nurse, and with intervention and support from health care teams, and other supporting factors such as education. Confidence in nurses will influence nursing practice and patient care outcomes. Nursing as a profession has an opportunity to provide broader networks for new graduate nurses in support of their learning and nursing practice.

Post script

I chanced to meet with a participant at a study day last year, who spoke with me about change, and power and diversity in her team which was prompted by the content of the day. Without prompting, she spoke of our study interview, and how she had thought

about confidence since we had last talked together. She was now consciously thinking what was good about her practice, how she was feeling during difficult times with patients, and when things went well for her. Her reflection about practice had changed, and she was thinking about what she did know in practice rather than about what she did not know. (Jo Greenlees-Rae, November 2015)

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Appendices

Appendix 1: Consent to participate in research



CONSENT TO PARTICIPATE IN RESEARCH

What helps new graduate nurses develop confidence in their professional practice?

I have read the research information sheet explaining this research, and I have understood the contents.

I have had an opportunity to ask questions and have had them answered to my satisfaction. I understand that I may ask further questions at any time.

I understand that I may withdraw myself (or any information I have provided) from this study before 1 December 2014 without having to give a reason, and if so the data I have provided will be destroyed.

I understand that any information I provide will be kept confidential to the researcher and the supervisors. I understand the published results will not use my name and that no opinions will be attributed to me in any way that will identify me. I understand that the audio recording of the interview will be wiped at the end of the project.

I would like the audio-recording of my interview returned to me at the conclusion of the study

I understand that I will have an opportunity to check the transcripts of the interview before publication

I would like to receive a summary of the results of the research when it is completed

I agree to take part in this research

NAME OF PARTICIPANT: _____

SIGNATURE: _____

DATE: _____

Appendix 2: Ethical approval



Phone 0-4-463 5676
Fax 0-4-463 5209
Email Allison.kirkman@vuw.ac.nz

MEMORANDUM

TO	Jo Greenlees-Rae
COPY TO	Jo Walton
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee
DATE	22 April 2014
PAGES	1
SUBJECT	Ethics Approval: 20351 What helps new graduate nurses develop confidence in their professional practice?

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 31 March 2015. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Human Ethics Committee

Appendix 3: Research information sheet



Research Information Sheet

What helps new graduate nurses develop confidence in their professional practice?

The study:

I am Jo Greenlees-Rae, a Master's student with the School of Nursing, Midwifery and Health at Victoria University of Wellington. As part of this degree I am undertaking a research project which will examine what helps new graduate nurses develop confidence in their professional practice. This research project has received approval from the Victoria University Human Ethics Committee.

I am inviting registered nurses who have completed their first year of nursing practice, and who have been professionally practicing for 1 to 3 years, to participate in this study.

You will take part in an interview of approximately 45-60 minutes.

During this time we will discuss your nursing practice and your views on confidence, and how you believe this has grown and been shaped your first year of nursing practice.

The interview may be held in a venue or over the telephone, at a time and place negotiated with you.

What happens to your information?

The interview will be audio taped and I may make some notes during the interview. I will transcribe the information that has been recorded, which will then be analysed for themes. You may check the transcripts of the interview before publication. This material will be collated in a thesis presented to the School of Nursing, Midwifery and Health at Victoria University of Wellington for assessment. The thesis may be assessed by other university personnel outside the Wellington region.

The research material may also be used in a journal publication, or at a presentation to nursing colleagues.

You can indicate on the consent form if you wish to have the audio-recording returned at the end of the study; or a summary of the study findings at the completion of the study. I will take your contact details so this may happen.

Confidentiality and Privacy:

If you decide to participate in the interview, all information that is discussed will be treated as confidential.

At all times, during the collection, collation, writing, assessment, presentation and publication processes, and the research material will remain confidential.

The research material will be discussed between myself and my two supervisors, all of whom will maintain your confidentiality. It will not be possible for you or your workplace to be identified.

All notes, transcripts and audio recordings will be stored in a locked cabinet for the duration of the study, and the electronic data and thesis will be password protected. At the conclusion of the study written notes will be destroyed via the Victoria University of Wellington confidential document destruction company. Audio-recording tapes will be cleared of any electronic information.

Withdrawal from the study:

If you choose to participate, you have the right to withdraw from the study, without question at any time before 1 December 2014. You will need to inform me at the time if you choose to do this.

Further questions or queries:

If you have any further questions please contact me at any time, the contact details are below.

What do I do next?

If you wish to participate, I have enclosed a consent form for you to complete, giving your consent to participate in the study. Please contact me and we will arrange a time and place to meet.

Appendix 4: Interview Plan

What Influences new graduate nurses to develop confidence in their nursing practice?

