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FINDING MY OWN WAY:

NURSING IDENTITY DEVELOPMENT FROM LAYPERSON TO NEW BN GRADUATE

BY
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Approval of Thesis

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DEDICATION

I dedicate this thesis to the memory and amazing legacy of Ashley Anne Schlag.

Ashley, I thought of you often while writing this thesis that focused on ideal values and whether we are enacting them. Your ability to "make a difference" through your effortlessly genuine way of being helped me realize that a person does not need to be exceedingly scholarly, have works published, or seek other such means of validation to matter and make a real positive difference in the lives of others. I now see that seeking this type of recognition as somewhat self-indulgent and if we are not careful, can encourage pretention and self-importance. You were able to make a difference because you lacked pretention and focused on making others feel important. I miss how important you made me feel. You taught me that a person can, and should, choose to make a difference for others every day by simpler means…attending to the little things. Losing you in the middle of this process brought new clarity for me. I now look forward to shifting priorities and genuinely enacting the values I claim to possess.

Thank-you for all you have given us.

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After a lengthy absence from academia I returned to school in 2008 to begin undergraduate courses and then began graduate courses in 2010. To date, the process has spanned six years and several life-altering events for me and those around me. During these years, my time was continually divided-- and not equally so. More than my lack of presence, my husband Scott and sons Ryan and Ethan also had to put up with a litany of "woe is me" tirades. They were forced to witness unnecessary meltdowns over technological glitches and imperfectly edited papers. They puzzled at my angst before hitting the dreaded "submit for grading" button (thank-you Ethan for pushing that button for me when I was having trouble). Your sufferings should soon be lessened. Perspectives and priorities have been shifted and I look forward to making up for lost moments!

Abstract

One goal of Baccalaureate nursing (BN) education is to influence Nursing Identity (NI) development of graduates. The purpose of this study was to examine the process of NI development from the perspective of recent BN graduates in Manitoba. The emerging grounded theory FINDING MY OWN WAY is proposed as a provisional explanation of the individualized journey of NI development from layperson to registered nurse (RN), where one is seeking a balance between one's Ideal Nursing Identity and the Lived Nursing Identity. This journey involves four interrelated, overlapping, and at times recurring phases: (1) Choosing Nursing, (2) Being the Nursing Student, (3) Becoming an RN, and (4) Being the New RN, each phase influenced by the context of Personal Identity and Environment which together generate Meanings, Choices, and Actions. During these phases, the person is first, aligning, then refining and redefining, and finally customizing how this NI will be enacted.

Keywords: nursing, nursing identity, identity development, BN education

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CHAPTER I
INTRODUCTION

Nursing education in Canada has undergone many changes over the past several decades. The primary change has been the movement away from hospital "training" programs based on an apprenticeship model designed to serve the needs of an employer, to college level diploma education "training" programs, and in the past decade, to university baccalaureate (BN) level education now being required to be registered as a nurse in Canada. The goal of BN education is to provide a more comprehensive education so that graduates are better equipped to meet expanding professional and disciplinary requirements (Canadian Nurses Association and Canadian Association of Schools of Nursing, 2004). Similar changes have occurred worldwide.

Concomitantly, there has been a shedding of the traditional behaviourist pedagogical approaches associated with nursing education's historical affiliation with medical models of health and education (Anthony & Landeen, 2009; Romyn, 2001). Current educational priorities focus on the development of Registered Nurse (RN) professionals who can practice according to RN values and who possess a spirit of inquiry, are adaptable, and who think critically (Forbes & Hickey, 2009; Giddens & Brady, 2007; Williams et al., 2012). Such attributes cannot be taught via the transmission of information alone. Instead, the nursing student must experience, reflect upon, and internalize values and attitudes congruent with the profession (McAllister, Tower, & Walker, 2007; Williams et al., 2012).

In Canada, an RN's roles and responsibilities to the public, to the profession, and to themselves, are encompassed within the Canadian Nurse's Association (CNA) *Code of Ethics for Registered Nurses* (CNA, 2008). These roles and responsibilities are further described in the standards of practice documents delineated by each provincial self-regulatory body, and are enacted under the aegis of provincial legislation. These documents serve as the foundation for instruction delivered to students about their roles as professional BN RNs. Reflected in these documents is the expectation that RN practice must be based on principles of holistic patient-centered care delivery, that the RN will judge how to enact this care using critical thinking skills, and that the overall focus is on the development of caring relationships. There is an expressed belief that the RN is an

autonomous, accountable professional, a defender of social justice, and an advocate for the client as empowered decision maker. These descriptions of the RN's expected ethical comportment, and professional role and skills, form the basis for the collective professional identity of RNs in Canada today and nursing students are encouraged during their BN education to embrace such a professional nursing identity (PNI).

Discrepancies between this characterization of an RN's PNI and the lived experience of Canadian RNs have been addressed in the literature (Allen, 2004; Austin, 2011; Beagan & Ells, 2007; Cohen, 2006; DeCola, & Riggins, 2010; Doane & Varcoe, 2007; Duchscher & Myrick, 2008; Peter, Macfarlane, & O'Brien-Pallas, 2004; Rodney et al., 2009; Sellman, 2011). By and large, the business model driven values of federal and provincial governments and subsequently of employers have created barriers to the consistent application of RN values in practice. For example, RN values such as integrity and commitment to human dignity can come into direct conflict with employer targets for hospital lengths of stay (Sellman, 2011) and some customer service models may discourage genuine connections with patients and families (Austin, 2011; Doane & Varcoe, 2007). Conflict exists because RNs often feel "strong pressure to pattern one's actions in ways that enable the organization to work" (Doane & Varcoe, 2007, p. 199) at the expense of delivering care according to RN values. Though the majority of researchers examining such conflicts in RN practice have focussed on institutional settings such as hospitals and long term care facilities, organizational and governmental barriers to ideal community health nursing practice in Canada have also been reported (Cohen, 2006; Falk-Rafael & Betker, 2012). Duchscher and Myrick (2008) captured this crisis of identity in the following nursing decree, "I love being a nurse, but I hate my job" (p. 195). The authors went on to explain that the disparity between the way nurses wanted to practice professional nursing and the way they found themselves functioning in practice settings caused many to leave direct care positions or the profession altogether (Duchscher & Myrick, 2008).

This discrepancy in desired versus actual practice is evidence that professional autonomy and control over nursing practice are areas where RNs continue to struggle to gain a strong foothold (Austin, 2011; Doane, Pauly, Brown, & McPherson, 2004; Greco, Laschinger, & Wong, 2006). Environments which support RN autonomy and the ability

to practice according to RN values have been shown to result in improved job satisfaction for RNs (Canadian Health Services Research Foundation, 2006; Laschinger, Finegan, Shamian, & Wilk, 2003; Leggat, Bartram, Casimir, & Stanton, 2010; Perry, 2005) and improved outcomes for patients (Purdy, Spence-Laschinger, Finegan, Kerr, & Olivera, 2010; Spence-Laschinger, Gilbert, & Smith, 2010). Inability to enact one's PNI and related values in practice can cause RNs to experience moral distress (Registered Nurses' Association of Ontario [RNAO], 2007; CNA, 2008). Alternatively, this inability can result in an RN reworking his/her identity, making less ideal forms of RN practice more acceptable thereby reducing or avoiding this moral distress (Deppoliti, 2008; Maben, Latter, & Macleod-Clark, 2007; Takase, Maude, & Manias, 2006). Despite some RNs having little freedom to exert control over their actual day-to-day practice, the identity of the RN as autonomous professional continues to be reinforced to students during BN education. Students often experience firsthand the much more constrained identity RNs are able to display within the reality of some practice settings.

Purpose and Guiding Questions

The purpose of the current study was to examine the process of professional nursing identity (PNI) development in baccalaureate nursing (BN) education as informed by Manitoban (MB) new graduate BNs. The central question guiding the study was

> *How do new graduate BNs describe the process of Professional Nursing Identity development*?

Other guiding questions included,

> *What do BN graduates feel influences the development of PNI*?
>
> *What factors do BN graduates feel are positive versus negative influences on PNI*?
>
> *How do New Graduate Nurses translate their PNI's into actions?*

Significance of the Study

Registered Nurses who feel that they are able to practice in ways congruent with their values experience increased work satisfaction and decreased attrition from the profession (Laschinger et al., 2003; Quality Worklife-Quality Healthcare Collaborative, 2006; CNA, 2006; Rhéaume, Clément, & LeBel, 2011; Takase et al., 2006; Zurmehly, Martin, & Fitzpatrick, 2009). In direct association, RNs who practice in accordance with their codes of ethics and uphold RN mandates, contribute to a healthy and effective workplace (Canadian Health Services Research Foundation, 2006; Livsey, 2009; Kramer et al., 2009; RNAO, 2007). Registered Nurses who enjoy a strong and positive professional nursing identity are better equipped to assert their right to professional autonomy and control over RN practice (Austin, 2011; Doane et al., 2004; Sellman, 2011). Thus, there is evidence to support the importance of BN students graduating with positive and strong individual and collective professional identities in order to advocate for themselves and their patients for healthy work environments. A healthy PNI may increase the likelihood that BN graduates will be able to consistently display their RN values in practice and thus experience greater job satisfaction (Leggat et al., 2010; Perry, 2005, 2008) and enable them to be positive role models for others (Perry, 2009).

To date, researchers have measured self-assessed abstract values or concepts related to professional identity of nursing students or practicing RNs (Fagermoen, 1997; LeDuc & Kotzer, 2009; Leners, Roehrs, & Piccone, 2006; Weis & Schank, 2009) but have not examined how these concepts are translated into practice or what specifically influenced changes to the student or RN's sense of identity. In the current study, the process of PNI development was examined from the initial stage of when the student as a lay person considers entering a BN program through the educational experience and finally into the first year of practice. Also setting the current study apart was the soliciting and analysis of concrete examples of behaviours the participants felt were representative of their PNI which served as an illustration of PNI as enacted. It is this PNI as *enacted* in practice that directly impacts patient care and the image of nursing projected to the public.

The findings of the current study can inform nursing education and practice about the development a healthy PNI in BN graduates. Additionally, the results suggest changes

which could improve the RN's ability to practice in ways congruent with nursing values and to improve patient outcomes (Purdy et al., 2010). The ultimate long-term vision, which is the spirit behind this investigation, is to ensure RNs, their colleagues, and our patients all experience nursing practice that is congruent with the type of nursing BN students are formally taught and which are depicted in our codes of ethics and standards of practice. This study constitutes one step to address the gaps in knowledge about professional nursing identity development among Canadian BN students, gaps identified as a result of a thorough review of the literature.

Definitions

The following terms and acronyms are defined here as they will be used in the current study. As varied interpretations of common terms may exist, these definitions serve to enhance clarity for the reader in the sections to follow.

REGISTERED NURSE (RN) – a nurse who is bound by the Canadian Nurses Association's (2008) Code of Ethics and the standards of practice delineated by their provincial self-regulatory body, and who are actively registered with this regulatory body.

NURSING - the Registered Nurse profession.

NURSING STUDENT- a person enrolled in a Baccalaureate nursing (BN) program.

SENIOR STUDENT- a person who is taking part in the final course of a BN program which takes place in a clinical setting. They are still a student of the University or College but are supervised by a staff nurse or staff nurses, referred to as Preceptors in this setting.

SENIOR PRACTICUM- final course required for successful completion of a BN program usually requiring a set amount of hours working in a clinical setting and being supervised by a preceptor.

CLIENT- a person being cared for by a nurse and the family members of this person.

CLINICAL EDUCATION FACILITATOR or CLINICAL INSTRUCTOR- the Clinical Instructor is an RN employed by the educational facility who supervises students in healthcare settings off-campus usually in groups of one Clinical Instructor to 6-8 students.

BUDDY NURSE- a nurse who is an employed by the healthcare facility where students are attending clinical courses with their Clinical Instructor. The Buddy Nurse is generally the nurse assigned to care for the patient(s) whom the nursing student is working with for a given clinical day.

NEW GRADUATE (NG)- a graduate of a BN program who may or may not have completed the national licensing exam but who has practiced less than 24 months since graduation.

TRADITIONAL BN EDUCATION – pedagogical approach for undergraduate BN education based on the medical model. The medical model focuses on areas of practice and various diseases and is considered compartmentalized and reductionist in its approach (Barbour, 1997).

PROFESSIONAL NURSING IDENTITY (PNI)-on a collective level, the identity shared by RNs and reflected in their codes of ethics. On the individual level, the personal understanding of one's identity as an RN.

PROFESSION- "An occupation having an independent body of knowledge, an ethical code, education controlled by the occupation, and accountability for actions" (Goodrick & Reay, 2010, p. 75).

Summary

This chapter served as an introduction to the current study presenting the background of the phenomenon being studied- Nursing Identity development in BN education in Canada. To position the study for the reader, the purpose of the study and guiding questions were offered. The significance of the study focused on how the findings might address gaps in the current literature and inform interventions to benefit the nursing profession and related stakeholders such as nurses, nursing students, and clients. Terms and acronyms used in this document were defined.

CHAPTER II

REVIEW OF THE LITERATURE

An initial integrative literature review (Whittemore & Knafl, 2005) was undertaken to determine the extant knowledge of the factors influencing baccalaureate (BN) professional nursing identity (PNI) development (Enns, 2011). A second review of the literature was undertaken to further explore the key themes related to PNI development revealed during the first review.

Strategies

An online search for empirical and theoretical literature was conducted for the initial integrative review using Academic Search Complete, ProQuest Nursing and Allied Health Source, Cumulative Index of Nursing and Allied Health Literature (CINAHL) databases, and Google Scholar search engine. Search terms included "research," "professional identity in nursing," "nursing identity," "nursing self-concept," and "professional identity development" with refining terms of "nursing education," and "Canada/Canadian."

Inclusion criteria for these nursing-specific articles resulted in a purposive sample. English articles from Western Europe, Australia (AUS), the United States (US), or Canada (CA) were included with preference given to empirical and theoretical articles from Canadian sources published after 2000. Due to the focus of the review being BN education, articles examining PNI in nursing specialties, such as oncology, mental health, or community health nursing were excluded as these articles focussed on PNI development after taking additional education, or based on the specialization, or after an accumulation of years of nursing experience.

Constant comparative analysis of the initial 22 articles accepted for review revealed themes that necessitated a return to the literature to explore "values," "nursing values," "values and behaviour," "values in education," in conjunction with "research." To better understand the individual, social, and educational factors which influence one's values and thereby the formation of PNI, literature from a variety of disciplines including psychology, sociology, social psychology, and education, in addition to nursing-specific literature were included in the second narrative review.

Findings

Based on the first integrative review (Enns, 2011), it was concluded that the foundation of a healthy professional identity lies in individuals possessing strong nursing values, being committed to enacting these values in practice, and working in environments which support the upholding of these values in practice. Themes revealed through constant comparative analysis included the core theme of VALUES and three subthemes: (1) Professional Nursing Identity as Perceived by Self, (2) Professional Socialization's Influence on Professional Nursing Identity, and (3) Professional Nursing Identity as Enacted. It was apparent that a literature search about the nature of human values and how one's values are translated into behaviours within the context of a social environment was needed for additional clarification. Thus, a second review of the literature was undertaken. Subsequently, a closer examination of the concept of identity was also undertaken to inform the preliminary analysis. The synthesis of these three reviews provides a comprehensive overview about what is known about PNI development in undergraduate nursing education.

Professional Nursing Identity: Theories and Concept Analyses

Some authors, notably, Fagermoen (1997), Öhlén and Segesten (1998), and Roberts (2000) developed theories about PNI and operationalized its meaning. Fagermoen (1997) conducted a descriptive analysis of the survey responses of 746 Norwegian nurses with varied years of experience about the delivery of nursing care, followed by a hermeneutic and narrative analysis of semi-structured interviews of six of these nurses. Fagermoen (1997) used this data to develop a theoretical framework for what PNI is, centering on altruism which she described as "the moral orientation of care" (p. 439) and the promotion of human dignity as comprising the core values of nursing. Fagermoen (1997) also concluded that "values are inherent in developing and sustaining professional identity and are expressed in nurses' actions in relation to others" (p. 436). Öhlén and Segesten (1998) similarly concluded that values associated with caring were central to a nursing identity. Apparent in both Fagermoen's (1997) theoretical framework and Öhlén and Segesten's (1998) study based on the hybrid model of concept development was that values needed to be applied in practice for nurses to extract

meaning and satisfaction from their work. This connection between applying core nursing values in practice and satisfaction with one's work was also found in Perry's (2005) phenomenological study with Canadian nurses.

In comparing their findings with research conducted in various Western nations, Fagermoen (1997) and Öhlén and Segesten (1998) both noted that the professional identities of nurses were very similar despite the varying cultures in which nurses were situated. Fagermoen (1997) posited that a "transcultural common core of nurses' professional identity seems to be surfacing, namely, the actualization of the values of dignity, personhood, being a fellow human, and reciprocal trust, which depicts nursing as a human and moral practice concerned with providing personalized care to patients" (p. 439). Other studies examined representing a wide range of Western countries, supported this commonality of perception among nurses (Akhtar-Danesh et al., 2013; Apesoa-Varano, 2007; Deppoliti, 2008, Fagerberg & Kihlgren, 2001; Maben et al., 2007; Perry, 2005).

Roberts (2000) presented a model which was largely based on gender issues and the oppression of women. She concluded that nursing's association with women's history contributed to a negative PNI via internalized oppression and poor self-esteem. Based on Freire's (1970) theory of oppressed groups, Roberts (2000) used Cross' (1971) model of stages of liberation for African American women in the US, as a source for developing a model for positive PI development in nurses. The five stages begin with *unexamined acceptance* at the oppression end of the model and culminate with *political action* at the liberation end. She theorized that when immersed in an oppressive environment nurses can accept the status quo as the way things should be and they do not try to rise above their subservient role. Instead of adhering to and celebrating the values inherent in nursing, nurses denied or even admonished these values and adopted the more masculine, biomedical values of their oppressors, which weakened nursing's collective PNIs as well as that of individual nurses. In contrast, a healthy PNI stemmed from incorporating nursing values into one's self-concept and taking action for the creation of work environments where such values could be enacted (Roberts, 2000).

What is an Identity?

The question of what an identity actually *IS*, was not explored during the first literature review, and is not directly addressed in the nursing literature. As a result, theories from the areas of social psychology were examined**.** Identity is described as "a set of self-relevant meanings held as standards for the identity in question" (Burke, 2006, p. 81). It is also accepted that we can hold a variety of identities at any given time, based on social or gender definitions or our occupational roles (Farmer & Van Dyne, 2010; Verplanken, Trafimow, Khusid, Holland, & Steentjes, 2009). Adams & Marshall (1996) list the five most commonly documented functions of identity as:

> (a) providing the structure for understanding who one is;
> (b) providing meaning and direction through commitments, values, and goals;
> (c) providing a sense of personal control and free will;
> (d) striving for consistency, coherence, and harmony between values, beliefs, and commitments;
> (e) enabling the recognition of potential through a sense of future, possibilities, and alternative choices. (p. 432)

Authors who mentioned identity development or identity formation theories tended to refer to social identity theory (Adams, Hean, Sturgis, & Clark, 2006; Stockhausen, 2005). Identity development is influenced by many factors but overall, is considered a social process (Ashforth & Mael, 1989). Adams & Marshall (1996) described the social influences in general identity formation as coming from macro levels of society and political systems to the midlevel influences of communities and the more micro levels of families and face-to-face contact. The cumulative effect of identity formation is the creation of both individual identities and group identities. Being unique contributes to one feeling significant on a level of personal agency, but there is also the need to feel a sense of belonging to a group identity (Adams & Marshall, 1996; Hotho, 2008; Kirpal, 2004).

What is Personality?

To enhance the clarity of terms, the distinction between the similar concepts of personality and identity was examined. Personality is viewed as a collection of traits, such as extroversion or openness to experience that remain very stable, are considered endogenous, and are unlikely to be altered over time (Olver & Mooradian, 2003). While personality as a collection of traits is considered part of one's identity, these traits are not the lone contributor to one's self-concept.

Values

The fact that the primary theme of VALUES was revealed during the integrative review of nursing literature pertaining to PNI is in keeping with theories proposed by scholars from the field of social psychology. Feather (1992) and Schwartz and Bilsky (1990) suggested that values are directly tied to how individuals define themselves and those values to which we assign core importance are central to our identities. Schwartz (1994) defined values as follows:

> Values are desirable trans situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity. Implicit in this definition of values as goals is that (1) they serve the interests of some social entity, (2) they can motivate action giving it direction and emotional intensity, (3) they function as standards for judging and justifying action, and (4) they are acquired both through socialization to dominant group values and through the unique learning experiences of individuals. (p. 21)

Bernard, Maio, and Olson (2003) added that values are the foundation of our attitudes and beliefs and "encapsulate the aspirations of individuals and societies and encompass deeply engrained standards that determine future directions and justify past actions" (p. 64). Thus, our values are the measure by which we determine importance and weigh our options; values are a key determinant in our choices and actions (Bardi, Hofmann-Towfigh, Lee, & Soutar, 2009; Lonnqvist, Leikas, Paunonen, Nissinen, & Verkasalo, 2006; Verplanken & Holland, 2002).

Personal values and the public perception of nursing. Historically, the nurse's role was seen as an extension of the domestic unpaid labour traditionally performed by women within families (McPherson, 2003; Melchoir, 2004). This fact combined with the view of nursing as a vocation, or a response to a higher calling, supported the societal

view that nurses should not be in the practice of nursing for personal gain or to fulfill personal ambitions (McPherson, 2003; Melchoir, 2004). This association of nursing with altruistic women's work generated stigmas and stereotypes which impeded the acquisition of professional status for nurses (Adams et al., 2006; Apesoa-Varano, 2007; Brodie et al., 2004; MacIntosh, 2003; Öhlén & Segesten, 1998; Roberts, 2000; Thorpe & Loo, 2003). Over the past several decades, on going advancements in the professionalization of nursing has resulted in a distancing of nursing from this image of female servant toward the more desired image of independent professionals (Brodie et al., 2004; Ohlén & Segesten, 1998).

Nonetheless, these evolving historically and socially-mediated images of nurses have continued to affect the type of person who chooses nursing as a career (Brodie et al., 2004; Gordon, 2005; MacIntosh, 2003; Öhlén & Segesten, 1998). It was found that such associations have resulted in contemporary Canadian (Bolan & Grainger, 2009), American (Cook, Gilmer & Bess, 2003), and British (Brodie et al., 2004) students beginning nursing programs with simplistic and idyllic views of nursing and have contributed to them being surprised at the degree of responsibility nurses have for their own practice and the amount of academic knowledge required (Brodie et al., 2004).

The perception of nursing work as menial and subservient rather than autonomous knowledge work has also made it a less attractive career choice among gifted, or high-achieving high school students, as illustrated in the results of a survey of Canadian high-school students by Miller and Cummings (2009). Though students' early impressions of how congruent the values of nursing were with their own was reached largely via a public perception of nursing, Adams et al. (2006) found that for students in the United Kingdom (UK) it was also modified by personally knowing nurses or having worked in the healthcare field.

Values of undergraduate nursing students. It was generally accepted that personal values were largely formed by the time someone was weighing career choices and it was the perceived alignment of these personal values with the given career that guided this choice (Adams et al., 2006; Brodie et al., 2004; Cook et al., 2003; Fagerberg & Kihlgren, 2001; Thorpe & Loo, 2003). Personally valuing altruism and the belief that nursing was a caring profession influenced one's decision to enter nursing (Cook et al.,

2003; Mackintosh, 2006; Thorpe & Loo, 2003). Results of a qualitative study by Cook et al. (2003), a quantitative comparison study by Thorpe and Loo (2008), and an exploratory factor analysis study by Adams et al. (2006) supported that new students had already developed some sense of PNI before they were exposed to extensive professional socialization.

In comparing Canadian undergraduate nursing student value profiles with those of management students, Thorpe and Loo (2003) discovered significant differences between the two groups. Personal development (to develop as a person) and altruism (a desire to help others) were the most significant values for nursing students, while management students valued lifestyle, advancement, autonomy, and authority, to a significantly greater degree. It has been suggested that these other-centered values such as altruism, common in the type of people attracted to nursing, contribute to a lack of self-promotion and therefore decrease the amount of control nurses exert over their professional practice (DeMarco, Roberts, Norris, & McCurry, 2008; Roberts, 2000).

The majority of research reviewed regarding student PNI development during education focussed on the degree of student value change based on the results of quantitative instruments measuring self-assessed professional values (Cragg, Plotnikoff, Hugo, & Casey, 2001; Kubsch, Hansen, & Huyser-Eatwell, 2008; Leners et al., 2006; LeDuc and Kotzer 2009; Martin, Yarbrough, & Alfred, 2003). Leners et al. (2006) and LeDuc and Kotzer (2009) both employed the Nurses Professional Values Scale (NPVS) (Weis & Schank, 2009). The NPVS is a Likert-scale self-assessment tool based on the American Nurses Association Code of Ethics (Weis & Schank, 2009). Though no such tool has been developed based on the CNA Code of Ethics, the basic values expressed in each related to nursing practice are very similar. Analysis of 782 NPVS surveys supported validity and reliability via confirmatory factor analysis and a total scale alpha coefficient of .92 (Weis & Schank, 2009). Leners et al. (2006) conducted a longitudinal study with 158 students upon entry to, and upon graduation from, a single BN program in the Western US and found the mean ranking of values increased overall but students entered and exited the program with similar ranking of these values in order of most to least important. LeDuc and Kotzer (2009) compared the results on the NPVS between 97 students, 46 NGs, and 84 experienced nurses and found no statistically significant

difference between the mean value rankings of these groups. According to Bardi et al. (2009) mean-level ranking changes are to be expected when a group experiences similar events and experiences. Thus, it may not be meaningful to see a set of students from one nursing program or even a group of nurses from similar backgrounds having these mean result similarities, especially when the instrument being used to measure them uses wording based on a code of ethics they are familiar with. Cognitive gains and normative expectations can be expected to impress upon the respondent how they *should* respond on such values measures.

If such findings are not triangulated with a person's related actions and behaviours, how the individual *interprets and enacts* the values being measured cannot be known (Bardi et al., 2009; Bardi & Schwartz, 2003; Farmer & Dyne, 2010). Rest (1994) summarized findings from several studies in psychology and noted that these findings supported only a modest correlation between a person's cognitive understanding of the right thing to do and their actions.

Unfortunately, no contemporary research using direct observation or interviews eliciting concrete examples of behaviours representative of values being enacted in practice settings, could be found in the literature. However, Williams et al., (2012) presented very positive findings from a qualitative study designed to ascertain the learning gains of graduates of a context-based learning BN program in Alberta. The authors described this as

> transformational learning … based on active, realistic experiences that engage students in self-directed inquiry and critical thinking... students assume the role of a registered nurse as they work in small peer groups to discuss real practice scenarios on a daily basis in the classroom. (Williams et al., 2012, p. 417)

These graduates (some up to ten years post-graduation), accredited the program design with better preparing them for professional practice, compared to graduates of more traditional nursing programs. The graduates believed themselves to be self-directed learners who were more effective advocates for patients and the nursing profession. Whether these students actually practiced in the way they reported in the interviews cannot be validated. The fact that the majority of these students had engaged in continuing education and offered examples of leadership activities (Williams et al., 2012) does support aspects of PNI enactment in practice.

The Link between Identity, Values, and Personality

As discussed above, personality and values are both considered components of identity. While there can be correlation between certain values and personality traits, such as being open to new experiences being negatively correlated with the values of security and tradition, it should be noted that traits and values serve different purposes and exert different influences related to our choices and behaviours (Olver & Mooradian, 2003). We assign importance to our values, which represent stable goals and act as guiding principles. Our values are more open to change over time as a result of our life experiences, compared to our traits (Roccas, Sagiv, Schwartz, & Knafo, 2002). Values are viewed by the individual as desirable whereas one's personality traits may be viewed as positive or negative and are largely seen as beyond the person's realm of choice. Another important distinction is the fact that values serve as justifications for our choices and actions, and they are the standards we use to evaluate others' behaviour (Olver & Mooradian, 2003; Roccas et al., 2002).

Professional Nursing identity as Perceived by Self

A secondary theme which emerged from the integrative analysis was that PNI comes from within the self, or from the internalized feeling of being a nurse (Öhlén & Segesten, 1998; Ware, 2008). Professional nursing identity was essentially an individual's sense of "what it means to be and act as a nurse" (Fagermoen, 1997, p. 435). Thus, in order to adopt the identity of *nurse*, the individual must first personally define this identity and its associated values and internalize these into their self-concept (Blumer, 1969; Fagermoen, 1997; Stryker & Burke, 2000). How one initially conceptualizes the image of a nurse in the generic sense is influenced by personal values and the public perception of nursing. These early impressions served to attract or dissuade a person from considering nursing as a career option. For those choosing to enter a nursing program, these initial beliefs then have the potential to be modified through educational and social experiences in both classroom and clinical practice settings.

Professional Socialization's Influence on PNI

The integrative review revealed that nursing scholars view socialization as an important influence on PNI development. Nursing researchers from AUS (du Toit, 1995; Grealish & Trevitt, 2005), Sweden (SWE) (Ohlén & Segesten, 1998) and CA (Reutter, Field, Campbell, & Day, 1997) discussed socialization primarily as related to the interactions of students with others in practice settings. In nursing education today, students learn in real and virtual classroom, laboratory, and practice environments. Hands-on clinical education takes place in healthcare settings where students engage in nursing activities with patients and families alongside healthcare practitioners. Benner's (1984) influential theory regarding the process of moving from novice to expert nurse is founded on the Dreyfus model of expertise development that advocates situated learning for the development of a skill via experience (Benner, 2004). In general, BN students have indicated that practical experience was the most valuable part of their education (McAllister et al., 2007; Ralph, Walker, & Wimmer, 2009; Papp, Markkanen, & von Bonsdorff, 2003). Socialization of the student or NG into nursing culture is best accomplished via learning in "real" practice environments (du Toit, 1995; Reutter et al., 1997).

The two most common models of clinical instruction are students being supervised in a group by a clinical instructor employed by the educational facility or being supervised one-on-one by a preceptor who is a nurse employed by a hospital or by some other healthcare employer (Gaberson & Oermann, 2010). The second model, the preceptorship model, was demonstrated to be the favored model used in Canadian clinical education by nursing educators, based on a literature review by Billay and Myrick (2008). Hartigan-Rogers, Cobbett, Amirault, and Muise-Davis (2007) found Canadian BN students also felt that preceptorship was superior to clinical group models. They believed learning with a staff nurse let them experience "the real world" (Hartigan-Rogers et al., 2007, p. 8) of nursing.

Many researchers have reported on the negative effects of learning in practice environments such as students experiencing moral distress, (Doane & Varcoe, 2007) feeling marginalized as a learner, (Jackson et al., 2011; Reutter et al., 1997) or the student

making choices that conflict with his/her beliefs about best practice (Reid-Searl, Moxham, Walker, & Happell, 2010; Smallwood, 2006). Common examples of the negative experiences associated with learning in the practice setting included students and NGs witnessing, or being asked to participate in, uncaring or unsafe practice, and experiencing bullying at the hands of educators, staff nurses, or physicians (Brodie et al., 2004; Doane & Varcoe, 2007; Jackson et al., 2011; Maben et al., 2007, Reutter et al., 1997; Thomas & Burk, 2009). Given the possible negative effects of socialization on the learner, the term *socialization* requires qualification. While some authors have presented socialization as an exclusively positive term and a primary goal of nursing education (du Toit, 1995; Reutter et al.,1997; Ware, 2008) others openly acknowledged the potentially negative effects of socialization. For example, Benner, Sutphen, Leonard, and Day (2010) used the term "formation" (p. 86) to represent positive effects of learning in the workplace and presented socialization as something that can exert positive or negative influence.

Clarke, Kane, Rajacich, and Lafreniere (2012) conducted a survey based on the 25-item instrument developed by Stevenson, Randle, and Grayling (2006) with 674 Canadian BN students across all four years of their respective programs. This tool was found to have high internal reliability with Cronbach's alpha coefficients ranging from 0.86-0.93. The authors found an average of 88.72% students experienced some form of bullying with third and fourth year students citing more incidents than those in their first two years of study. The identified sources of bullying were primarily clinical instructors (30.22%) followed by staff nurses (25.49%) (Clarke et al., 2012). The fact that the clinical nursing instructors themselves were the most likely source of behaviours perceived as bullying by these students is especially troubling. However, in a survey conducted with U.S. BN students Cooper, Walker, Askew, Robinson, and McNair (2011) using an instrument developed by the researchers that focused on 12 key bullying behaviours such as someone "yelling or shouting in rage"(p. 8), found classmates were the primary source of bullying. Cooper et al. (2011) defined bullying as

> long-term aggressive or negative acts or behaviours, carried out repeatedly over time, and directed at someone who finds it difficult to defend him / herself because of a relationship with the bully that is characterised by an imbalance of power. (p. 2)

Clarke et al. (2012) reported classmates as third most frequent source of bullying and did not define bullying but offered alternate terms such as "horizontal violence, relational aggression, incivility…" and proposed that, "Regardless of the label, all terms encompass negative and unwanted acts toward others" (p. 270). The ramifications of such experiences, given the importance of clinical learning in student PNI development have not yet been adequately investigated but is has been found that experiencing bullying causes one to consider leaving the profession (McKenna, Smith, Poole, & Coverdale, 2003).

Some authors noted that individual self-esteem and sense of professional self-efficacy was a precursor to PNI (Cook et al., 2003; Livsey, 2009; Öhlén & Segesten, 1998). Bandura (1986) defined self-efficacy as the personal assessment of one's ability to exert control over and succeed in specific situations. An individual's increased sense of professional self-efficacy was shown to promote and strengthen PNI (Fagerberg & Kihlgren, 2001; MacIntosh, 2003; Reutter et al., 1997). Öhlén and Segesten (1998) also believed healthy self-esteem through valuing of self, was essential to developing positive therapeutic relationships with patients. Central to increasing self-esteem and self-efficacy and thus, promoting positive PNI in students, were positive clinical learning experiences with supportive role models (Bradbury-Jones, Sambrook, & Irvine, 2011; Gillespie, 2002).

Hartigan-Rogers et al. (2007) examined Canadian BN students' opinions of their clinical learning experiences and discovered that the student experience can vary greatly between settings, with some offering fewer learning opportunities compared to others. Positive learning environments tended to be areas where more resources were available and where students felt more supported as learners compared to areas where nurses had fewer resources and seemed more stressed. In negative environments students felt unwelcome and felt that they had to continually prove themselves. Gillespie (2002) in a qualitative study with CA BN students concluded that feeling safe and connected to their clinical teachers allowed students to "focus on learning, synthesize knowledge, and integrate the ways of knowing, being, and doing that comprise clinical nursing practice" (p. 574). Conversely, when the student felt the teacher was disconnected and overly critical the student focused on pleasing them, thus reducing learning and professional

development. Experiencing a sense of belonging in clinical settings was credited with contributing to positive PNI development in several other studies (Bradbury-Jones et al., 2011; Brodie et al., 2004; Jackson et al., 2011; MacIntosh, 2003; Myrick et al., 2006; Pearcey & Draper, 2008; Secrest, Norwood, & Keatley, 2003).

Role models. Critical to this discussion is that educational approaches such as preceptoring, rely heavily on practitioners acting as role models (Myrick et al., 2006). In nursing literature, role models are primarily described as educators or practicing nurses with the latter depicted as exerting the primary influence on how students and NG come to view the nursing profession (Bradbury-Jones et al., 2011; Fagerberg & Kihlgren, 2001; Grealish & Trevitt, 2005; MacIntosh, 2003; Öhlén & Segesten, 1998; Reutter et al., 1997; Thorpe & Loo, 2003). It should be noted that although most of the discussion about role modeling focusses on clinical settings, it is also taking place in the student's other educational settings. Sawatzky, Enns, Ashcroft, Davis, & Harder (2009) asserted that "teaching excellence is reflected in role modeling caring in the classroom, clinical, and laboratory settings" (p. 262).

Professional Nursing Identity as Enacted

It was noted in the review of the nursing literature that one's PNI was often studied through self-assessment without qualification of how one enacted this identity in practice. This distinction needs to be made because although one can develop a cognitive sense of one's moral self, it has been shown that a poor correlation between these cognitive assertions and actions taken can exist (Darley & Batson, 1973; Maio, Olson, Allen & Bernard, 2001). This is a complex topic as researchers examining the relationship between values and behaviour have discovered that one's personal values, the degree of incorporation of these values into one's identity, the degree of activation of this identity in the context of a given moment, and social interactions all contribute to the resulting action that displays one's identity to others (Bardi et al., 2009; Farmer & Dyne, 2010; Verplanken & Holland, 2002). Thus, these various factors could result in a nurse's self-perceived PNI being different from the PNI enacted in a given moment.

Social normative pressures have repeatedly been cited by researchers in social psychology as a primary reason for acting in ways incongruent with the values we claim

to possess (Bardi & Schwartz, 2003; Bardi et al., 2009; Bernard et al., 2003; Farmer & Dyne, 2010; Lonnqvist et al., 2006). When one is presented with a situation that necessitates choosing how to act, perceptions about role expectations and the actions of others around them can influence the individual's chosen path (Bardi & Schwartz, 2003; Farmer & Dyne, 2010; Lonnqvist et. al, 2006). Bardi et al. (2009) offered the example of an employee being asked to comply with a request that is in conflict with a personally held value. Rather than resolving this conflict in a social vacuum, the employee includes role expectations and the cultural norms of the work environment when weighing their options. Witnessing another employee complying with the same request can exert a normative push toward compliance and can suppress self-direction (Bardi et al., 2009).

Studies with nursing students from the UK (Levett-Jones, & Lathean, 2009; Smallwood, 2006) and AUS (Reid-Searl et al., 2010) and NGs from the US (Kelly, 1998) supported the premise that social conformity and the desire to "fit in" caused students and NGs to comply with behaviours they knew they shouldn't exhibit. Similarly, researchers from CA (Myrick et al., 2006; Reutter et al., 1997) and AUS (Grealish & Trevitt, 2005) reported students remained silent, when witnessing bad practice or when subjected to disrespect from staff members.

Researchers in social psychology discovered that if a person values conformism or has been conditioned in the current social situation toward conformism, he/she will be more susceptible to behaving in a way that is inconsistent with his/her other values when conflicts arise (Lonnqvist et al., 2006). Thus, students or nurses who feel a need to conform may portray little correlation between their self-perceived PNI and the PNI they enact. Lonnqvist et al. (2006) also posited that despite the influence of conformity, individuals who possess a strong personal basis for the value being challenged are much less likely to conform to social norms, and that this choice was mediated by anticipated regret, or the personal weighing of how they will regret the "wrong" choices. These results were supported by the social psychology research of Bernard et al. (2003) who determined that creating self-relevant arguments for upholding a value made this value less susceptible to suppression if challenged.

This need to be personally committed to a value in order for it to influence our actions is congruent with Higgins' concept of *self-guides*. Higgins (1987) described the

ideal self-guide (p. 321) as the internalized desirable self or how we feel we *want to be* as people. In contrast, the *ought self-guide* (Higgins, 1987, p. 321) is based on values we are aware of but have not internalized, thus they are external constructs imposed upon us, telling us how we *should be*. Higgins (1999) also found that people felt personally remorseful when they did not adhere to the values associated with their ideal self-guide. Values not assigned self-significance were relegated to the *ought self-guides* and rather than remorse, people felt agitated or anxious when they violated these values, but only if this violation had been visible to others. In other words, these values mattered only when someone else was looking. To apply this theory from the field of psychology to nursing education, one can hypothesize that if a student accepts the values expressed in the CNA (2008) *Code of Ethics for Registered Nurses* only because they are mandated to do so by educators rather than as a result of reflecting on the personal relevance of these values, these values become *truisms* or something that is accepted as true and desirable without question (Maio & Olsen, 1998). These values would then be assigned to the student's *ought self-guide* and are less likely to be incorporated into their PNI, making them more easily abandoned in times of conflict.

Social psychologists Verplanken and Holland (2002) in a series of six studies revealed that values that had recently been cognitively activated and which were central to one's self-concept were more likely to influence behaviour. The authors explained that central values are those we associate with our self-concept, or identity, and these are tied to a stronger emotional response when a conflict arises. Thus we are more likely to remain constant to these values even if there is a perceived negative consequence to the self and we consistently enact behaviours representative of these values. Thus, to facilitate a positive PNI, values central to professional nursing need to become part of the student's or nurse's self-concept so that he/she are more apt to enact his/her PNI despite barriers which may be present.

Complicating the concept of PNI as Enacted is the fact that people have co-existing identities, or roles. For example, we can be committed to both the role of parent and employee and these roles can come into conflict, causing similar values held for each role to compete for an opposing choice (Stryker & Burke, 2000). Do we choose to complete a work project or attend the school play? Specific to this discussion, nursing

students have felt like they fluctuated between the identities of student and nurse (Lindh, Severinsson, & Berg 2007; Wilson, 1994) and the NG and practicing nurse assume the roles of employee and professional, two identities which often present conflicting values as previously cited. Identity theory explains that the identity that we feel is most salient in a given situation, or that which we feel more commitment to, will influence how conflicts are resolved and therefore, how we express our identity to others through our behaviour (Stryker & Burke, 2000). Thus, if a nurse or student feels aligned to his/her professional role in a given situation, he/she would be more likely to act in a way consistent with their PNI.

Factors contributing to PNI enactment in BN students. During the initial integrative literature review, special attention was paid to articles that addressed how BN students experienced enacting of a PNI. Rodney et al. (2009), in a thematic analysis of focus group data that included practicing nurses and BN students from Western Canada, reported that these participants faced conflicts in everyday practice that pitted their values against the norms of the practice setting. The authors explained that when the nurse or student could act in a way congruent with his/her nursing values, i.e. enacting their perceived PNIs, there was a sense of accomplishment and satisfaction with having done "the right thing" (Rodney et al., p. 301). Others who felt they couldn't enact their PNI, expressed feelings associated with moral distress, including feeling that they were delivering unsafe care and that they were powerless to address this. How these groups differed and what factors were key in contributing to a positive versus negative outcome was not explicitly investigated. However, in an article based on the same study by Rodney et al. (2009) Doane et al. (2004) concluded that when a nurse or student trusted their own assessment of a situation and viewed him/herself as moral agents, he/she was better able to find the "confidence and courage" (p. 250) to overcome power hierarchies and his/her own fears and enact his/her PNI at times when nursing values were in conflict with the agendas of others.

Similar to the findings by Doane et al. (2004), Jackson et al. (2011) in a study with BN students in Australia, discovered that while some students considered quitting nursing education due to negative clinical experiences of aggression and witnessing poor nursing role models, others challenged the power hierarchies which allowed such

experiences to take place. So despite being exposed to similar risks to self, different students chose different paths. The authors believed the students who resisted the actions of negative role models were able to do so because they had a "sufficiently developed personal [level of] resilience and professional identity which enabled them to discern and respond to damaging behaviours in a manner that was productive and active, rather than harmful or passive" (p. 108). The authors did not describe how these students came to possess this "sufficient" PNI, i.e. the processes involved, or the factors that lead to one group's path being different from the other.