Interview questions: Plan

Appreciative Inquiry 4D Cycle:	Aim of 4D cycle stage:	Approach	Interview Question(s)	Other considerations	Questions to stimulate further interaction, encouraging thought, or to gain information
Discovery	Individual motivation and meaning (of new graduate nursing, and confidence)	Semi structured interviews and open ended questions: to uncover and encourage stories, examples, metaphors and particulars of real experiences or events.	<p>Opening question:</p> <p>As you reflect upon your first year of nursing practice, you may recall ups and downs, or high points and low points. I would like you to reflect on your first year of nursing practice, at a time or situation when you felt most confident as a nurse. Please share your story or experience, (where was it, what happened?)</p> <p>Topic Questions:</p> <p>Can you explain what confidence means to you?</p>	<p><u>Cultural Safety</u>: awareness of cultural differences is recognised to ensure the new graduate nurse feels culturally safe. Recognises that there may be a power imbalance between myself as a senior nurse and the new graduate nurse. The new graduate will have their differing cultural needs met without bias, and will have the option to withdraw from the study without any repercussions. (NCNZ, 2010)</p> <p><u>Treaty of Waitangi</u>: Acknowledgement of Te Tiriti O Waitangi as underpinning the social and professional development of the Maori new graduate nurse, advocating to ensure participation in research, protection of their right to express the unique contribution to nursing knowledge, and partnership</p>	<p>-How do you feel about it?</p> <p>-Can you explain that further?</p> <p>-Can you remember when this kind of situation worked well? (Billings & Kowalski, 2008)</p>

			<p>(Cooperrider, Whitney & Stavros, 2008)</p> <p>What were your feelings or thoughts about that moment of confidence?</p> <p>What was it that helped or influenced you develop your confidence (in this situation)?</p> <p>Why do you think this experience was memorable for you?</p> <p>Can you tell me about any other influences on your ability to confidently practice as a nurse?</p> <p>Can you tell me about any other experiences when</p>	<p>between Maori health providers and the researcher; ensuring they make an informed choice to participate; integrate Maori models of health as appropriate and as identified by the new graduate nurse (NCNZ, 2011b)</p> <p><u>Code of Conduct</u> (NCNZ 2012): recognise this as overarching document that describes researchers professional conduct, ensuring researcher establishes trust in using personal information; is aware of perceived power imbalance between researcher and participant; respect the dignity and individuality of the new graduate nurse to hold own beliefs, values and goals; respect the right of the new graduate nurse to withdraw from the research, respect Kawa Whakaruruhau cultural safety; respect privacy and confidentiality and gain consent; make explicit that confidentiality will include ensuring the graduate nurse's manager or other nursing personnel do not have access to research discussion or data; follow recognised research guidelines (eg VUW); ensure duty of care as applicable is maintained.</p> <p><u>Code of Ethics:</u> (NZNO, 2010)</p>	<p>-What made it meaningful?</p> <p>-What did you like most about the experience?</p> <p>-Can you give some examples</p> <p>-What were the successes (Carter et al, 2007)</p> <p>-Please share the story of the experience, where was it, what happened, what were your feelings and insights (Cooperrider et al, 2008, p 108)</p>
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			<p>you have felt confident as a nurse?</p> <p>Can you explain to me how your confidence in your nursing affects your patient?</p> <p>Are there any other aspects of patient care that are affected by your confidence?</p>	<p>Autonomy for new graduate nurse; privacy within the context of research is maintained; autonomy ensuring freedom of choice and informed consent; beneficence (doing good) ensuring a partnership exists between researcher and new graduate nurse, and respecting their own experience; non-maleficence (do no harm) ensuring cultural safety is maintained for the individual nurse, recognise cultural norms with respect to information; Justice (fairness) respect what would be an appropriate outcome for the new graduate nurse.</p>	
Dream	Envision a transformed practice	<p>Semi structured interview continues to explore hopes or dreams for their practice.</p> <p>Imagining transformative practice.</p> <p>Create positive images for the future.</p>	<p>Reflecting on your confidence in your practice, what is your vision for your future nursing practice</p>		

Design	Plan the first steps to initiate change in practice (prioritising, planning)	Semi structured interview, to plan and present the vision by prioritising and planning for future practice	Reflecting on your future vision on your nursing, what needs to be implemented as a priority to help you get there?		
	Learn from reflection/action		What do you think would be your first step in realising that vision of where you want to be?		
Destiny	The future: policy, education, research, practice	Discussion section and write up. Jo: reflections		Recommendations for future clinical, research, policy, education. Celebration of the findings (Cooperrider et al. 2008)	

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