Proposed Description of Professional Nursing Identity

The following proposed description of PNI was generated based on the literature reviews:

> Professional nursing identity encompasses both the individual's sense of self as a nurse and the image of nurse they project to others. Born out of personal and professional values, PNI permeates the nurse's' being, influencing his/her choices and behaviours. PNI is mediated by internal factors of self-esteem and self-efficacy and by external factors related to interactions with others and the environment. These internal and external factors interact and modify PNI over time. (Enns, 2011, pp. 25-26)

Summary

Professional nursing identity is borne out of values and encompasses both the individual's sense of self as a nurse and the image of nurse he/she projects to others (Enns, 2011). There are established transcultural values associated with the profession of nursing including altruism, caring, and the promotion of human dignity (Fagermoen, 1997; Öhlén, & Segesten, 1998) and it is one's views about nursing and the perceived congruence to one's own personal values that attract certain people to nursing (Cook et al., 2003; Mackintosh, 2006; Thorpe & Loo, 2003). Students' values can change as the result of exposure to education and in particular to experiences in the practice setting, but researchers to date have not examined the process involved in any value changes noted, relying instead on instruments employing self-assessed, quantitative measures of mean-value change. Role models in the clinical setting appear to exert significant influence on the development of PNI and this process of socialization can have positive or negative

effects (Doane & Varcoe, 2007). When negative, some students and NGs may suppress their nursing values due to the silencing and disempowering positions in which they find themselves, and they may then be denied the opportunity to strengthen and/or express their PNI (Maben et al., 2007). Others may challenge the situation and remain true to their own values (Doane et al. 2004; Jackson et al., 2011).

The values a student, NG, or nurse state that they possess can come in conflict with the agendas of others (Austin, 2011). The co-existing roles of employee and professional contribute to the balancing of these conflicting values in the context of a given situation that results in a choice exhibited as an action or behaviour (Bardi & Schwartz, 2003; Stryker & Burke, 2000). According to studies in social psychology, generating self-relevant cognitive arguments for a value (Bernard et al., 2003), internalizing a value as central to one's self-concept (Verplanken & Holland, 2002), and reducing the value assigned to conformity (Lonnqvist et al., 2006) have all been shown to reduce the vulnerability of values to suppression in times of conflict. These relationships affecting the development of PNI have not been examined in nursing research to date. This study investigating PNI development constitutes one step to address the gaps in knowledge identified as a result of these reviews that relate to PNI development from the perspective of new graduates Canadian BN students.

CHAPTER III

METHODS

In this chapter, the purpose of the research and the research question are briefly presented followed by a description of the methods used in the current study. A rationale is offered for choosing grounded theory (GT) including the philosophical underpinnings of this methodology. The procedures used for sampling, recruitment, data collection, and analysis are outlined and samples of coding and reflective memos are offered. Finally, steps taken to enhance the rigour of the study and ethical considerations are presented.

Purpose and Research Question

The purpose of the study was to examine the process of professional nursing identity development in baccalaureate nursing (BN) education as informed by Manitoban (MB) new graduate BNs. The research question was, What is the process of Nursing Identity development from the perspective of newly graduated Canadian Baccalaureate Nurses?

Methods

For the study GT as outlined by Strauss and Corbin (2008) was determined to be the best approach to address the research question. Grounded theory is used to examine social processes, to discover patterns in these processes with the goal of explaining how the social world influences behaviour and interactions (Corbin & Strauss, 1990; Cutcliffe, 2005; Hall & Callery, 2001). In the current study, the process of NI development and the factors affecting this process were examined, thus GT was deemed a suitable methodology.

Philosophical Underpinnings

The ontological and epistemological foundations of GT are rooted in symbolic interactionism and pragmatism (Strauss & Corbin, 2008). Symbolic interactionism was described by Blumer (1969) as having three core assumptions: (a) people assign meanings to things and others which influence how they act toward them, (b) people develop meanings by interacting with others, and (c) interpretation occurs as a process which modifies these meanings over time. Strauss and Corbin (2008) cite Dewey's

(1929) position on pragmatism, which posits that problems spur on thought and this thought results in action. The outcome of these actions determines the merit of the knowledge applied, thus truth is relative and provisional. Driven by pragmatism, the researcher using GT applies methods for the goal of solving a problem (Hall & Callery, 2001) and the resulting theory is only seen as valid if it is useful for those to whom it applies (Cooney, 2011; Strauss & Corbin, 2008).

Recruitment and Sampling

A convenience sample of NGs working in Manitoba was sought. Additional inclusion criteria included individuals who: a) were English-speaking graduates of a Canadian Baccalaureate Nursing Program; b) had no previous nursing education (such as Practical Nurse or diploma-prepared Registered Nurse education) prior to enrolling in the BN program; and c) had worked as an RN or GN for approximately 24 months or less. Since recalling recent educational experiences is integral to the study, it was important that the participants be recent graduates.

A third party database search and email service offered by the College of Registered Nurses of Manitoba was used to email 200 potential participants (Appendix A). Unfortunately, this yielded no participants. Word-of-mouth through colleagues and direct contact with new graduates by the researcher, and the resultant snowball sampling, were the recruitment activities which yielded nine participants.

A unique and secure email address and cell phone number were provided to potential participants on a business card, with the selection criteria for the study included (see Appendix B). After contact was established, the participant was emailed a copy of the Research Information Letter for Participants (see Appendix C) and the Informed Consent Form (see Appendix D) to review prior to confirming participation. In the email response, participants were also encouraged to pose any questions about the study; none were posed. Once participation was confirmed, a meeting time and place for the first interview was chosen in collaboration with the participant.

Theoretical sampling. Following initial and subsequent data collection and analysis activities, participants who were considered best able to inform the emerging concepts and theory, based on the richness of their data provided, were re-contacted via email. Four of the six participants contacted replied, one via phone and three responded

to questions via email. One participant was approached for an initial face-to-face interview after preliminary analysis of the 8 previous interviews and thus was asked questions specific to the emerging theory. This theoretical sampling involved posing questions about emerging concepts to further develop the theory as is recommended by Strauss and Corbin (2008).

Data Collection

Data consisted of demographic information as well as recorded interviews, transcripts of these interviews, phone and email responses, and general notes written about the interview.

Interviews. Initial face-to-face interviews were set up in locations and at times convenient to the participant, generally in a private setting. In one case, the interview took place at a coffee shop at the participant's request. The participants were reminded that the interview was to be audio recorded and they each signed two copies of the Informed Consent. One copy was given to the participant to keep. To protect participant identities each was given the choice to either choose their own pseudonym or have one chosen for them. The form upon which this pseudonym was recorded was kept with the participant's signed consent and demographic information and stored separately from all participant interview data.

All nine initial interviews were conducted by the researcher using an unstructured approach. Participants were first asked demographic information (see Appendix E), which served as an ice breaker (Vandall-Walker, 2006).This information can enhance the thickness of the description and aids others in determining transferability of the findings to other locales (Polit & Beck, 2010). Following this, each participant was asked various open-ended questions as outlined in the Interview Guide (Appendix F) and the subsequent Revised Interview Guide for the five initial interviews conducted after January 17, 2013 (Appendix G).

Six interviews were transcribed by the researcher using Dragon ® software. Three interviews were submitted to a professional transcriptionist, Colette Lebeuf of CML Transcription using an online uploading system (Appendix H). Though time consuming, researcher involvement in transcription resulted in intimate knowledge of the data and facilitated reflection without the need to reread transcripts for recurring or related themes.

As mentioned, after analysis of the first few transcribed interviews, participants who were deemed to be the best sources of additional information were contacted for a second interview. Four participants were re-interviewed a second time and a ninth participant was recruited. Specific questions related to the emerging theory were posed to these five participants. One responded via a telephone call and three wrote their replies in emails as this was their preference. The 9th participant engaged in a face-to-face nterview. One participant offered a third email interview to clarify the researcher's interpretation of the participant's responses.

Notes. Notes were taken immediately after the face-to-face interviews to record overall impressions of the interaction with participants and the details that could not be captured in the interview data, such as details about the setting and demeanour (Montgomery & Bailey, 2007).

Analysis

Analysis, described by Strauss and Corbin (1998) as the "interplay between researchers and data" (p. 13), began as data were collected and it is this immediate and ongoing analysis that guided subsequent data collection decisions (Corbin & Strauss, 1990). In keeping with Strauss and Corbin's (2008) description, coding of the data did not occur in discrete steps despite the fact that the steps are described here as open, axial, and selective coding stages. The goal of analysis is a comprehensive theory, and additional tools for theory development were used, including analyzing for process and the use of a conditional matrix. Both coding and reflective memos were recorded in typed notes as these are also central to GT methods (Strauss & Corbin, 2008).

Open coding. Open coding is described as line-by-line reviewing of the data for the discovery of concepts, but Strauss and Corbin (1998) cautioned against taking this literally as it is the detail of that analysis which matters more than the unit of text. By detail, Strauss and Corbin (2008) meant that words carry various meanings and the researcher is to consider each of these when coding, rather than simply using the first interpretation of the word or phrase as the basis for a code. Initially, lines of text were separated to isolate concepts. These lines were then assigned one or two words that conceptually represented an interpretation of the participant's meaning in context (Strauss

& Corbin, 1998). All codes were linked to the raw data sources using either tags or links in the OneNote electronic notebook file, created for data management. Though it was attempted to move coding to table format and notes in MSWord ®, this method was found to be slower and more restrictive from a creativity perspective and so, OneNote was used for the remainder of the analysis.

Once a code was created, subsequent data which had the same properties and dimensions, were assigned this code and if the data did not match an existing code, a new one was be created. These codes were then be compared, grouped, and collapsed to form categories and subcategories (Strauss & Corbin, 2008). A sample of open coding and collapsing of categories is provided.

> Participants being told by others about their performance, is captured by the code "feedback". This was chosen as it was a term used directly by some of the participants and fit with data within all the phases that emerged. This information in the form of opinions about the participant's performance, or "feedback" from more experienced nurses was deemed especially important to their development. With further analysis, "feedback" became a subcategory of "feeling supported" and "feeling supported" became a subcategory of "beginning to belong."

Axial coding. The various concepts were then related to each other by assessing their properties and dimensions and the factors which effected actions and interactions (Hallberg, 2006; Clark & McCann, 2003). Strauss and Corbin (2008) referred to this as axial coding, which is not a discrete step that occurs after open coding is completed, but rather, is another way of thinking about the data that aids in theory development and can occur while open coding.

For example, axial coding helped in exploring the concept of the Environment revealing it to be a contextual condition that influenced the students' and NGs' experiences of the act of nursing, their interactions with others, the levels of support they experienced, and their ability to enact their values in practice. Further analysis using axial coding for this concept, helped reveal the various ways participants viewed the Environment, their levels of control over this influential context, and the various coping strategies employed to help them seek positive outcomes if the Environment was viewed as a barrier to their goals.

Selective coding and theory development. Again, rather than being a discrete analytic step, Strauss and Corbin (2008) described making theoretical comparisons and

using questions and memos as tools used throughout data analysis. To develop the theory, theoretical sensitivity came into play when examining the categories and integrating them, paying attention to how they were related, where they could be reduced, and the story being told. The evolving schema was arranged and rearranged in this way - a creative process - until a *core category* was revealed. This category, *Finding My Own Way,* related to all other categories and subcategories, appeared frequently in the data and was sufficiently abstract to meet the criteria outlined for a central category by Strauss and Corbin (2008). Tools applied to refine categories included developing a storyline using the concepts and diagrams (Strauss & Corbin, 2008).

Analyzing for process. As mentioned, GT is used to explore social processes that change over time. In order to code for process, analytical questions were reflected on such as how the conditions were changing relative to time and what connected one sequence of events to another. This reflection revealed the factors that caused movement or shifting in the concepts and outlined the stages or sequences that occurred within the phenomenon (Strauss & Corbin, 2008).

For example, participants were asked to compare their initial image of nurse with their views after entering BN education and then again to compare this to their current views. Participants were questioned about changes in their values, identity, and perceptions about self as RN, from the time they decided to pursue a career in nursing to their current nursing situation, in order to capture process and add to the quality of the resulting grounded theory.

The analysis for process revealed the four phases individuals move through from laypersons to RN; (1) Choosing Nursing, (2) Being the Nursing Student, (3) Becoming an RN, and (4) Being the New Graduate RN.

The conditional matrix. The conditional matrix is an analytical tool that helps the researcher examine the interplay of factors affecting the phenomena at various micro (individual) to macro (global) levels allowing for more complete theory development (Walker & Myrick, 2006; Strauss & Corbin, 2008). The primary focus during this part of the analysis was at the meso and micro levels of influence. Various levels of influence were examined to enhance the explanatory power of the theory. At the same time, axial coding helped reveal the relationships between these levels of influences. For example,

system-related policies influenced the number of patients a single nurse was assigned and this influenced the NG's access to nurses for support which influenced the process of identity development.

Memos. Memos were linked to the raw data using OneNote™ linking features to capture thoughts about the data as a form of "developmental dialogue" (Strauss & Corbin, 2008, p. 117), and to reveal preconceptions and biases which might have influenced the analysis. Additionally, these dated memos, in which decisions were tracked, served as an audit trail, increasing the trustworthiness of the findings. An example of a reflective memo follows:

> Still interesting as to why there is such a difference for some compared to others [about choice of unit to work on]. Why is caring about the welfare of children a reason some go into a pediatric area to help alleviate their pain, and these same values can cause someone to not be able to bear witness to the same pain? Ability to relate, wanting to understand the patient position was important to Janice so was this an important nursing value/priority? What stood in her way of enjoying the pediatric experience? Was she placing herself in the shoes of those who loved these suffering kids? I felt the need to relate to her position during the interview as it is one I share quite strongly and always have...I have long felt some guilt or failure, given I am obviously passionate about the welfare of children, but I chose a path that allowed me to ignore it as a way of coping with these strong feelings. I have no idea how people can watch a child die and go home and have dinner with their family.... I just could not work in a place with sick kids and have no idea how people manage to cope.

Ensuring Rigour

Morse, Barrett, Mayan, Olson, and Spiers (2002) described five activities for ensuring rigour in qualitative research: a) striving for methodological coherence; b) ensuring sampling sufficiency; c) developing a dynamic relationship between sampling, data collection, and analysis; e) thinking theoretically; and f) developing theory. Methodological coherence was addressed in terms of the coherence between the question, the grounded theory approach, the philosophical coherence between researcher and GT, as well as by being well-informed about the Strauss and Corbin GT methodology and analyzing until a theory is revealed. The procedures were re-examined during analysis for adherence to the GT approach.

To address sampling sufficiency participants were chosen based on their ability to best inform the topic, as much as was reasonably possible (Morse et al., 2002).

Recruitment was slow and all available and all candidates who met the selection criteria were accepted as participants. There was a lack of diversity due to all participants being female, educated in very similar MB nursing programs, and employed in hospitals and all but one in a tertiary care hospital. However, in terms of gender and work environment, this sample is reflective of nursing in Canada wherein 93.4% are female (Canadian Institute for Health Information, 2011) and 77% of work in either hospitals or other health facilities such as long-term care (Pyper, 2004).

As previously mentioned, theoretical sampling was undertaken to reveal conditions and variations within concepts to help increase rigour (Morse et al., 2002; Strauss & Corbin, 1998). An important aspect of variation is the inclusion of negative cases or those that represent an "extreme example of variation in a concept" (Strauss & Corbin, 1998, p. 212). There were a few examples of variations in the concepts related to how one came to define *connecting* and the interpretation of the benefits of accepting additional responsibilities, but no absolute negative cases were found in the data or sample. It would have been desirable to have more variation in the sample and subsequent data to increase validity. However, self-selection of the participants likely resulted in a bias toward NGs who may have been more likely committed to a sense of helping others and who therefore shared similar values, which were at the center of what was being investigated, thereby skewing the data toward being representative of more homogeneity than one would expect.

Collecting and analyzing data concurrently created an iterative process that allowed for self-correction via continuous monitoring of the analysis for congruence and fit (Morse et al., 2002). During the analysis, the data drove the process and if data did not support a hypothesis, the hypothesis was discarded to ensure the validity of the findings (Corbin & Strauss, 1990). Being alert and responsive to the fit of the data to concepts, helped to ensure that no conclusions were forced (Morse et al., 2002; Strauss & Corbin, 2008). Thesis supervisor feedback was also sought, and numerous discussions were engaged in about the research process as well as the analysis of concepts and categories, their relationships, and the emerging theory, to increase the quality of the analysis.

Research processes were recorded electronically thus generating an audit trail of the research activities. The use of date stamps on documents and coding sessions was

included. However, audit trails have limited use in confirming validity (Richards & Morse, 2007) and Morse et al. (2002) stated that audit trails cannot "ensure an excellent product, but only to document the course of development of the completed analysis" (p. 16). Memos and the decision trail contained therein are the greater contributors to validity (Morse et al., 2002; Strauss & Corbin, 2008). Strongly held beliefs and preconceptions about nursing education, values, and practice necessitated discussion with the thesis supervisor and careful attention to memos about coding decisions, and reflection about how often these preconceptions may have influenced the analysis. An example of such a reflective memo by the researcher follows:

> As an educator I have had the experience of some students saying they want feedback but can then be very resistant or defensive if this feedback is not entirely positive. Given how many participants felt it was important to be able to discuss their understanding or progress with someone deemed more knowledgeable….I wonder if some students are impeding their development by discouraging instructors from offering feedback b/c of their defensive responses or excuse making. This may stem from the evaluative relationship b/w student and instructor and their need to self-protect in order to make it through. The fact that some see themselves as powerless in the relationship makes this desperation make sense. Some deal with this by not presenting their case when feeling unduly criticized but others may attempt to cover-up a learning need to appear more competent/knowledgeable so they can protect their clinical grade. I find myself wondering this about the participants who complained about harsh or unapproachable instructors. However, I recognize that their experience is what is being studied and thus accept their experience at face value for the purpose of analysis… while recognizing the varying perspectives that may exist about the events being described.

Power dynamics in the researcher-participant relationship is a concept not explicitly mentioned in the qualitative criteria for rigor described by Morse et al. (2002) but some feel needs to be addressed when using a GT approach (Charmaz, 2000; Plummer & Young, 2010). Hall and Callery's (2001) suggestion of integrating theoretical sensitivity with reflexivity and relationality in order to address the power relationships were applied in the current study. The fact that the participants were peers helped to equalize the power dynamic. But, as several of the participants were known to me as former students with differing degrees of direct involvement, there was the fear that this prior relationship interfered with the ability of the participant to be completely honest. One of the participants with whom I had fairly close one-to-one interaction as an

instructor, seemed rather nervous during the interview. Reflective notes from this interview are provided.

> I wondered if our previous interactions set her off-ease. She offered long pauses to many of the questions and often replied with "I don't knows" so I could feel myself unsure as to how to draw her out at times, which I feared may have led to some over direction on my part. After listening to it back, my fears about the interview were confirmed and I even contemplated not sending it for transcription. In the end, I did, and recognized the value of having a variety of types of interviewees and hopefully learning about interviewing techniques as well.
>
> After reviewing the transcription, I realize I did not lead or rush the participant as much as I had feared. The pauses were many and at times were in excess of 10 seconds. I am impressed I was able to stay silent for that long, as it is not my forté! Still, why she had more difficulty responding is unclear and could have been related to any number of factors including her own confidence and conversational style and my lack of interviewing knowledge.

Ethical Considerations

Ethical approval for conducting this research was granted by the Athabasca University Research Ethics Board (AU-REB) on September 17th, 2012 (see Appendix I). A subsequent amendment was approved on January 17th, 2013 (see Appendix J) allowing for recruitment of new graduates at a conference being held in Winnipeg and for revisions to the Interview Guide. Informed consent was confirmed in writing, before any interviewing was conducted. The researcher introduced herself as a Master's of Nursing student and though she knew some of the participants when they were in their prior student role, the voluntary recruitment process helped ensure that anyone contacting her did so without any coercion, be they past student or not. All participants were informed about the measures to protect their identity including the removal of names and identifiers from the transcripts, the secure storage of data as per AU-REB protocol, and being assigned a pseudonym. For any published reports, the data will be presented in such a way that participants cannot be identified by others.

Potential benefits to the participants included the opportunity to explore and reflect on their educational experience and current practice. Reflection on one's practice is a requirement of the College of Registered Nurses of Manitoba (2012) Continuing Competence Program (CCP) and has been promoted as a way to improve professional

practice (Schon, 1987). Participants were able to report this activity in their yearly CCP portfolios if they so chose. In order to collect rich data, I asked them to explore thoughts or opinions that they may not have reflected on before, but none of the participants appeared uncomfortable outside of having some difficulty figuring out how to respond.

Digital audio recordings of the demographic data, interview, and interview notes were stored along with all research-related materials on a password-protected laptop computer owned by the researcher. Print data was backed up to the secure password-protected internet storage site, SkyDrive™ thus eliminating the risk of data being misplaced as can happen with storage devices such as a flash drive or disc. No identifying information was saved to this internet storage site, transcribed, or included in memos. Audio recordings were backed up to a password protected USB drive and stored in a locked filing cabinet. The pseudonym key, consent and demographic data forms were kept secure in separate files and will be destroyed after five years as stipulated by the Athabasca University REB (2009), so by December 31st, 2018.

Summary

In this chapter, the methods chosen were presented as most appropriate to address the purpose and research questions posed. Grounded theory methodology as outlined in this chapter was applied to the best ability of the novice researcher and was enhanced by the support of a researcher more experienced in GT methodology. Limitations imposed by the homogeneity of the sample were discussed and analysis procedures along with examples were offered to increase transparency for those appraising the current study. Strategies used to enhance rigor and improve the quality of the resulting emerging grounded theory, FINDING MY OWN WAY, were included. The steps used in adhering to ethical guidelines were outlined.

CHAPTER IV

FINDINGS

In this chapter the findings resulting from analysis of the data are presented. An overview of the proposed and preliminary grounded theory of Nursing Identity (NI) Development, entitled, FINDING MY OWN WAY is described first, including remarks about the contextual factors that influence NI development and the four phases of the process of NI development: (1) **CHOOSING NURSING**, (2) **BEING THE NURSING STUDENT**, (3) **BECOMING AN RN**, and (4) **BEING THE NEW GRADUATE RN**. The context of Personal Identity, participant characteristics, and Environmental factors related to the educational program and healthcare systems are then reviewed in detail, followed by a comprehensive discussion of the four phases of the process of NI development (see Figure 1).

NOTE: All pronouns used will be in the feminine forms since all participants were female. Also, the choice of the singular "my" for the proposed preliminary theory, reflects the singular and unique journey of NI development that an individual experiences within the collective experience of NI development. Throughout this chapter, when the term "theory" is used, it refers to both a "proposed" and a "preliminary" grounded theory. Inclusion of the term "preliminary" is considered necessary as a result of sampling constraints that prohibited saturation of data and adequate theoretical sampling. As the participants in the study were practicing in the role of Registered Nurse, the acronym RN is used when discussing findings which relate to the scope of practice and role expectations. In their responses, participants did not qualify diploma-prepared RNs from degree-prepared RNs nor did they distinguish RNs from Licensed Practical Nurses (LPNs). The participants only used the term “nurse” and could have been referring to a nurse from any three of these levels of educational preparation. Thus, for findings related to relationships with other nurses, the term “nurse” will be used when it is unclear what level of nurse is being referred to.

Acronyms such as NI to represent Nursing Identity, and NG to represent New Graduate will be preceded by the article “a” as these are less familiar terms, and thus the reader is likely to read them as full terms rather than as the representing acronyms. However, given the familiarity of using the acronym RN to represent Registered Nurse,

the article “an” will be used prior to RN as the reader is likely to read this as the acronym itself.

Overview of the Proposed and Preliminary Grounded Theory: FINDING MY OWN WAY

The proposed grounded theory, entitled FINDING MY OWN WAY is presented as a preliminary explanation of the process of Nursing Identity (NI) development from laypersons to new Registered Nurse (RN). This theory is comprised of the four-phased process engaged in by individuals within the context of a) Personal Identity (personal values, attributes, and characteristics), b) the Environment which encompasses macro, meso, and micro levels. c) Meanings assigned to experiences, and d) Choices and Actions taken based on these meanings.

Individual Personal Identity is central to the process of Nursing Identity development, and as such, constitutes an integral contextual factor in FINDING MY OWN WAY. Personal Identity is comprised of personal understandings or perceptions about one’s values and attributes as well as such characteristics of age range, sex, and nursing experience to name a few, and helps define for each individual who she IS as a person. In other words, the individual has a sense of personal identity that includes values, i.e. what matters and is meaningful to her, and which therefore influence each phase of the individual’s Nursing Identity development. This means that although individuals experience a similar Bachelor of Nursing (BN) education, unique meanings are generated from one’s interpretation of these experiences based on the context of one's Personal Identity and results in the individualized journey of NI development of FINDING MY OWN WAY from layperson to RN.

An important distinction exists between NI that is a perception of who a nurse SHOULD BE - the Ideal NI, and the NI that the Nurse enacts - the Lived NI. Abstract values and ideals create the perception of who the person as nurse SHOULD BE. This image of who the person SHOULD BE remains relatively constant during all phases of NI development and influences meanings created about educational experiences, including how she will view other nurses whereas the perceptions of the duties and responsibilities associated with the role of RN is amenable to modification by educational experiences. Finally, the HOW of nursing is added to identity development once she

experiences, first-hand, the RN practice setting and discovers HOW BEING and DOING can be enacted thereby translating the Ideal NI into the Lived NI.

Personal Identity in combination with the Environment at all levels and including the social interactions in these Environments, result in a collection of experiences for each Nursing Student or NG/RN. In turn, these experiences are subjected to the Nursing Student's or NG/RN's unique perceptions in the moment, resulting in the creation of Meanings for her about these experiences which then influence her Choices and Actions. It is in choosing and acting that the Nursing Student or NG/RN translates her NI into a unique Lived NI. This journey of NI development involves four relatively linear, interrelated, overlapping, and somewhat recurring: (1) **CHOOSING NURSING**, (2) **BEING THE NURSING STUDENT**, (3) **BECOMING AN RN**, and (4) **BEING THE NEW GRADUATE RN**.

The first phase in FINDING MY OWN WAY is **CHOOSING NURSING.** During this phase, the, context of Personal Identity exerts a great deal of influence, as the layperson is *ALIGNING* nursing with her a) ***Personal values*** b) ***Personal preferences*** and c) ***Personal attributes***. Nursing is viewed as a career that provides individuals with a way to live out ***Personal values*** associated with connecting with others and making a difference. Also, people who choose nursing have a ***Personal preference*** for being associated with a career that is seen to be respected, dynamic, and stable with a variety of practice opportunities. Based on aligning ***Personal attributes***, she chooses nursing as being a "good fit" and the assessment that she has the attributes and aptitudes to be an effective nurse.

The second phase, **BEING THE NURSING STUDENT** begins once the person has chosen nursing and to begins nursing education. The Nursing Student Identity is a prerequisite identity to becoming an RN but is quite distinct from the RN identity. During this phase, the Nursing Student is ***Experiencing*** a) ***Formal Learning,*** b) ***Nurses***, and *c)* ***Clients***. These experiences occur in the educational and healthcare Environments and result in new meanings being created, and as a result, there is a *REFINING* of NI. While **BEING THE NURSING STUDENT,** the individual ***is on the Outside*** and she is working at ***Getting through.*** This requires engagement in ***Passing courses and the Nursing program*** and ***Protecting self***. Thus, while **BEING THE NURSING STUDENT**, one is being

most influenced by the Environmental context of the educational program, and to a lesser degree of the healthcare system, including the persons, policies, and procedures, which all encourage conformity. Meanings from experiences are modified by each Nursing Student's Personal Identity and thus, results in unique educational experiences for each Nursing Student within the framework of this proposed theory.

The third phase in FINDING MY OWN WAY begins when the Nursing Student is immersed in the nursing work Environment during senior practicum as a Senior Student and continues as she first works as a NG/RN. This important phase of **BECOMING AN RN** is when ***Experiencing RN reality*** first occurs and results in a *REDEFINING* of NI in order to meet new expectations. When in this final course, the Senior Student finds herself ***Letting go*** of some of the facets of her Ideal Nursing Identity as her Lived NI unfolds. New experiences within the RN's reality reveal ***Gaps in her knowledge***. During this period the Senior Student/NG is ***Beginning to Belong*** to the RN collective identity by increasingly a) ***Feeling competent and confident*** and is also fitting in with the nurses in the work environment by b) ***Feeling supported*** which is facilitated by employing the strategies of c) ***Carrying a full load*** and d) ***Avoiding ward politics.*** Thus the Senior Student/NG remains influenced by the Nursing Student identity and feels the need to conform in order to belong and to adjust to new expectations. Conformity is now being influenced most by the practice Environment. Personal Identity is exerting more influence now compared to when **BEING THE NURSING STUDENT**, as the Senior Student/NG often chooses an area for her senior experience that she feels is a good fit to her characteristics and attributes. She also becomes increasingly independent and less supervised as she progresses through this phase.

The fourth and final phase, **BEING THE NEW GRADUATE RN** is a time when the NG/RN's Personal Identity exerts even greater influence in combination with the Environment, than in Phase 3, as there is an increase in autonomy and she no longer must meet the expectations of the educational system. This allows for a *CUSTOMIZING* of her Lived NI***.*** During this time, the NG/RN begins ***Separating from the Nursing Student identity*** by ***Assuming RN responsibilities*** and she begins ***Describing self as nurse***, and exploring ***Nursing My way.*** The NG/RN's originally aligned value of connecting with others to make a difference is still part of what she thinks she SHOULD BE and so is also

Connecting to find meaning by ***Stealing moments*** and ***Attending to the little things*** during this phase. In so doing, she is *CUSTOMIZING* her NI by adapting that which she learned through education and experiences to suit her personal preferences. However, increasing awareness about the limitations imposed by the Environment results in increased awareness of the factors that contribute to ***Disconnecting*** from clients at times. As each NG/RN creates new Meanings through experiences, she is making Choices and taking Actions thus creating a unique Lived NI that encompasses her Personal Identity and informs her own way of nursing.

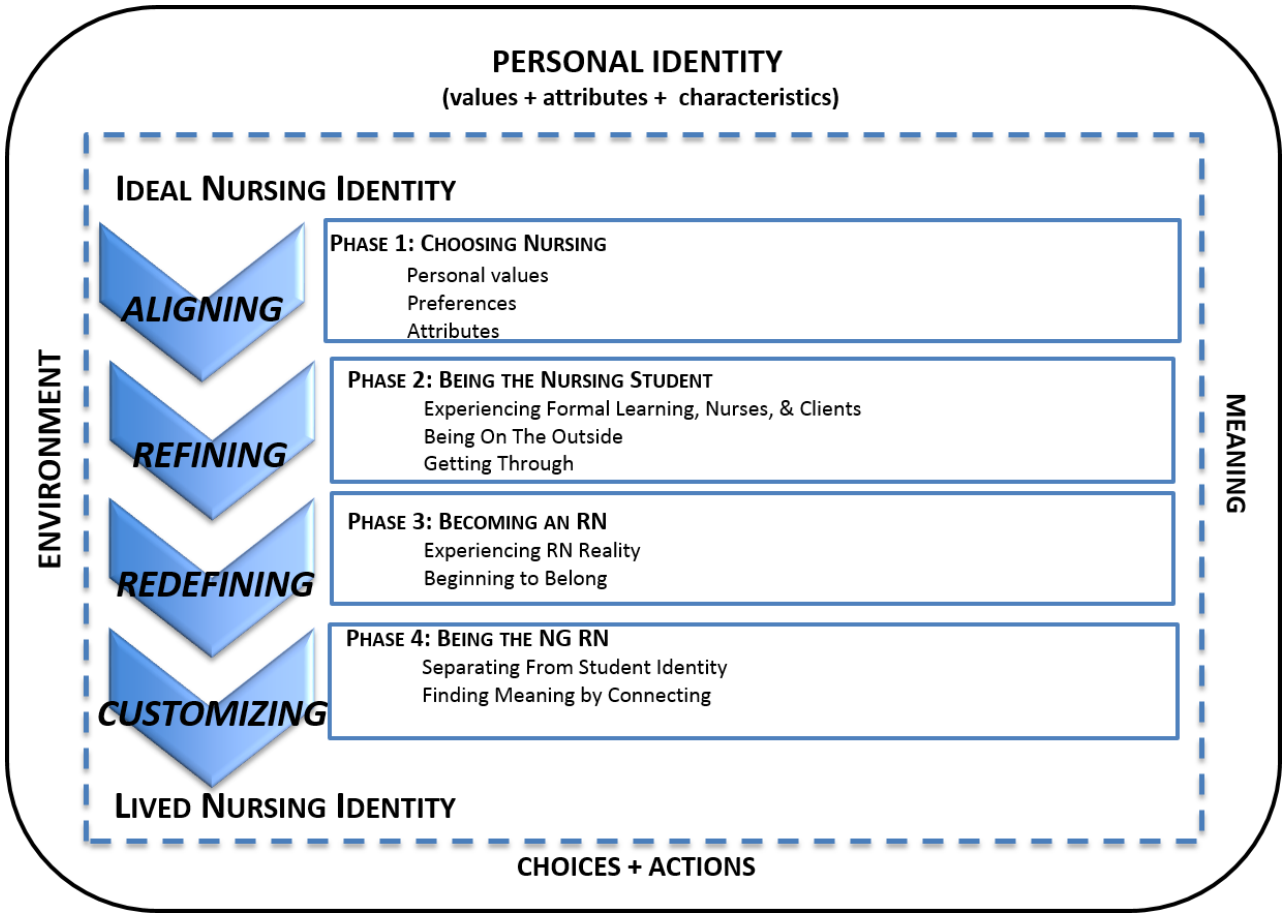

Figure 1. Theory of NI Development**:** FINDING MY OWN WAY

The Context of Nursing Identity Development

In the provisional grounded theory of NI development, entitled FINDING MY OWN WAY, the process of NI development is influenced by four contextual factors. The first, Personal Identity, includes the personal values, attributes, and characteristics of the individual. The second, Environment, includes macro, meso, and micro environments. Meanings assigned to experiences, and the Choices made and Actions taken based on these meanings, exert further influence on the process, but at a sub-contextual level. Each of these factors is presented, including discussion about how and at what stage, they exert influence on the process of NI development.

Personal Identity

Before entering nursing education, each person has an existing identity encompassing personal values, and attributes and characteristics. This identity modifies the process of NI development by creating expectations and forming the lens through which experiences are viewed. Because new information from subsequent experiences is processed through existing perceptions, the information is individually modified and creates unique meanings over the journey of FINDING MY OWN WAY to a unique NI. Consequently, NI is created through a process of becoming a newly formed but ever-evolving component of one's Personal Identity. The person is now an RN in addition to any previously held identities.

Values. Internally, one's sense of self, or Personal Identity, centers on what one believes to be most important to them as a person, i.e. their personal values. The image of self and of nursing helps shape the person's experience by creating a sense of "fit," or alignment between self and the image of nurse held by each person. As individuals, there are nuances in how the abstract concepts of personal values are conceptualized as behaviours or actions. For example, caring for and connecting with others can exist as differently understood or enacted concepts for different people. Notwithstanding, each individual develops a picture of an Ideal NI. This Ideal NI is an imagined ideal based on an individual's value-based perception of who nurses OUGHT TO BE. This ideal represents what the person aspires to become as an RN and forms the expectations

against which the person evaluates herself, other nurses, educational teachings, and healthcare Environments.

Attributes. The individual imagines attributes required of nurses and compares these to the attributes they believe themselves to possess. These beliefs about their own attributes may be based on feedback from others or achievements and the resulting perceived aptitudes. If the alignment between their self-assessed attributes is sufficient, this makes nursing a good fit and promotes **CHOOSING NURSING.** Additionally, the attributes they perceive as representative of an Ideal NI, such as being approachable and caring, influence how they come to view other nurses.

Characteristics of the participants. Personal characteristics include such information as, the participants' age range, sex, and current number of positions held as a NG/RN, to name a few. All the characteristics influence individual's perceptions and understanding of who they are, integral to their individual identity. This information is presented here to provide the reader with additional contextual information for understanding the source of the data, and are not discussed specifically in terms of how these characteristics influence NI development.

The nine participants, all female, were graduates within 24 months of the interview, of a BN program in Manitoba. All were graduates of either the 4-year Baccalaureate (BN) program at the University of Manitoba or the Joint Baccalaureate Nursing (JBN) program of Red River College and the University of Manitoba. In the JBN program the first 3-years of study take place at Red River College and the fourth year takes place at the University of Manitoba.

Participants' ranged in age from 20-30 years, except for two who were between the ages of 31-40. At the time of the interview participants worked in tertiary care settings with practice areas encompassing: Emergency Neonatal Intensive Care unit (NICU), Family Medicine, Acute Medicine/Family Medicine, Geriatric Medicine and in Long-term Care. Three participants had been practicing for between one and six months and the rest between seven and 12 months. For all but two of the participants the position they were employed in as a Graduate Nurse or RN at the time of the interview was their first position since graduation. Employment varied from part-time (expressed in percent equivalent of full time [E.F.T]) for four participants, to full time for five participants.

Two participants had experience working as health care aides (HCA) prior to enrolling in baccalaureate nursing education and one took a HCA position once she began her BN program and continued in this role during her education. Another participant had worked in medical records prior to entering her nursing program. Two participants held non-health related credentials prior to enrolling in nursing education: one a baccalaureate degree, the other a diploma. Many had enrolled in certificate or workshop education courses since graduation but none were enrolled in a post-graduate program. Selected demographic information is summarized in Table 1.

Table 1
Participant Demographic Information.

	Participant Pseudonym								
Characteristic	Janice	Coreana	Nicole	Elle	Joanne	Summer	Lynn	Raven	Marie
Year graduated program	2012 BN	2012 BN	2012 BN	2012 JBN	2012 JBN	2012 JBN	2012 JBN	2011 JBN	2012 JBN
Previous education	No	No	No	No	No	No	No	Yes	Yes
Age range	20-30	20-30	20-30	20-30	31-40	20-30	20-30	20-30	31-40
Months of practice	7-12	1-6	7-12	7-12	1-6	1-6	7-12	7-12	7 to 12
Previous healthcare/ health related field experience	No	No	No	Yes <6 months	Yes 15 years	No	No	Yes 4 years	Yes 10 years
More than one Position Currently	No	No	No	No	No	No	No	No	No

The Environment

External to the individual, the Environment directly influences NI development at the micro, meso, and macro levels. Health care and educational Environments where nurses work and students learn, are created within a societal context and this context permeates the individual's experiences. For example, at the macro level, Canadian societal norms influence governmental policies which in turn help shape the meso level

of health care and educational organization and prioritization. Within these larger systems, individual healthcare and educational facilities will have subcultures that impress varying messages upon the people interacting with and within them. Within these specific institutions, various nursing courses and nursing areas will also carry messages specific to the prevailing culture of the people and routines found there.

Specific to the current study and at the meso environmental level, the BN and JBN educational programs from which participants graduated existed as Environments that determined to a large degree, what the participants would experience as they learned about nursing. These two programs were affiliated with one another and used similar curricula and teaching methods and these methods which are categorized here as *traditional BN education.* The primary method of information delivery in this traditional BN education is through didactic lecture in the classroom with technical skills practiced in laboratories. Nursing students attended clinical practice associated with certain content courses being studied, generally designed around medical practice areas such as surgery, medicine, or pediatrics. The organization of the learning material for both programs is based on the traditional medical model and thus is focused on the physical and biological aspects of life stages and specific diseases and conditions. One distinction between the programs is that the JBN students began their clinical practice in the first year of their program while the U of M students engaged in general university studies during their first year with clinical experiences introduced in their second year. In their fourth and final year, the JBN students attend classes at the U of M; thus all participants took courses at the U of M for their final year of study. At a more micro level of influence, individual educators and other nurses send messages through their actions and behaviours to the developing nurse.

All of these levels of influence should be taken into account when considering the contextual influences on the identity development of the nurse. Though the current study focuses primarily on the meso and micro-levels of influence it is not to be forgotten that the more macro influencers create the reality in which these other levels exist. Experiences within these Environments create Meanings which are filtered through individual's Ideal NI. Additionally, Environments may advantage or disadvantage certain Choices and Actions and the eventual Actions taken come to represent Lived NI. Thus,

NI is lived out within varying degrees of alignment- from dissonance to accord, between the Ideal NI and the eventual Lived NI. The NG/RN eventually discovers what works for her within the context of her individuality and the unique Environment in which she is **BEING THE NG/RN**.

Meanings Assigned to Experiences

Experiences while developing a NI take place within the context of the aforementioned Environments and therefore, the Environment greatly influences these experiences by determining who the Nursing Student and New Graduate will interact with, the type of work she will do, and the objectives she will be expected to meet. However, though the Environmental context may be the similar, each Nursing Student or NG/RN creates unique Meanings from the experiences within these Environments due to the contextual influence of each one's Personal Identity generating perspectives and interpretations unique to her. These Meanings that are generated then serve to inform the Nursing Student's or New Graduate's subsequent experiences, creating a cumulative effect of experiential influence on NI development.

Choices and Actions

By combining Meanings created based on previous experiences with the perceptions about the current experience, the Nursing Student or New Graduate makes Choices and takes Actions. These Choices and Actions are therefore directly influenced by the Nursing Student's or New Graduate's interpretation of her own identity, the Environment, and the Meanings she perceives as relevant in the moment when the Choice is being made. These Choices and Actions then alter this experience and have the potential to create new Meanings. This interplay between the contexts of Personal Identity and Environments and the resulting unique Meanings assigned to experiences upon which Choices and Actions are undertaken becomes an iterative process that by nature is unique to each individual and influences each phase in the process of NI development.

New Proposed Description of Nursing Identity

Nursing Identity (NI) exists as two constructs, the Ideal NI and the Lived NI. Ideal NI is unique to each person, is relatively stable and represents who a person believes she should be as the RN. Lived NI develops uniquely for each person over time via the following iterative process: Personal Identity modifies how experiences within the Environment are perceived and thus, modifies the Meanings created from these experiences. In subsequent experiences, these Meanings inform Choices and Actions and these Choices and Actions represent the RN's Lived NI at that point in time and also serve to alter this experience.

The Process of Nursing Identity Development

Four relatively linear, interrelated, overlapping, and somewhat recurring (1) **CHOOSING NURSING**, (2) **BEING THE NURSING STUDENT**, (3) **BECOMING AN RN**, AND (4) **BEING THE NEW GRADUATE NURSE**. Following, is a comprehensive discussion of each phase, including the categories and sub-categories revealed for each. For each phase, an overview of the theory which emerged from the analysis is first presented followed by a presentation of the detailed findings including examples of the data from which the theory was developed.

Phase 1: CHOOSING NURSING

The decision to enter a nursing education program is based largely on one's perception of the degree of "fit" between the image of nurse held and one's Personal Identity. In other words, the potential student is *ALIGNING* her Personal Identity with the imagined identity and practice of the nurse. Primarily, this *ALIGNING* focusses on the individual's ***Personal*** a) ***Values,*** b) ***Preferences*** and c) ***Attributes*** (see Figure 2). For example, nursing aligns with the ***Value*** of wanting to "make a difference" as it is viewed as a meaningful and altruistic career choice through which the nurse can exert a positive influence on the lives of others. Meaning is found in the choice of nursing due to the perceived value-aligned opportunities to form connections and be influential in the lives of others.

The person aligns her ***Preference*** for being associated with a career which is seen to be a respected, dynamic, and stable with a variety of practice opportunities with her

perception that nursing is a career with these properties. Also, if the potential student believes she possesses qualities and aptitudes which she sees as necessary to be successful as a nurse, she is also **CHOOSING NURSING** as a good "fit" and believes she has the potential to succeed in the role of RN. Within this concept of *ALIGNING* Personal Identity to nursing, various areas of nursing are perceived as more or less aligned for the individual in terms of the types of clients and type of nursing care required. Thus, one's perceptions of self and of various areas of nursing can continue to influence the act of *choosing* as the person is constructing her individual NI over time.

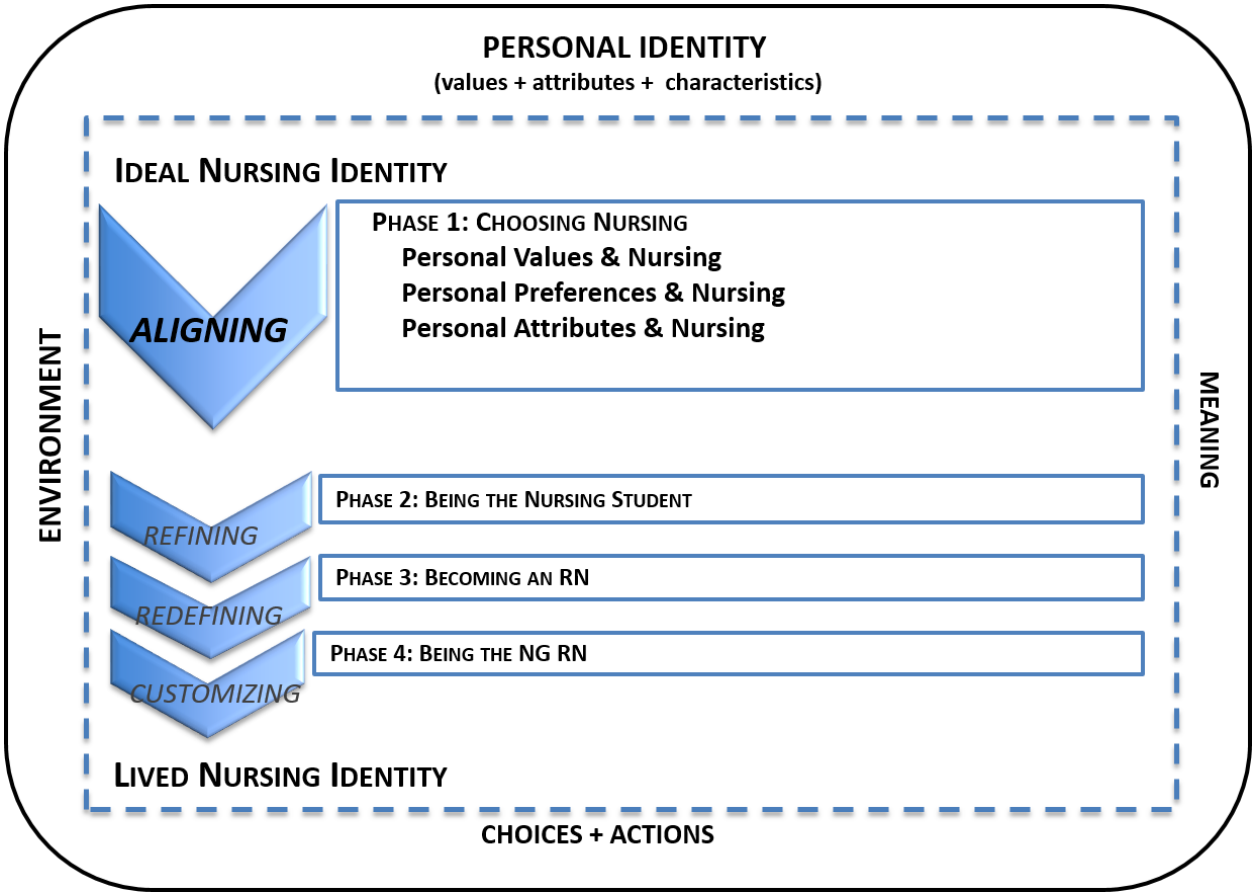

Figure 2. Phase 1: CHOOSING NURSING

Personal values and nursing. Motivations for choosing nursing voiced by participants included a desire to "make a difference," "care for others," and "connect in a meaningful way." When asked why they felt nursing was a good fit for them, participants tended to align their view of nurses as caring, compassionate persons with their own perception of self as caring and compassionate. The participants desired a career that would be meaningful to them and that would enable them to live these values out. This was described as a personal priority by Lynn, "*It's always been important for me to feel like I'm making a difference."* Janice stated it simply as "*I wanted to enter nursing because I wanted to care for people and have the privilege of being able to impact on someone's life in a certain way."*

Others recognized family-instilled values as aligned with their image of nursing. Nicole noted that her family took pride in having careers in public service and she always knew she would work in a field like nursing or social work *"Both my parents did jobs that helped people… they taught me to care for others."* For Summer, nursing role models in her extended family were influential in her desire to enter nursing as well.

When asked why "making a difference" or "caring for others" was a value that mattered to them personally, participants did not articulate a specific reason other than to say as did Lynn, that *"I have always been a caring person"* or as did Elle, *"I was just always told I was an empathetic person."* Summer attributed *"being caring"* to her personality and cited an example, "*I guess personality-wise, even with my own grandparents, doing things for them, taking them to a doctor's appointments. This, that, and everything else. So it's just my personality."*

However, most participants had difficulty finding examples of actions they undertook that demonstrated that they were caring. Instead, it was expressed as a more abstract and accepted truth about themselves, as articulated by Raven, "*I don't know, just that I was always a caring person. I don't know what it is that I do exactly."*

Personal preferences and nursing. Participants viewed preferred career choices in terms of status and societal image and this factored into the decision to choose nursing, as a respected, dynamic, stable career with a variety of practice opportunities**.** Janice stated, *"I'm really proud of it* [being a nurse] *and I think it's really respected when I tell people too."* Some level of prestige and a positive societal image associated with nursing

were factors that made nursing an attractive choice as noted by Raven who said a nurse is, "*someone that's well-respected, knowledgeable, a people person."*

Other lifestyle values that participants mentioned as influential in their choice of nursing as a career were the flexibility of hours and the freedom associated with job security. Participants viewed nursing as a dynamic, interactive alternative to the less desirable image of an "office job" as expressed by Janice, "*I didn't want to be working in a cubicle."* Janice went on to explain that nursing was also an alternative to the routine of a 9-5 existence, "*But I definitely like the hours and that it was all over the place and it's flexible."* It was clear that prior to beginning nursing education all held the view of the nurse as being employed in a facility and working shifts.

The variety of opportunities available to nursing graduates also appealed to participants in addition to the prospect for flexibility and stability. As Lynn stated, "*I don't always have to work full-time, and I can go anywhere. I don't plan on staying in* [the city] *forever, and I don't have to with this job."* Raven felt nursing offered her a reliable and permanent security: "*I needed something to be independent, to rely on, something that nobody would be able to take away from me."*

Despite job security being cited, participants did not voice financial security as a motivator for choosing nursing for example Nicole stated, "*You always have a job with nursing.*" However, if money as a motivator was mentioned, it was to describe others who had chosen nursing for, as Elle put it, "*the wrong reasons*." Raven also felt monetary motivations would not be sufficient to keep a nurse satisfied.

> *If you're in it for the money, then you're not going to be satisfied with your job. Because you want to be able to help people and enjoy that because you deal with a lot of people and a lot of crap out there sometimes. You've got to really want to do it.* (Raven)

Additionally, aligning Personal Identity with preferred working conditions resulted in participants believing they would enjoy certain areas of practice more than others. This was often not known until directly experienced, but primarily the choices were based on the clients encountered in certain practice areas and the participant's perceived ability to relate to these clients as well as her perceptions about the type of nursing care required.

Coreana's experiences working with younger people prior to entering nursing education influenced her choice to practice nursing with this population, while one fellow student who had worked with older people chose a geriatric setting. Summer, who had worked with children and wanted an opportunity to work with families, chose areas that she perceived as offering this type of opportunity. Summer commented, "*I always go back to the caring and teaching and wanting to be working with families. Palliative Care was my first choice, and then NICU was my second choice."*

Personal attributes and nursing. Weighing different career options highlighted participants' views about what they felt nursing had to offer them, and what they could offer to nursing. Reflecting on her decision to enter nursing education, Summer said, "*I thought nursing would be a good fit… personality-wise."* Coreana was weighing her options between nursing and a career in medicine. She saw nursing as offering a deeper level of "connectedness" than the role of physician, while being a good fit with her aptitude in biological sciences.

> *I considered going into medicine but I felt that you don't get that patient interaction and get to develop that therapeutic relationship with them and I just find that with doctors they hardly come to see their patients and, you're the one who's dealing with caring for them most of the time.* (Coreana)

It was the desire for, and perception of, more human interaction in addition to the scientific aspect of nursing that aligned with her aptitudes, that swayed Coreana toward choosing nursing. Nicole felt that nursing seemed to offer a balance of scientific knowledge and the opportunity to experience deeper human connections which resulted in her choosing nursing over social work. When asked how she weighed her choices Nicole responded, *"I think the interest in the human body and the science aspect of it. Both deal with people and help people but it was more the sciencey part that drew me to [nursing]."*

Words used by participants to describe the attributes nurses should possess included "*good communicators*," "*hard-working*," "*trustworthy*," and "*multi-taskers*." So, if the participant believed she possessed these attributes she could imagine herself as a nurse and this influenced the decision to enter nursing education, as expressed by Elle, "*I knew that I would bring empathy… a very strong work ethic, because I do have that from*

my parents. And the ability to communicate because I think I have pretty good communication skills."

Phase 2: BEING THE NURSING STUDENT

Once an individual goes through the **CHOOSING NURSING** phase as a lay person to reach the decision to enrol in nursing education, she moves to the second phase of Nursing Identity (NI) development, which is **BEING THE NURSING STUDENT** (see Figure 3). While in this phase, the Nursing Student discovers new things about nursing which result in her *REFINING* her original understanding of what it is RNs DO. How RNs should BE, based on judgments about nurses made prior to entering a nursing program remain constant. While **BEING THE NURSING STUDENT**, one is *REFINING* the image of nurse through ***Experiencing*** a) ***Formal learning***, b) ***Nurses*** and *c)* ***Clients***. Another important aspect of **BEING THE NURSING STUDENT** is that it is very different from the RN identity and thus, this *REFINING* happens while she is ***Being on the Outside*** of the RN collective identity. Due to the influences of the Environmental context of education, especially in clinical courses, the Nursing Student experiences a very different way of nursing compared to the one she experiences once she becomes a New Graduate RN (NG/RN). The Nursing Student identity is also a temporary one and therefore the focus is on marshalling strategies for ***Getting through*** this phase in order to move on to the next phase.

During BN education misconceptions are dispelled and new knowledge is gained about the discipline, profession, and practice of nursing. However, the more abstract concept of Ideal NI, i.e. who an RN SHOULD BE, remains relatively unchanged by these educational experiences. In fact, the underlying Personal Identity determined by the self-described values that one aligned when **CHOOSING NURSING** not only remains intact, but permeates the Nursing Student's experiences. These values, and the related perceptions and beliefs that underpin her expectations of nurses, of self, and of nursing education affect how educational and interpersonal experiences are interpreted. They are the source of the Meaning she ascribes to the experiences and to the Choices and Actions that result.

Experiencing formal learning impresses upon the Nursing Student that RNs are more knowledgeable and responsible than many lay public realize. The RN's role of

client advocate is highlighted during nursing education, and the Nursing Student embraces this message and incorporates it into her image of the ideal nurse. However, other formal teaching about codes of ethics are seen by Nursing Students as essentially common sense and serve to reinforce existing personal values rather than to influence the acquisition of any new values specific to the emerging Nursing Identity. Thus, it is one's own Personal Identity and the values embedded therein that are viewed as *ALIGNING* with the collective Nursing Identity as expressed in codes of ethics.

As the Nursing Student is ***Experiencing Nurses*** these nurses are being viewed through the Nursing Student's lens of value-based expectations and this leads to judgments about the staff nurses and nursing instructors with whom the Nursing Student interacts. The evaluation of nurses is therefore, a result of the Nursing Student underlying assumptions about how a nurse SHOULD BE and her interpretation of any given nurse's actions and words. It is the nurse's actions that create an image that is either congruent or incongruent with how the Nursing Student believes a nurse SHOULD act. This results in creating meaning for the Nursing Student about the nurse as a positive or negative role model. The primary trait that enables a staff nurse or nursing instructor to create a positive relationship with the Nursing Student is the nurse's ability to relate to, or empathize with, the Nursing Student and be a source of support and encouragement. If a nurse is unable, or unwilling, to consider the Nursing Student's perspective this nurse is less able to relate to the Nursing Student. This creates the perception that some more experienced nurses may be less likely to be a positive form of support for the Nursing Student.

In trying to come to terms with witnessing nursing instructors or staff nurse behaviours that are incongruent with the Nursing Students' image of nurse, the Nursing Student may dismiss the behaviour as being the result of the stress of the work, or as simply part of the nurse's personality. Finding reasons to explain value-incongruent behaviour helps the Nursing Student make sense of these incongruences between expectations and experience. If the Nursing Student believes there is nothing that can be done about the behaviour because it is rooted in personality or stress, avoidance of these nurses becomes the best solution. In addition to avoidance, the Nursing Student may use these nurses as examples of how NOT to be as a nurse. However, it should be noted that

this negative assessment of the nurse is based on existing value-based expectations and therefore, the Nursing Student technically already knows not to behave in this way.

An important distinction between relationships with nurses in this phase and subsequent phases is that the Nursing Student is experiencing these relationships from outside the RN reality and as a Nursing Student, from the perspective of a less powerful member of the social hierarchy. ***Being on the outside,*** and the Nursing Student's focus on ***Getting through***, results in power imbalances that influence the Nursing Student's Choices and Actions in these relationships with RNs while **BEING THE NURSING STUDENT.**

The Personal Identity of persons who choose nursing includes viewing the self as caring and having the goal of making connections to make a difference and these values and attributes will influence the Nursing Students' actions when ***Experiencing clients*.** These experiences can strengthen existing values and help refine how these values are enacted. Some clinical areas provide Nursing Students with more opportunities to experience encounters with clients that serve to reinforce their belief that nursing is about *connecting with others to make a difference*. The specific area of practice and the resulting differences in how the work is organized are the primary factors generating these different experiences. The more closely the Nursing Student is able to interact with clients and families in ways congruent with her Ideal NI, the more positive an area of practice is viewed.

The Nursing Student experience is greatly influenced by how the work of Nursing Students is organized as a result of the education institution's educational and administrative policies and the practices of individual instructors and staff nurses. The way nursing education is organized and the fact that the Nursing Student role is a temporary one focusing on education rather than practice, results in the Nursing Student identity being experienced as very different from the RN identity. The cumulative effect of how the Nursing Student role is experienced is that the Nursing Student feels on the outside of the nursing collective identity, looking in. Specific reasons the Nursing Student experiences ***Being on the outside*** are because the Nursing Student is a) ***Dressing differently***, b) ***Nursing differently***, and c) ***Feeling in the way and less than***. The role of Nursing Student exists as a temporary identity but a prerequisite one to becoming an RN.

These differences between the Nursing Student identity and RN identity affect NI development as images of self and of nursing are refined during nursing education but redefined when transitioning to the RN role.

In nursing programs, the uniforms Nursing Students wear in clinical settings are often chosen by the nursing faculty and there are policies that outline how the Nursing Student is to dress, which are different from how nurses dress in clinical practice. ***Dressing differently*** makes the Nursing Student feel that she stands out from staff nurses.

How clinical learning is experienced by the Nursing Student is in part, determined by the clinical education model being used by the educational institution, and the contracts that exist between educational and healthcare institutions. The Nursing Students experience ***Nursing differently*** due to being transient visitors to clinical practice areas and being assigned to care for only one or two clients. Though there is a shared responsibility with the buddy nurse, the Nursing Student knows she is not ultimately responsible for the clients' care. When caring for clients, Nursing Students are often expected to deliver total physical care, essentially performing the duties of healthcare aides along with some of the RN's duties. Despite being expected to perform all physical care, Nursing Students are often not involved in more complex interprofessional, interpersonal, and care management discussions. This "protection" from the full role of RN contributes to the Nursing Student focusing on developing competence in targeted aspects of care. Once in senior practice, the Nursing Student begins to see a "bigger picture" of nursing, not apparent when a Nursing Student.

Because Nursing Students move between various facilities they are often unfamiliar with their surroundings. This "newness" results in the Nursing Student often feeling unsure and less competent than those around them and ***Feeling in the way and less than***, and as such, unwelcome. This further separates the Nursing Student from the nurses in a hierarchy where the Nursing Student is acutely aware of her lower standing. However, within these realities of clinical education, certain Environments support a greater sense of belonging, and an individual staff nurse can enhance this sense of belonging if when he/she is welcoming and understanding of the Nursing Student's situation and learning needs.

Because the role of Nursing Student exists as a finite and prerequisite identity to becoming an RN, this experience can be something the person is ***Getting through,*** something to survive, so as to reach one's goal of becoming an RN. ***Passing courses and the Nursing program*** are needed to get through successfully. ***Protecting self*** also enters into the mix of getting through the student journey. Due to the temporary nature of the student identity, the Nursing Student can feel it is best to just put up with less than ideal experiences so she can continue to move through the program. At times assignments and expectations may not resonate with the Nursing Student as relevant to her future role as RN but she dutifully completes these tasks and performs as she believes it is expected of her. Silence and avoidance are the most common strategies employed as the Nursing Student focuses on ***Getting through*** nursing education. When a Nursing Student feels she is being treated unfairly, "rocking the boat" is not seen as worth the risk so she does not speak up or challenge the instructor.

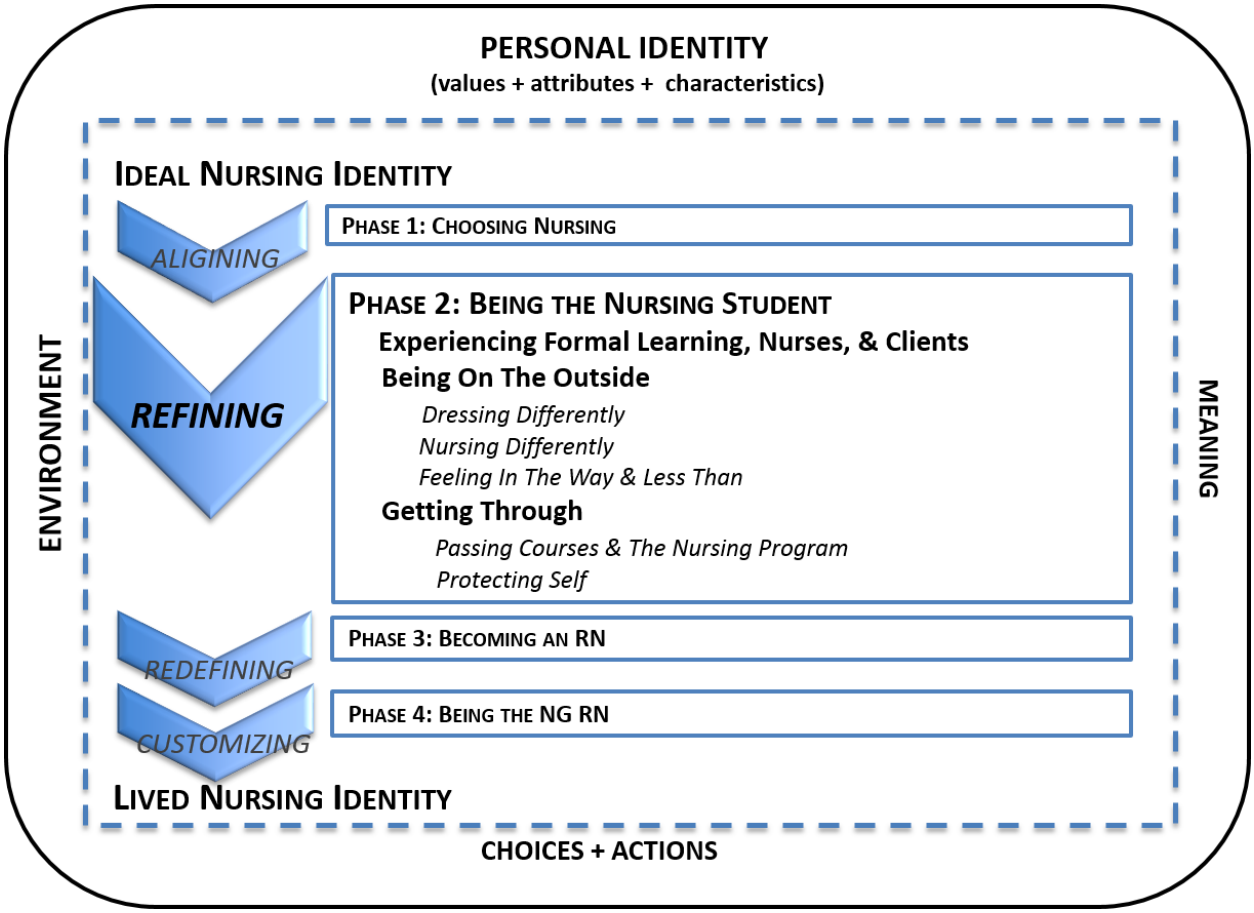

Figure 3. PHASE 2: BEING THE NURSING STUDENT

BEING THE NURSING STUDENT

Once analysis revealed the concept of Nursing Student identity as distinct from RN identity, subsequent participants were asked directly, "While you were enrolled in nursing school were there times you felt like a nurse?" The response was consistently negative. For example, Lynn responded, *"No!" Student, always a student,"* and Raven responded, "*No, no, not at all!*" Nicole also distinguished between how she felt in the student versus RN role, "*I didn't feel like a nurse really. I mean I did a little bit but once I did my practicum then I really felt like it…it was just a different feeling."* Raven also remarked that during nursing education, being a Nursing Student was like a "*job in itself*" and she did not see a great deal of correlation between the role of Nursing Student and her current role of RN.

Participants had a preconception about how nurses SHOULD BE as demonstrated by judgments about nurses that they made prior to entering a nursing program. This image of how a nurse SHOULD BE when interacting with others was a constant for all participants. For example, Coreana had an experience as a patient when hospitalized as a child. Even then, she knew how a nurse SHOULD BE in her interactions with Coreana as the patient. Coreana commented,

> *When I had my knee surgery when I was younger I had a bad experience with this grouchy nurse and she was probably doing all of her skills right but you know… I needed something a little bit more…. I was a kid having surgery and I remember thinking, I don't want to **be** like that nurse.*

Lynn saw positive images of nurses prior to becoming a Nursing Student and formed an opinion, about nurses then based on her perceptions and expectations. Lynn shared her reflection on this experience, "*I remember how wonderful the [nursing] staff was. And if that's what I remember, I want to **be** that person, and I think I can be, so...."*

Experiencing formal learning. The most notable adjustment to the original image of RN for participants was about what nurses DO. These new insights into the RN profession were welcomed by the participants. Lynn acknowledged that her views about the depth of knowledge required to be an RN were inaccurate *"Before going into school, I didn't realize how knowledgeable nurses are [laughs]. You just picture them as these caregivers at the bedside and just providing comfort to people."* Through her education Coreana discovered the level of responsibility required of RNs and said

> *Even if the doctor makes an order if it's not really appropriate for that patient at that time we [nurses] are still in the wrong so you have to use your head. Yeah, I found after going through school there was more responsibility on us.*

Participants also embraced the knowledge that as a nurse they would be expected to act as a client advocate. Elle attributed this realization to her BN education, "*I learned that going through school. It's a part of your job as a nurse; you need to advocate."* Janice also felt client advocacy was emphasized in her educational experience, "*…through my education I learned that this [advocating] was a very important role for a nurse to undertake."*

When asked if learning about the Canadian Nurses Association's (CNA) Code of Ethics (2008) and nursing ethics in general brought any new understandings about nursing Lynn responded, "*I think a lot of it is just your personal beliefs…If you're feeling that this isn't ethical, then it's probably not something you should be doing. And there's probably a Code to go along with it."* Summer agreed, "*It wasn't like once I took the course, it was an "Aha" moment. To me, most of it is common sense. I don't know how much it* [*learning about the* Code of Ethics] *impacted anything…."*

The existing values of the participants were seen as the core of their nursing values. On a follow-up interview Janice explained how her education influenced her nursing values,

> *I think my BN education did influence my nursing values in the sense that it strengthened my values and I felt that my values were being backed up by the Code of Ethics. There was actual legislation [that] would back up my values and had the same values, so this profession would correlate well with ethics I held myself.* (Janice)

Similarly, Raven felt that her personal values were already aligned with the values expressed in the CNA (2008) Code of Ethics and therefore, she easily related to them.

> *It seemed pretty straightforward to me —being respectful, being kind, compassionate. On reserve as a Native person, those are skills that are built into you as a kid... The Seven Teachings — be respectful, be helpful, be gentle…And those are just the basic values of just being a good human being, and... I found it kind of correlated.* (Raven)

Experiencing nurses. Participants encountered both staff nurses and nursing instructors while **BEING THE NURSING STUDENT** and often described nurses as either positive or negative role models. When participants were asked to describe the

behaviours of positive role models, the focus was more often on how the individual treated the participant. Raven described her most positive role model as, "*Non-judgmental, always willing to help… didn't ever give off that vibe of, 'You're bothering me, go away.' Just always willing to help, very approachable, never laughed at you, never made you feel insecure or inferior in any way."*

Outside of the nurse-nursing student relationship, participants viewed nurses who were strong advocates for clients as positive role models. Nicole respected a nurse who put the client first even when meeting resistance from a physician, "*She always says the patients come first...the Dr. was giving her grief but she was doing what was best for the patient. So [she] didn't care what he had to say."* Janice also valued the advice of a nurse who encouraged her to overcome her apprehension about bringing concerns to physicians by focussing on the client instead of herself. "*So I've always kept that in the back of my mind. It's not about me being shy or me being unsure myself; it's about the patient… that's it."* (Janice)

The participants' underlying value-based expectations of others created judgments of nurse educators as well. Sometimes, these judgments extended to the profession as a whole. Summer's experience with an unsupportive clinical instructor, caused her to judge the profession and said, "*I kind of questioned the profession and who is teaching us about this profession… I would never think of treating someone that way."* Lynn, felt a particular faculty member of her nursing program disregarded her needs and was not willing to assist her in resolving a program-based issue that caused her a great deal of distress. This resulted in feeling failed by the nursing profession, and Lynn explained "*At the time, I was feeling incredibly defeated and felt like the profession that I was intending to go into had already failed me."*

Interestingly, several of the participants recalled feeling least supported by their nursing instructors when they made an error while in the student role. Summer appreciated that as a Nursing Student she was "*caring for real people*" and should be "*held to a standard.*" But she also felt the reaction to errors should be supportive rather than "*condemning*." Summer said, "*Mistakes happen, and students need to know that they're not going to be condemned for making errors if they do occur."* Summer also experienced a "*different"* reaction than "condemnation" when in senior practicum

because, "*I felt in senior practicum, I was one of the team."* In particular, Summer felt betrayed by her clinical instructor who ridiculed her by discussing her performance in a negative way with staff nurses. She commented, "*I overheard my clinical instructor bad-mouthing me to all the nurses at the desk. So that just shoots your confidence right down. To me, that was inappropriate and uncalled-for. It* [the error] *wasn't done intentionally."* Thus, for Summer, feeling unsupported became intertwined with feelings of incompetence due to feeling judged as incompetent by this more experienced nurse. Coreana also felt that making an error as a Nursing Student exposed a negative side of nursing instructors, "*I found [that] if you made one mistake it was the end of the world and they threatened to kick you out... And so I didn't feel as supported in nursing school just from the head people."*

Coreana explained that the experience of being "*penalized so heavily"* could make a student "*afraid to go and admit their mistake to others because of all these consequences that they had in nursing school."* She also felt penalties that were disproportionate to the error could increase a student's fear and stress which would make the student *"get so uptight that they're going to make a mistake."* Coreana also explained that practicing nurses responded in a more understanding way to errors *"I had one nurse tell me every mistake you make you learn from them and certain things you do you'll never do it again because you've learned of the consequences of that mistake.*" And she felt this reaction was "different" from how nursing faculty responded adding, that though she was taught "*you should admit your mistakes*" Coreana felt the resulting reaction contradicted the message that she would be supported by faculty and that they did not "*practice what they preached.*"

Negative role models were those who were perceived as treating either the participant or others poorly. Joanne expressed the effects of working with these nurses as, "*I feel nervous to do things… I'm not as comfortable in carrying out my tasks because I'm nervous that this person's going to say something."* Summer described what she judged as "unnecessary" behaviour by staff nurses: *"a nurse was just being completely rude [to another student] and condescending. Comments were made that were inappropriate and should never have been made in a clinical setting."*

Participants expressed a belief that nurses would be more able to relate to the Nursing Student if they had recent experience with the Nursing Student's situation. Coreana said, "*You can really tell the people who have been a Clinical Education Facilitator or have just graduated or have started a new unit because they know exactly what it's like to be in your shoes."* This contrasted with how she saw some nursing professors. Coreana reported, "*I think some of the profs haven't been in the practice setting for a long time and maybe they kind of forget what it's like to be out on the floor."* Summer felt it was rather ironic that nursing instructors could not relate to Nursing Students. "*I feel like some of them* [instructors] *weren't understanding of what it's like to be a [laughs] student."* Summer seemed more understanding of experienced nurses' issues relating to students, *"I know it's hard for senior nurses to be like, Oh yeah, I was there once."* Elle also explained how some of these older nurses were "*very, very bitter"* which meant they did not give very good feedback about nursing whereas someone younger who still "*absolutely loves being a nurse*" was able to give "*positive feedback."*

Participants also described personality as a reason for the poor relational skills of some nurses with Nursing Students and others. Lynn, when describing a co-worker said, "*It's just a personality thing. She's not a very warm person... she's not mean or anything, but she's not approachable."* Nicole also felt it was best to avoid some nurses due to their personalities and said, "*I don't know if it's just their personality but I wouldn't go to those nurses. Why have them snap at you?"* However, there were exceptions to the assumed correlation between years of practice and negative treatment of Nursing Students and a negative attitude toward nursing. For example, the positive role model described by Raven was a *"non-judgmental"* and *"approachable"* nurse with over 20 years' experience.

The participants also judged role models based on a comparison between what the participant believed was best practice as learned in nursing education and what was being done by the nurses in the practice setting. Elle said

> *What I learned along the way in school is that, I can't believe someone's doing this! I'm not going to be that kind of nurse. So I learned from that; saying I would not be that kind of nurse...*

So, these actions witnessed and related by Elle led her to categorize this person as a certain "kind of nurse" and she viewed this as a "kind" she would not like to emulate. Marie found it was more often the older nurses who were less familiar with current best practices and who also were less receptive to learning new ways of doing things and commented

> *Some older nurses who have been in the profession for a long time … if we say, "Well actually we don't do it like that in practice anymore"…not telling them what to do but you want to steer them towards best practice and some of them will close up pretty quick.*

Participants noted different relationships with staff nurses depending on the areas of practice. This usually focused on how well the student felt accepted as part of the team. Palliative units were viewed as areas that integrated participants into the team more than other areas. This reinforced the participant's Ideal NI because they felt like they were being listened to and that they could influence outcomes, i.e. they were *making a difference*. This served as a contrast to clinical experiences where participants were not invited to be involved. Summer described her experience

> *I think it depended on the area. I know in Palliative, definitely... and I felt like the staff there looked at us... would ask, especially in rounds... we were included in rounds as students, as student nurses, which to me, that was basically unheard of.*

Experiencing clients. Participants expressed that forming relationships with clients while Nursing Students helped enhance their ability to be empathetic and compassionate. As explained by Janice, "*I think it* [my compassion] *has developed. I think I always had it but it's developed further by seeing people this sick."* Raven agreed that experiencing clients *"probably reinforced* [my values] *a little bit more, just because you're seeing the side of the human being that you're taking care of... such a vulnerable side, that you get more of an insight of what they're going through."*

For many of the participants, Palliative Care units offered an opportunity to practice in a way they felt best correlated with their Ideal NI. Palliative areas of practice were viewed as providing greater opportunity to make connections, feel appreciated, and make a difference. Raven stated

> *My Palliative rotation was really a powerful one. I liked the personal side of it, when families come to you and they thank you, and you just create that*

> *relationship with them. And that's what I really enjoy at the end of the day, was being able to make a difference in other people's lives and helping them.*

This experience allowed Raven to get a glimpse of the nurse she hoped to be; she was able to feel as though she was enacting her Ideal NI while still in the Nursing Student role. Lynn believed the positive experience of the Palliative clinical rotation was a result of the combination of taking this course at the end of the BN program when she felt more competent coupled with the organization of the work in Palliative areas. Lynn felt that her Palliative rotation helped make her the nurse she "*envisioned*" by combining four years of "*knowledge*" with being a "*compassionate, caring nurse."*

The focus of palliation was viewed as comfort care of the patient and support of the family. Summer felt this differing focus of client care reduced the number of psychomotor tasks to be performed and allowed her more time to connect with clients and their families.

> *Med-surg areas are more task-oriented sometimes. You're not necessarily able to sit and talk to your patients. But in Palliative Care, it's easier to focus on that* [holistic care] *more because you're not focussing on treating the illness; you're focussing on the person as a whole.* (Summer)

Initial perceptions about working with certain clients could be altered by directly experiencing practice Environments and discovering a different sense of personal fit than the participant originally anticipated. For example, Janice, having worked with children in her youth always thought she would end up working in pediatrics. She was surprised to find that the emotional costs of working with sick children and their parents were more than she had bargained for. This experience was pivotal in creating a new image of herself as nurse, as far as where she would prefer to be working and influenced her future choices about nursing practice.

> *I never worked with sick kids. It's a whole different ballgame. It was much harder emotionally than I ever thought. I figured going into it- I don't know these kids, I don't know these parents; I'll just get the job done. And then I get there and it was a whole different thing…And I always thought I would end up working with kids and after doing that rotation for nine weeks I thought, "No way, no how."* (Janice)

Being on the outside. The participants shared stories of feeling like outsiders when entering clinical settings as Nursing Students due to a) ***Dressing differently***, b)

Nursing differently, and c) ***Feeling in the way and less than***. They were very aware that they were entering the domain of practicing nurses and other healthcare providers and that they were essentially guests in this Environment. This outsider status greatly influenced how they viewed their identity as Nursing Students. For example, Marie felt challenged by coming in from the outside and said, "*It's hard as a student because you're the person coming there for one day.*" And Summer expressed the effects of being the outsider as, "*Sometimes I felt like we were just lowly students*."

Dressing differently. Participants identified how the student "whites" set them apart from the staff nurses, and added to their *Being on the Outside*. When Nursing Students in their uniforms came to the unit where Coreana was employed as a staff nurse she stated, *"They were all in their whites … I do not miss that."* The dislike for the Nursing Student "whites" was also expressed by Summer who commented, "*You kind of stick out like a sore thumb."* Nicole was relieved when in senior practicum, she could wear whatever she wanted. "*I was wearing whites during my clinical rotations and then when I got to my senior practicum I didn't feel like I stuck out like a sore thumb anymore because I could wear whatever I wanted*." (Nicole)

Nursing differently. Participants described caring for clients while Nursing Students as differing greatly from client care expectations once they became RNs. Fewer clients to care for as a student created more time for care delivery. This created challenges later on once the participants found themselves responsible for more clients during their senior practicum and as NG/RNs as Nicole affirmed, "*you had maximum two patients and then when you have more patients it's, oh no!"* Infrequent, isolated encounters in the clinical area also reduced their ability to see effects of care on their clients and meant that they were not able to gain cumulative experience with the same clients, as Summer noted, *"It's difficult to gain that experience when you're only there once a week."*

Participants were expected to deliver total physical care to patients and were not expected to delegate tasks to other health care professional while Nursing Students. This reduced interaction with team members outside of the nurse assigned to the clients being cared for and their clinical instructor and thus, reduced opportunities to learn how to delegate and communicate with team members. Coreana appreciated assuming the duties

of the health care aide when a Nursing Student as it enabled her to appreciate and understand the role of health care aides more fully. However, she also saw that the Nursing Student role did not assist her in developing the skill of delegating, which "*all of a sudden*" became necessary when assuming the care of more clients.

> *In palliative we were doing the health care aide work and the nurse's work. We were giving the meds, giving the baths, and feeding them--doing all the work as student. And all of a sudden you're a nurse and you're thinking you should get your patients fed and you don't have time to do that. You have to get your meds and you're like, "Oh yeah right, I have to ask someone else to do this."* (Coreana)

Similarly, Marie noted that clinical education was designed in such a way that the teamwork aspect of client care delivery was not learned. Marie said, "*They [clinical instructors] say, 'You're going to do all the meds and you're going to do all the care as well'… so then you don't get that teamwork because you're doing it all by yourself."* Marie also noted that due to the lower number of clients Nursing Students are expected to care for, she became accustomed to doing "*everything for them"* and this approach to caring for clients became "*stuck in [her] mind.*" Once in senior practicum Marie quickly realized that "w*hen you have seven or eight, it's not really ideal."*

Participants acknowledged it would not be "*practical*" for students to have full patient assignments during clinical experiences but Nicole shared that "*every day of clinical was helpful*" and thought "*education could include more clinical."* Once practicing as NG/RNs, participants were able to reflect on the contrast between the "protected" role they enjoyed as a Nursing Student versus the increased responsibility as a NG/RN when they had to find ways to deal with new issues on their own. Elle felt protection from clinical instructors reduced her ability to resolve interpersonal conflicts.

> *I get [that] the clinical instructors want to protect their students but I also think that if there is a conflict between a buddy nurse and a student they should just let them duke it out. It would really give them the experience for when they're on their own. Just try to resolve conflict on their own…that's the hardest thing I think.* (Elle)

Participants did not always view this "protection" in the same way. Janice saw the protection from the full nursing role as positive for learning as a Nursing Student.

> *I think it is fine the way it is. I wouldn't change anything. As a student you're always so nervous about everything. I was glad that all I had to focus on was*

> *getting those skills done, doing maybe the smaller tasks and taking my time with them because I didn't have a ton of other things to do.* (Janice)

Participants tended to feel task-oriented while Nursing Students compared to their current focus on a "bigger picture" as RNs. As expressed by Janice, "*I was really task oriented when I was in school and just focussed on getting the IV started; getting those skills under my belt."* Nicole added that she also felt the need to do these tasks *"in a certain way."* For participants who were attracted to nursing because they wanted to interact with clients, the focus on tasks was in contrast to their initial images of nursing. Nicole expressed it this way, "*I wanted to spend time talking to people, getting to know your patients, and then I found that nursing was just getting the tasks done …that's how I felt."*

Feeling in the way and less than. In addition to being dressed differently and having a different set of responsibilities and workload compared to staff nurses, the participants' often possessed less knowledge than others in the Environment and this made them feel on the outside looking in and as if they were a burden to staff nurses. Janice described her experience: "*Seeing everyone bustle around and busy you don't want to ask anybody because they seem so busy and you don't want to burden staff; you don't want to get in the way."* Joanne also felt that the addition of students into the nurses' Environment added to the staff nurses' frustration and said, "*I think the stress load of nurses, and then to have students around that are kind of in their way and, they get frustrated … and then kind of lashes back on the student."*

Knowledge that seemed "basic" to the participants now, presented challenges to them when they were Nursing Students. There was a sense that their "newness" and "not knowing" made them vulnerable. Feeling at risk resulted in some participants feeling nervous about exposing knowledge gaps and possibly being reluctant to ask for help. Janice reflected on a clinical experience when both she and a fellow student were unsure about how to work an automated blood pressure machine. They decided they had to ask their instructor, who did not realize the students had never been exposed to this machine before. Janice said, "*I had never seen a Dynamap in my life. I didn't even know what button to press and… you don't want to break anything or touch any buttons."* This "newness" diminished confidence and increased fear as it meant that they were not able

to predict what might happen or rely on their knowledge since they were very often entering unknown territory. Raven said, *"You're just so scared all the time that you're going to screw up. I'd say more scary just because of the unknown."*

Participants also felt "less than" as they were at the bottom of the hierarchy of healthcare providers with whom they were interacting. Summer explained students sometimes were not taken seriously. Summer said, "*For instance, you would go talk to the doctor about something that was going on with your patient, and they would brush you off. I felt like we weren't taken seriously."* Summer also felt that the power the nursing faculty had over their experiences made students feel vulnerable, "*It's hard on students because I feel like sometimes course leaders will back their clinical instructors and not necessarily...be fair."* (Summer)

Getting through. Participants recognized nursing education as the necessary path to their goal of becoming an RN. To succeed they needed to focus on a) ***Passing courses and the program*** and b) ***Protecting the self.*** The participants' were very aware of how the student identity was temporary and therefore, different from that of an RN. They described how stress from course workloads with at times unrealistic expectations, added to their perception of nursing education as something to survive in order to reap the reward of becoming an RN. Coreana stated that she felt proud at her graduation *"because it was a lot of work to get through the program and lots of hours."* Lynn reflected on the challenges of getting through as well: *"It's still hard to believe that I even made it this far because I didn't think I'd get through First Year, let alone four years [laughs]."*

Passing courses and the program. Some participants focused on passing their courses by complying, even when in disagreement, with what was being taught, how it was being taught, or if the content did not seem relevant to them. Fear of failure kept them quiet and compliant. Raven noted that program policies influenced how students' viewed their learning, and shared, "*In nursing, you can only fail once, and you can voluntarily withdraw once. And so that fear was always there, that I had to do it the way they want me to do it, so I could pass. I mean, you just don't want to rock the boat."* Even though a participant disagreed with course content or an instructor at times, passing the course was seen as more important than expressing disagreement. Raven said, *"I've been in positions where I would clash, but I knew if I didn't do it this way, I would fail, and...*

that would set me back a whole year." Joanne also focused on achieving the grades necessary to get through and said, "*I think that I was more focussed on trying to get marks."*

Protecting Self. Participants mentioned using a number of tactics to self-protect in order to get through. One was avoidance, which could be achieved by dropping a clinical course when a participant experienced conflict with a particular clinical instructor, or if the participant felt at risk of failure.

> *There was already so much stress being a nursing student that I didn't want to add that additional stress of having to appeal a grade… Because I've had friends go through that, and they weren't successful. They'd lose a whole year of their nursing school, and…I just didn't go there, I just did what I was supposed to do.* (Raven)

Participants weighed their options when in these situations based on their judgment of the people they had available to support them. For example, Joanne sought out a mediator in the clinical course leader when she encountered a clinical instructor who she felt was unfair. She felt things then somewhat improved for her. Summer found herself in a similar situation but she felt that the clinical course leader in her situation was "unapproachable", so she chose to drop the course. This decision, largely based on Summer's perceptions about access to support, delayed her graduation but this was determined to be a necessary sacrifice in order to protect herself and ***Get through*** the program. Summer stated, "*The course leader at the time, I didn't find her approachable, or understanding of students. I ended up dropping that clinical because of that, so that was just a bad experience."*

Elle also felt that education experiences were not necessarily fair due to the expectations of clinical instructors being inconsistent, or "*never being on the same level*." Elle said that she would, "*hear this clinical instructor does this and then this one does something else."* This seemed to make relationships with these instructors unpredictable, again contributing to feeling the need to self-protect.

Phase 3: Becoming an RN

The transition from the Nursing Student Identity to the RN Identity begins in earnest during the last course of the program, the senior practicum, and continues into the

early New Graduate RN (NG/RN) experience. Still classified as a Nursing Student during senior practicum but learning while ***Experiencing the RN Reality***, the individual straddles two identities at this time, that of Nursing Student and of RN resulting in an intermediate identity, that of Senior Student. At this time the Senior Student/New Graduate RN has the sense that she is now **BECOMING AN RN** (See Figure 4) but this is tempered by the knowledge that she still needs to pass this final course and the RN examination in order to become an RN.

When completing the senior practicum or beginning their first job Senior Students and NG/RNs are attending clinical practice full-time and in the case of the Senior Student, alongside one or more staff RNs who act as their preceptors. Now, they are immersed in the RN's work Environment. The initial images of who nurses SHOULD BE, which existed prior to **CHOOSING NURSING** and which remained stable while **BEING THE NURSING STUDENT**, continue to remain intact during this third phase. However, the Senior Student/NG comes to more fully appreciate the reality of HOW being an RN can be lived out as she experiences the complexities of every day RN practice.

During this phase, the most critical in NI development within this emerging theory, the Senior Student/NG is *REDEFINING* a) HOW her Ideal, acontextual NI will be translated into her less ideal, contextual Lived NI and b) her place in the RN collective identity. Removed from the protection of the Nursing Student identity, the Senior Student/NG has new experiences within this Environment which contributes to the creation of new Meanings. These new Meanings influence the consequent Choices and Actions that represent her current Lived NI.

The alteration in the organization of work during senior practicum and early practice, exposes the Senior Student/NG more fully to the complexities of the RN experience. This leads to ***Letting go*** of idealistic expectations and how this is experienced will depend on the individual's degree of commitment to her ideals and whether the organization of work facilitates or impedes practicing in a way aligned with these ideals. So the NG/RN may be ***Letting go*** of few or many of her expectations of self and others while adjusting to ***Experiencing the RN Reality***

Experiencing the complexity of RN practice also reveals to the Senior Student/NG her ***Gaps in knowledge***. Becoming aware of these gaps causes the NG/RN to make

assessments about her BN education and how it prepared her for practice. The Senior Student/NG builds on her education to address these gaps. At this time, the narrow Nursing Student focus on technical skills expands into a more comprehensive focus on the multifaceted interpersonal and care management skills required of the RN.

Within her new role, the Senior Student/NG is finding her new place in this social milieu and is feeling more like an RN. No longer relegated to the margins, she strives to complete the transition into the collective identity of RN. Whether the Senior Student/NG successfully experiences ***Beginning to belong*** will depend on the degree to which the Senior Student or NG/RN is a) ***Feeling supported*** by colleagues and managers and b) ***Gaining competence and confidence***. The Senior Student/NG becomes influenced by her new colleagues and seeks ways to meet expectations and gain their approval. The Senior Student/NG's understanding of her Ideal NI and the resulting expectations of herself and others, also influence how easily she integrates into the collective values of the practice setting. Setting high expectations for self and others can actually create the negative effect of feeling different from the majority, hindering the development of a sense of belonging.

A differing dimension exists between striving to belong to the RN p*rofession* versus belonging or "fitting in" with colleagues in a particular practice setting. Feeling part of the RN profession can be determined by an internal process of validation based on the existing Ideal NI and self-assessed cohesion between this ideal and one's actions. However, "fitting in" involves trying to be accepted by the NG/RN's new colleagues. Thus, "fitting in" and ***Feeling Supported*** can be accomplished by acting in ways that either align or conflict with one's Ideal NI, and this depends on the norms of the practice setting. Strategies employed by Senior Student/NG to gain a sense of acceptance so as to ***Feel Supported*** by their colleagues include ***Carrying a full load*** and ***Avoiding ward politics***. New Graduates discover that being able to manage a full patient assignment improves how they will be viewed by colleagues as they are helping and not seen to be "in the way". Although they want to fit in, they do not want to jeopardize being rejected by a subgroup and thus Senior Students/NGs are ***Avoiding ward politics*** as a way to stay neutral in the "cliquey" interpersonal setting of some institutions and nursing units.

During this third phase, the Senior Student/NG's is ***Gaining in confidence and competence*** as a result of daily practice experiences where they meet self-defined parameters of competence, and when they believe or hear that others view them as competent. Sometimes the positive feedback from others is needed to balance the Senior Student/NG's self-doubt and negative self-assessment of their own performance. Therefore, competence plays a role both in feeling a sense of belonging to the collective RN identity and in "fitting in".

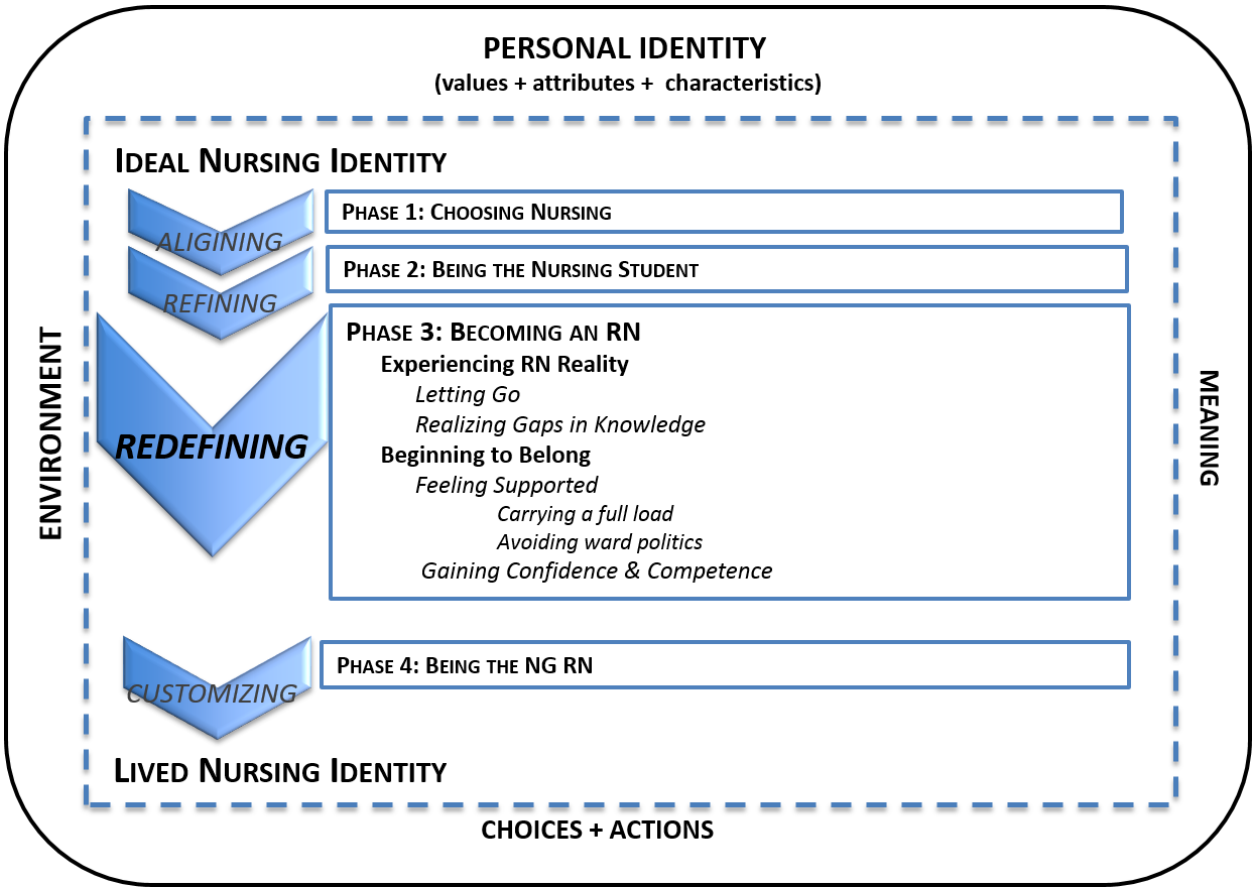

Figure 4. Phase 3: BECOMING AN RN

Experiencing RN reality. Misconceptions about nursing that were not corrected while participants were students were dispelled during the senior practicum. Janice discovered how inaccurate the image of RN practice from the media was, once she experienced "*the job*" of nursing for herself. "*I only had an image from TV. I thought it was this glamorous life where you are saving lives left, right, and center… and then I got to the job and [thought] "Oh, no! Not quite!"* (Janice)

The full scope of a nurse's experience was not encountered until the senior practicum. This caused some participants to realize the limits of their student experience and as a result, the limits of their nursing knowledge and skills. Nicole felt the experience of senior practicum *"helped to tie it all together and you could see the whole picture of nursing."* Janice agreed that senior practicum was key in assembling the puzzle of what nursing really is. Janice remarked, "*It was in my practicum that I learned how to put everything together."* For some participants, senior practicum was the first time they witnessed the full extent of an RN's workload. This was true for Nicole, who admitted she was "shocked" when seeing the overwhelming expectations placed upon her preceptor, an RN on an acute medical unit. Nicole said, "*You can see nurses busy but I don't think students get it until you actually are doing it …that you really don't have the time that you wanted to spend with patients."* Given that Nicole had been on a similar unit as a student previously and yet was not aware of the extent of the RN's role, demonstrated that nursing students may not be exposed to the realities of nursing practice.

Letting go. Once immersed in the complexities of the RN experience participants were introduced to challenges that required differing degrees of ***Letting go*** of some of the ideal images of self as nurse, forced by circumstance into *REDEFINING* of their NI. Coreana noted ***Letting go*** was part of transitioning while becoming a nurse and said, "*Definitely letting go of some things that you can't get to; you want to do everything to your fullest ability but you just can't."* ***Letting go*** was more difficult for some than others. Elle held high self-expectations and was distressed by the level of disconnect between her Ideal NI and the one she was able to enact.

> *And I think that's one thing I struggled with because I had listened to my teachers and took pride in the fact that I'm going to be this great nurse, I'm going to talk to my patients, I'm going to get to know them, make them feel good, and have this*

> *therapeutic relationship. And you try to do it all, but you can't. And then I got to the point where I had to let it go and I had to cut it out and I feel so bad.* (Elle)

Marie discovered that she had to adjust her expectations of self once in practice and accept these limitations.

> *Definitely you have a different idea from school and you have days once in practice where you think, "That was horrible; it's not how I wanted it go." You feel like you may have failed and that can shatter your confidence…and it can make you afraid to go back because you don't want to face tomorrow. But it does get better over time and you do realize you're not going to be super nurse and you just have to be the best nurse you can be this point and get better over time.* (Marie)

Elle's image of the nurse as advocate and champion for quality patient care led to disillusionment and anger when she compared these images with her experience once in the practice setting.

> *Well I think everything you're taught in school is a bunch of BS because you're taught, "Be there for the patient, patient quality care" but I'm sorry I see lack of patient quality care on my unit…and patient safety? I question it every day. Patients are at huge risk because we don't get to them fast enough.* (Elle)

Raven, speaking about patient-to-nurse staffing ratios being less than ideal was asked, "And has there ever been a time when you actually felt safety was compromised because of that?" she responded, "*Uh-hum, many times... my safety, the patients' safety, the safety of the staff... many times."*

Realising gaps in knowledge. Adjusting to the RN experience exposed participants' knowledge gaps. In senior practicum, and into their early stage of their practice, the Senior Student/NGs began to realize they needed additional knowledge in order to deal with certain aspects of their role. Participants acknowledged that their nursing education could not possibly have exposed them to all the contexts they would be exposed to in practice. Janice stated that her nursing education provided the "*basics*" and Raven used the term "*foundation*." Participants felt that they needed increased exposure to a variety of practice situations in order to build on this basic knowledge. Raven expressed how varying contexts change how one viewed nursing saying, "*In school, it's just the simple, basic stuff, whereas on the job you are building on it. It's the degrees in between and you go with your decision-making process because there are just so many different circumstances."* The compartmentalised delivery of nursing knowledge during

education was viewed as unavoidable and even preferred by some of the participants. For example, Janice said, "*I liked it personally because I like learning that way so I can put all my attention on one thing and really feel like I know that well before adding something into the bag."*

Some of the information delivered during their education was viewed by participants as lacking practical applicability. This created a lack of practical knowledge in certain aspects of nursing knowledge. Nicole wished she had more practical teaching about leadership concepts stating, "*These papers seemed pointless…my time would've been better spent learning something practical… and you do learn from those situations because it's a real life situation. That's when you learn the most I feel."* Marie also felt that learning theory without the opportunity to apply the concepts in practice, made learning difficult and said, *"Leadership course taught a bit about assertiveness but [it] was only theory and you are not getting to apply [it] in practice."* Participants now had the hindsight to recognize that they were lacking in the important interpersonal and diplomacy skills required when working as a NG/RN. Elle expressed her frustration thusly, "*It would've been nice to learn these kinds of things at the beginning… knowing what the political stuff is out there… that's my biggest challenge, the political stuff."*

While these are examples of knowledge participants would have liked more hands-on experience with, there was some information taught that some came to see as irrelevant once in practice. Joanne discovered "*Some of the stuff they taught us in school is like, 'Whatever,' compared to what you're actually doing... that it was almost not super-relevant."* Some of the depth of scientific knowledge expected in nursing courses was not always viewed as relevant to practice and essentially a waste of the participant's energies. Raven, who worked in acute medicine areas of a tertiary care facility at the time of her interview, said as an RN she never went "*that in-depth*" and felt because her nursing instructors "*went down to the histology of every disease process*" this took away from learning "*something more helpful or useful in reality.*"

Beginning to belong. Once in the practice setting, the participants felt more aligned with the role of RN as was articulated by Nicole, *"Once I did my practicum then I really felt like a nurse."* The participants felt an increasing sense of belonging through a) ***Feeling supported*** and b) ***Gaining competence and confidence***. Participants sought

ways to meet expectations and gain the approval of their new colleagues and thus, to feel positive about their acceptance into the RN group. As Marie described

> *I think having nurses saying you did a good job and they appreciate you coming to their unit - that can make you feel really good about yourself. As a new nurse that can really make you feel accepted.*

Feeling supported. The participants indicated that there was a need to know that other nurses will "*have your back*." When one of her patient's developed serious complications, Janice witnessed her colleagues rally around and support her. Though she felt the patient's deterioration was an example of a time when she was disappointed in her performance as a nurse, the experience had the positive effect of demonstrating teamwork and peer support as Janice described: "*I just knew then I could rely on them and trust them and I knew they would have my back when I really, really needed them."* However, when the team failed to meet a participant's expectations of being supported, there was a sense of abandonment and she still felt on her own, and on the outside. When asked if she was offered support, Elle said, "*Heck no, absolutely none. I've had to seek support because I need to talk to people and I literally had no confidence. I was at the point where I thought, 'I don't even belong on this unit.'"*

Participants appreciated receiving feedback about their performance from others. However, this form of support was not always available. This was noted by Lynn who, in her first six months of practice had not had "*a lot of feedback"* and had to *"assume"* she was *"doing well."* However, Lynn felt that she would appreciate feedback, good or "*bad*" as long as she could *"learn from it."* Nicole, who began her practice as a NG in an area that she felt had high patient-to-nurse ratios, found it difficult to access support and feedback and felt like she "w*ould never know if I was doing the right thing."* Nicole felt that nurses in particular need feedback in order to develop commenting, "*Especially as a nurse I feel you need some sort of feedback. How do you grow as a nurse if nobody's telling you anything?"*

In high patient-to-nurse ratio Environments, participants were also be presented with workloads that exceeded their current abilities and coupled with little access to support that would decrease their ability to deliver safe care. This was noted to be more an issue in acute medical areas as described by Elle *"I mean it's stupid because you're*

told to ask for help but people are really busy and don't want to help" and Nicole who commented,

> *I remember my first shift we were short I had 10 patients on a busy medical floor. It was crazy! It was so busy and the charge nurse said, "I'd like to help you but I just can't, I don't have time.*

At times, the lack of access to support was seen as resulting from institutional or ward-based policies as described by Elle,

> *And then you're told you're not supposed take over-time. They don't want to pay over-time so nurses don't want to help out. I was trying to get help today and they knew I was busy and no nurse came to help.*

Though all participants wanted to feel supported in the workplace, preconceptions about how nurses should act and treat others resulted in judgments that were used to evaluate co-workers and which modified how they felt about "fitting in" with the group. Therefore, if a participant believed nurses in the workplace exhibited values contrary to those they believed nurses should exhibit, they had a diminished desire to belong to this group. So, although there is still a desire to belong to the RN collective identity, belonging to a subgroup that was poorly aligned with the participant's Ideal NI was less important. For Elle, the lack of positive support in her practice area made her focus on self-assessment of her performance, *"So at the end of the day you have to think, what's the take home for you? If you feel like you did a good job and you're happy with yourself, then that's all that matters, right?*

Believing she did not share the same "*work ethic*" as her co-workers also made Elle less trusting that they would follow-up on issues. Elle voiced, "*Everybody says we're 24-hour work and if you can't get it done in one shift then the next will do it. Well, if you don't share the same work ethic with nurses that are following you…it doesn't get done."*

Carrying a full load. Despite the Ideal NI being thought of as *connecting to make a difference*, participants also felt a need get tasks done efficiently and noted being able to do so was a way to gain the approval of other nurses. Assuming a "full patient load" was a goal in senior practicum and there was the sense that the sooner one could manage this, the more they would gain the respect of other RNs in the Environment.

> *In senior practicum you're expected to do at least 75% of [the RN's patient assignment] by the end; but I was lucky enough to have preceptors say, "Well you just can do the whole patient load at one time." And at first I thought, "What?! I*

> *barely felt comfortable caring for two people!" But now 10 or 11 patients is not that daunting*. (Marie)

The focus on getting all their tasks done and not leaving any outstanding work from their shift for the next shift, was viewed as stemming from the need to appear efficient and competent in the eyes of other nurses. In her attempt to carry a full load and appear efficient, Coreana could sacrifice her down time and had to be reminded by senior nurses about the need to take breaks and delegate tasks.

> *I find I'm trying to finish up before I go for my break because I don't want to leave this for this nurse…and then everyone said, "You have to take your breaks now otherwise you are not going to get one."* (Coreana)

When asked what her priority was when beginning a shift Joanne said, "*I guess I go in telling myself that I'm going to complete all my tasks. Just make sure I'm helping out my pod mates."*

In order to get things done being organized and "*multi-tasking*" were the primary strategies. Coreana felt this was an important skill to develop commenting, *"Even in senior practicum the big thing was organization, like time prioritizing. So definitely that's a big skill."* Marie saw experience as the greatest contributor to improving the ability to multitask saying, *"I don't think you get that right away, so you work your way up to being able to do a few things at once and multitask a bit better."*

Avoiding ward politics. Integrated into a new group of people, the participants quickly discovered that nurses could be "cliquey" and navigating the social landscape was one of the complexities of RN practice that they had not been prepared to deal with. This was described by Coreana as, "*Each unit has a different morale and certain cliques and personalities.*" Although there was a desire to fit in, at this early stage the participants did not want to risk fitting in with one subgroup and being rejected by another. Instead, they employed techniques to portray themselves as neutral players in this social milieu. Participants indicated that they felt vulnerable and deemed it not worth the risk to get involved in any interpersonal conflicts as they attempted to fit into the collective NI. Marie described this strategy of avoiding politics: *"I know there's lots of rumors and gossip that goes around and so I try not to be involved in that part of the*

politics." Raven viewed this as one of the negatives of nursing that created challenges noting, "*It's the politics, lots of negative stuff that you have to endure."*

Both Raven and Janice found that being a float nurse and working with different people from day to day was a way to avoid the consequences associated with the interpersonal dynamics of working with a certain group of people. Raven felt it helped her because "*You don't really get too sucked into all of that stuff. You just go to work, you do your thing, and you go home."* Janice also felt it made it easier to get along with coworkers stating, *"I just come and go and am sort of friendly with everybody and they see you once and then not until later."*

Gaining competence and confidence. The most important contributor to gaining a sense of competence for participants was the accumulation of hands-on nursing experiences. With increasing first-hand experience of the complexities of RN practice, participants became increasingly familiar with varying contexts and this allowed them to more accurately predict, recognize, investigate, and intervene in clinical situations, i.e. they generated new Meanings about both the clinical encounters and about themselves that they could apply to future experiences. This helped them feel like they were becoming more like the RN. Nicole expressed relief when noting that clinical situations were becoming more recognizable to her. "*I think that every day that passes helps so much because you start to deal with situations and you say, Okay I've seen this before; I kind of know what to do. Rather than, Oh this is new!"* (Nicole)

Additionally, experience helped increase participants' familiarity with routines and as a result, their sense of efficiency; performing a task repeatedly made participants "*faster*." Marie said, "*I'm faster… you know your patients' medications so you are able to understand how to give the medication in a safe, effective manner."* Ultimately, experience enhanced the participants' sense of control over their experiences and Environments. As Coreana stated, "*It'll just come naturally to you and certain decisions are easier when you have more experience."*

Marie described the effects of experience on her confidence level: "*Like with everything else, it's with experience that you get better at what you're doing. And even now at the seven month mark, I feel way more confident than I did in my first month that's for sure."* Being able to identify patient issues, prevent complications, and answer other's

questions about their patients' statuses boosted their feeling of competence. Summer, practicing in the NICU, said she felt like she was being a competent nurse when she was "*Being competent in my knowledge-base of my patients and their diagnosis, their progression, throughout their hospital stay."* Similarly, Lynn felt competent when "*my assessments are up to par, and I catch the little changes, or I feel like I've done something right*."

In addition to cumulative daily experiences, being able to successfully navigate a challenging situation increased confidence. Sometimes, as a Senior Student/NG, a participant would mention having engaged in these challenges with anxiety and self-doubt. When participants discovered they had the skills and knowledge to deal with the challenge, their feelings of competence and confidence were augmented. Given the uncertainty about their own abilities, it was sometimes a senior nurse who "pushed" the participant into more challenging situations. These pushes could be viewed as another form of support offered by the senior nurses as it displayed confidence in the participant's abilities. In NICU, Summer's Charge Nurse assigned her to a more challenging level of patient than she had cared for recently. Anxiety needed to be tempered with positive self-talk about her abilities and positive feedback from the senior nurse to result in a successful outcome. This success may make caring for a similar patient in the future less anxiety-provoking and make Summer more confident in her abilities, contributing to a positive NI.

> *Am I going to be able to do this? I've only just finished. Do I have the ability to care for them? I have cared for kids in these circumstances, but my first day shift, they stuck me with a little one that had IV's and this, that, and everything else. And I thought, "Why did you stick me in here?" And she [Charge Nurse] said, "You did fine." And I thought, "I know, but..."* (Summer)

Other challenges faced by participants were not as calculated, but emerged due to the realities of the Environment such as "working short" or having fewer staff on a shift than was ideal. Marie was placed in another unit due to staffing issues and struggled to get through the shift caring for greater numbers of patients with whom she was unfamiliar. Feeling one step behind for the entire shift, Marie judged that she had not met the challenge and doubted herself. However, a nurse on this unit took the time to tell Marie *"you did a good job and all the health care aids liked you"* which contradicted her

self-assessment and allowed her to feel more positively about the experience and "*accepted."*

However, a balance needed to be struck between willingness to take on risks to self associated with a challenging situation, and the need for self-protection. Lynn was challenged with being assigned to care for a patient who required monitoring for which she was not officially certified. When her Charge Nurse was given the option to move this patient or let Lynn care for him, Lynn heard the Charge Nurse respond, *"No, she's [Lynn's] perfectly capable."* Lynn felt this was positive feedback about her abilities and she had no reservations about caring for this patient. However, there may have been a risk to Lynn if there were consequences to assuming care of a patient who required skills for which she was not "trained." So, Lynn could be viewed as having been willing to sacrifice some level of self-protection in order to meet a higher-level challenge and accept a greater level of responsibility.

Phase 4: BEING THE NEW GRADUATE RN

In the final phase of Nursing Identity (NI) development, there is a movement from the temporary identity of Senior Student to that of the New Graduate RN (NG/RN) the person is integrating her evolving NI into her Personal Identity, while **BEING THE NEW GRADUATE RN** (See Figure 5). Now, independent in her practice, she can more freely explore what works best for her and thus, Personal Identity plays a more dominant role now than when she was the Nursing Student. Thus, the NG/RN is *CUSTOMIZING* a Lived NI that is becoming enmeshed with her Personal Identity. During this time, the NG/RN begins ***Separating from the Nursing Student identity*** and reinforces ***Finding meaning by connecting.*** **BECOMING AN RN** and **BEING THE NG/RN** are seen as two phases that can overlap, co-exist, or be cyclical as one is still **BECOMING** or evolving as an RN even while **BEING THE NG/RN**. The internal sense of self as Nursing Student or RN is also seen as a quasi-linear and at times cyclical process and the NG/RN can still feel more like a student when exposed to new situations.

The movement from one labeled identity to another can be difficult. For at least four years, the person thinks of herself as a Nursing Student and carries this label externally. While a Nursing Student she was on the outside looking in and now she

belongs to this once external group known as RNs. The realization that she is now in a new role is highlighted when working with Nursing Students. With Nursing Students in the workplace, she is directly confronted with her transition from an identity in which she was once so entrenched and from which she is now removed. Seeing these Nursing Students from the "other side" as RN is also an opportunity to interact with the Nursing Students in ways she feels she should have been treated when an Nursing Student, and thereby to live out an aspect of her Ideal NI. The NG/RN further realizes that she is S***eparating from the Nursing Student identity*** when she begins ***Assuming RN responsibilities.*** The NG/RN also comes to a new understanding of her role as an RN and this influences how she describes her NI to others. When ***Describing self as nurse***, the NG/RN does not often qualify the role by associating it with the specific areas of nursing where she is working, nor does she necessarily qualify the image of self as a *professional*, instead, she simply speaks of being a "*nurse*". The lack of qualification may be related to the limited amount of time the participants in this study have spent in their specialty nursing roles.

The full responsibility of patient care now experienced by the NG/RN impresses upon the NG/RN that there is no longer a level of protection offered to them. There are varying levels of responsibility within the role of RN and while some NG/RNs embrace additional responsibility, others protect themselves from being responsible more than is absolutely necessary. These Choices often exist within a context of conflict between what one ideally feels she SHOULD DO and what she feels she CAN DO. Whether a NG/RN chooses an action which aligns with her Ideal NI or an action that is in conflict with it, depends primarily on the actions the specific NG/RN associates with the values in question. Additional factors include how strongly committed the NG/RN is to these values, and the personal understanding of the specific encounter in that moment. Thus, responsibilities and expectations result in a range of actions dependent on the NG/RN's perceptions about her obligations, her ability to influence others, and whether she believes she has the knowledge and skills required to act in a given situation. Also, messages being sent by other RNs in the Environment can influence Choices and thereby exert an important influence over how the NG/RN lives out her NI in that moment. For

example, if messages about taking action from other nurses are negative, the NG/RN may be more likely to accept that a particular action is futile.

Now, more personally accountable and no longer in teacher - learner relationships with RNs but engaged in collegial ones, the NG/RN is further ***Separating from the Nursing Student identity*** by discovering what works for her and so, ***Nursing My way.*** The NG/RN is able to consolidate ***Nursing My way*** during this phase as the result of an accumulation of experiences and Meanings generated in the previous phases that have resulted in her current NI.

In ***Separating from the Nursing Student identity***, the NG/RN is further challenged as she is ***Assuming RN responsibilities***. However, the values which she *ALIGNED* while **CHOOSING NURSING** still motivate the NG/RN as she strives to achieve the value-based goal of *connecting with others to make a difference*. In adjusting to the complexities of her practice, connecting as an action is *REDEFINED* and now lived out during task-related encounters with clients. Thus, the new experience of being inside the RN reality creates new Meanings for the NG/RN about what connecting looks like. A common strategy used for ***Finding meaning by connecting*** is by ***Stealing moments***. By employing this strategy, the NG/RN is able to adjust to priorities imposed by the Environment while holding onto values associated with her Ideal NI. While ***Connecting***, the NG/RN also discovers that Meaning in nursing can be found in ***Attending to the little things*** and she comes to this realization through feedback from clients.

However, the NG/RN also faces challenges to ***Connecting*** due to the effects of the Environment, her personal beliefs, and limits to her own emotional availability. The NG/RN can realize it is more challenging to make a difference with some clients compared to others and she can also be advised not to "*care too much*" by other RNs. Also, varying Meanings assigned to a client encounter and competing priorities can result in a NG/RN acting in a disconnected way without being aware of this disconnection. ***Disconnecting*** is more likely to occur if the NG/RN is working with clients with lifestyle-related illnesses, and who are viewed as "difficult," or if she is influenced by competing priorities that cause her to take an Action that does not align with ***Connecting***.

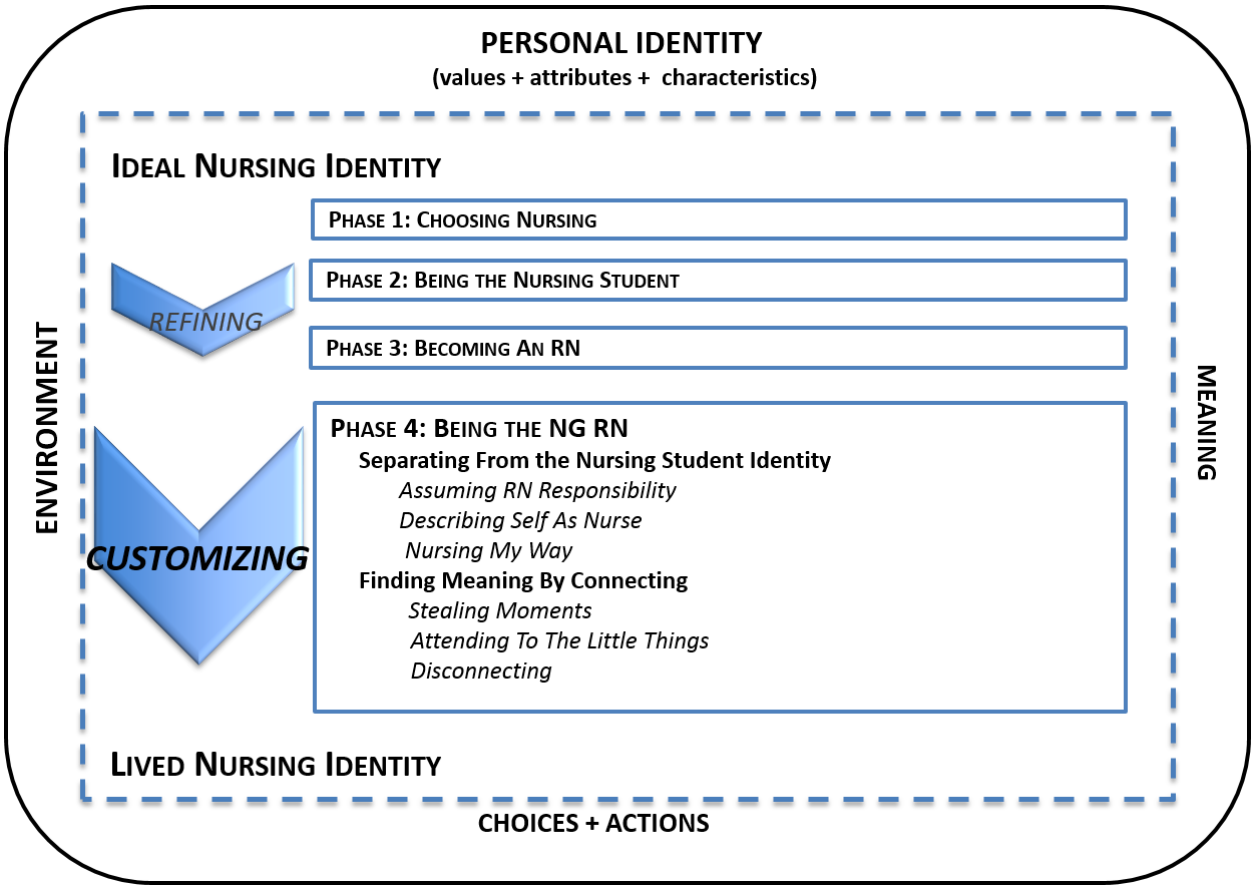

Figure 5. Phase 4: BEING THE NEW GRADUATE RN

Separating from the Nursing Student identity. Participants felt a sense of separation from the Student Nurse identity when they realized they were now ***Assuming RN responsibility*** but there was still an incomplete adoption of the RN identity while **BEING THE NG/RN.** Coreana described it as "*not feeling like an RN even if I have the letters: but I don't feel like the white scrub student anymore either."* Lynn described how, despite the transition to a new official designation, the previous identity of Nursing Student was still present. As Lynn expressed: *"It is weird. When somebody asks you what you do for a living, and you're like, 'Oh, I'm a nurse,' because I still feel like I'm lying a little bit because it's been four years [laughs]."* Also, ***Separating from the Nursing Student identity*** is nonlinear, based on the degree of the participant's exposure to unique experiences and Environments, which brings back feelings of being the student where much is unknown. Coreana's comment clearly supports this interpretation: *"I'm still in that transition phase where it's hard, I still see myself as a student sometimes, especially now I'm on a new ward learning all this new stuff."*

The presence of Nursing Students on the unit where they were now NG/RNs resulted in the participants' movement from one identity to another being more tangible. Coreana noted a contrast between her position and that of the students coming to her unit saying, "*I was just thinking back to when I was in their position. I kind of felt like, I'm not really a student anymore."* Elle found it both unsettling when confronted with working with students, as well as an opportunity to live out an aspect of her ideal NI. Elle said, "*It's kind of weird, we have students on the ward now and I [thought], 'Yay, it's my turn to give back'" and it feels really good. So it's kind of weird but it feels really good."*

Assuming RN responsibility. Participants described how once in the role of NG/RN, there was the realization that the responsibility once shared when Nursing Students with other nurses such as buddy nurses, instructors, and preceptors, was now primarily "*on them*." Elle described the increased responsibility of needing to accurately react to changes in patients' conditions: "*If a patient's health condition turned for the negative, you had a preceptor there backing you. Now you're on your own. Now you have to know what to do."*

The increased level of responsibility also forced participants to prioritize between meeting these responsibilities and spending time with patients. Lynn explained, "*It's rare*

that I get to spend quality time with my patients now. So I mean, with the responsibility, we have less time." While some participants saw increasing responsibility as a positive, Raven felt it would not be in her best interest to assume Charge Nurse responsibilities. She chose to protect herself (and perhaps her patients and colleagues) from any negative consequences should she assume a role for which she did not feel ready. So, instead of taking these perceived risks, Raven stated, "*I don't want that responsibility, first and foremost. I don't want to be a Charge Nurse, just because the responsibility is there."*

Differing perceptions of one's Ideal NI, how nursing values should be enacted, and perceived risk to self, combined to generate Meaning in a given situation. This Meaning influenced subsequent ways of enacting out a Lived NI. Marie felt she had to accept the risks associated with speaking up to management if she believed there was a risk to patient safety. Marie expressed, "*My responsibility is toward the patient and myself as well. So if I feel this is an unsafe situation I'm not going to keep quiet about it."* In contrast, Raven had a different Meaning, and felt that it was best to focus on self-development rather than to get involved in ward-level issues. Raven explained, "*I'm focused right now on myself and just learning what I need to do to further my career. I don't go to work saying, 'I'm going to try to change policies and procedures.'"*

Even if the participant did not feel safe she might still contemplate Action if her commitment to her self-defined Ideal NI was strong enough to create a Meaning about this experience which outweighed the perceived risk to self. For example, Elle was contemplating Action to address staffing ratios on her unit, but also acknowledged feeling vulnerable saying, "*I feel like we could change this but…I don't want to ruffle feathers because I'm so new. But I'm sorry, this is ridiculous! Staff's burnt out! Staff's bitter!"* For others, feeling overwhelmed by how much they needed to "DO" influenced how they viewed their options and the Choices made. Raven felt that safety issues that required acting outside the immediate tasks involved in delivering care to her patients, had to be deferred. Even though others may have viewed the issue of unsafe equipment as within a nurse's scope of responsibility, others could have viewed it as Raven did: "*I get pissed off at the time. Are you kidding me? If someone was doing their job properly this shouldn't have happened. But you don't have time to get mad because there's so much stuff you've got to do."*

When unable to influence a situation despite their efforts, participants expressed feeling defeated. An example of a combination of negative colleague influence coupled with feeling powerless was evident in Nicole's description of an encounter with a senior nurse.

> *The first shift I worked when we were a nurse short we filled out an unsafe workload report and the Charge Nurse said, "They don't do anything with this. We can go to the manager and they will just brush it off." And I thought, "What's the point if they're just going to keep working short?" And I thought, "Well what am I? What can I do? I couldn't do anything."* (Nicole)

Participants' experiences with attempting to take action sometimes generated new Meanings about how difficult it can be to effect change and that their Actions were considered futile. Raven spoke to a supervisor about poor practice by another nurse and was told there was nothing they would do about it. Raven described the exchange and her resulting feelings: "*My supervisor said, 'You know, you'll get a lot of those people everywhere, and there's really nothing much you could do.' I could have taken it up with the unit manager but it's just, why bother?"* In contrast, Marie believed she would be supported if professional practice issues such as staffing levels arose. She did not believe she would have to act alone, which reduced the risk to self and Marie explained, *"We're more supportive of each other. So if one nurse sees we're not staffed correctly they'll verbalize it and the rest of us will come together and support that person."*

Describing self as nurse. When asked how they identified themselves to others, none of the participants qualified the identity of "nurse" by also referring to their area of practice. For example, instead of identifying herself to others as a maternity nurse, Coreana said, "*I just say that I'm a nurse."* Similarly, Janice who worked in medicine responded, "*I would just say I'm a nurse."*

Although the study was clearly titled *Professional Nursing Identity Development in BN Education*, in all documentation provided to participants, this term "professional" was not referred to by the participants in reference to the type of nurse. The participants spoke of values, not professional values; they spoke of self as nurse, not as a "professional nurse." Some participants were asked to describe what being a professional meant to them. Raven equated it with being a "*respectful, supportive, and good person*" who was "*not going on a power trip.*" Without a dictionary to refer to, some participants

found it difficult to articulate what it meant to them personally to be part of a profession, as demonstrated by Lynn's response,

> *I think it [professional] represents a group of people who belong to a... who belong... who govern the same values and who have a certain amount of education. And oh, this is tough [laughs]*.
> Interviewer: It doesn't have to be a book definition, just what that term makes you think of, or even feel.
> *I think it's just like a group of people who have the same values and have the same goal and that is wanting to help people [laughs], and that's it, yeah.*

Nursing My way*.** As NG/RNs the participants no longer had to conform to the expectations of instructors. The realization that as NG/RNs, the participants could adjust how they enacted their Nursing Identities, was seen as a positive part of the process. No longer needing to conform while ***Getting through the Nursing Student Identity, they could now act on personal preferences and the meanings created through past experiences. This increased autonomy allowed the participants to personalize their approaches, nursing to suit their Environments and personal preferences. As Joanne put it, *"Once you're on your own, you kind of develop your own way of nursing."*

Elle was relieved when as a NG/RN, a colleague told her she could stop nursing as she had been directed to in the past, applying educational "*templates*" or by following directions of preceptors and "*just nurse the way Elle wants…and be creative.*" Janice explained that she discovered what worked for her out of the need to overcome time constraints and accept the realities of her new role. Janice said, "*They* [nursing educators] *never taught* [how to do many things at once]. *I just had to figure out how to do two things at once. Maybe it's not for everybody… But it seems to work for me."* The adjustments to nursing that take place after their formal education, was viewed as necessary, because as Elle put it, "*The real world of nursing is not black or white; there is a bunch of grey that makes this job really hard."*

Finding meaning by connecting. Despite the challenges faced, participants sought to find meaning in their daily practice by trying to make a difference. Their original values-based motivations for **CHOOSING NURSING** were still relevant. The fact that one's values-based Ideal NI exists outside the Lived, is captured in Nicole's succinct summary of her feelings: "*I think what nursing should be is totally different than what it is."*

Participants discovered ways to find meaning as NG/RNs by connecting with clients despite the constraints imposed by lack of time or reduced access to resources. Participants could make a connection with patients through relating to, or empathizing with them. When the participant felt successful in making a connection, this made the participant feel positive about her Lived NI and "fulfilled" by her work. The participant's success was often reflected in patient and family feedback. Elle described how if she felt family members viewed her as possessing the qualities she valued in herself, this was rewarding, "*It's kind of rewarding when you have a family member say, 'You know we can totally see that you're in it for the right reasons.'"* Raven also valued patient feedback and said, "*When the patients tell me I'm an excellent nurse, and that I'm doing a really good job, and they are happy to have me as their nurse - that's when I really love what I do."* She went on to explain the difference in satisfaction felt in relation to the technical versus the interpersonal aspects of nursing.

> *Not just the physical aspect, because anyone can do a dressing, anyone can give them a pill to fix this. But if you touch them spiritually, or emotionally, mentally, in another way, that kind of has a big impact on them. Then that's when I feel fulfilled.* (Raven)

When a participant was able to know the patient in a more personal way, this also made them feel positive about her efforts. Janice described feeling satisfied when she noticed it was a patient's birthday and she ordered her a cake as, "*It just makes me feel good about myself that I got to take the time to know them."* Sharing knowledge to make parents more at ease when taking their infant home was seen as a way for participants in NICU to fulfil this goal of *connecting to make a difference* as described by Summer: "B*eing able to help them understand the road home with their little one who's been in hospital for a little while...being able to make that difference in that."*

A participant believing that they had failed to make a difference contributed to a more negative sense of her Lived NI. Elle's distress at feeling ineffective was evident: "*When you can't even do that…even that sense of advocating for your patient… It's such a horrible feeling. Sometimes I go home and I think, 'God what did I do today? I feel like I did nothing.'"* Nicole felt her original work Environment made it very difficult to live out her NI in a way congruent her Ideal NI. The level of dissonance was such that it led

her to leave this first position and seek one in an Environment where she felt able to enact a NI more aligned with her Ideal NI. Nicole described this feeling:

> *I love the ward I'm working on now. Where I am now I have less patients than the other hospital so it is so much better now…. the stress is gone. I work with supportive nurses and it helps so much. It allows me to be a better nurse and learn more.* (Nicole)

Participants viewed themselves as caring people and as such, they needed to find ways to live out their caring identities while **BEING THE NG/RN.** When asked if they were able to live out their nursing ideals in practice, it was evident that participants relied on being able to feel empathy for their patients in order to feel like they were enacting their Ideal NI. Janice described trying to live out her values while caring for patients:

> *I do feel that I am trying to be compassionate and put myself in their shoes and be patient with these people and trying to just understand where they're coming from and how awful it would be if I was on the other side of the bed rails and not feeling good.* (Janice)

Patience was viewed as an important quality required to be able to express empathy and to respect the patient's needs. Patience aided participants in meeting the needs of the patient instead of focusing on the needs of the nurse, which is often to quickly complete tasks and move on. Summer stated, "*I think patience is a huge thing"* and Elle too felt nurses needed *"lots of patience."* When asked to describe what compassion looked like to her as an action, Janice described demonstrating respect to the patient through having patience.

> *Not rushing patients, and telling them to take their time even though in my mind I have 18 million things to do. But just saying, "It's okay. Take your time." I will go slow and actually take my time, and not rushing them….* (Janice)

Janice's ability to link her actions to her value-based motives brought cohesion between her Ideal NI and her Lived NI.

Although connecting with patients was a commonly shared value of participants, they had different Meanings associated with ***Connecting*** and about how connecting was best accomplished varied between individual participants. The participant's Meanings of ***Connecting*** also influenced how they came to view various clinical experiences or practice areas. As mentioned earlier, several participants found the type of clientele and nursing work offered via Palliative Care settings facilitated making meaningful

connections. However, Janice felt that "*In acute medicine, with younger patients, it's a bit easier if they are not confused and they can answer my questions appropriately. Whereas in the older population, it's much harder than I thought it would be."* Similarly, Coreana, when describing working with patients in Labour and Delivery said, "*I love the fact that they're there for mostly a positive experience and you can be there interacting with your patients. And in Palliative you just don't get the interaction sometimes."* For these participants, interacting with patients who could communicate more directly was more satisfying. The ability to directly converse with patients and have them participate in care and assessments enhanced the ability for Coreana and Janice to ***Connect*** which differed from the interpretation of other participants.

Stealing moments. The demands of the nursing work Environment altered how the participants lived out the value of *connecting to make a difference*. Rather than being able to sit down and get to know patients, the participants had to find ways to connect during moments of contact while conducting various tasks, such as medication passes or dressing changes. This strategy may or may not have been introduced to them during education. Janice explained her strategy: "*Because I don't see the time issue getting any better. So just… taking every minute that I have with the patient, actually talk to them about as much as I can."* Janice stated that she practiced this technique as role modeled by her preceptor, who impressed upon her the need to interact while performing tasks "*because you're not going to get another five minutes with them.*" Janice also conceded that is was not "*ideal*." Interestingly, Marie, a graduate from a different program and practicing in a different area had very similar plan of how to make connections.

> *My little therapeutic moments would be when I'm giving them their meds…getting them up, or washing them. You just try and fit as much conversation into it as possible, because sometimes you're not able to get five minutes to sit and talk to people. So just try to do the best you can.* (Marie)

Attending to the little things. Due in part to the fact that it was difficult to connect with patients in lengthy encounters, paying ***Attending to the little things*** became an important part of connecting and **BEING THE NG/RN**. Making eye contact or offering a comforting gesture are small in the time they take, but larger in the meaning to the participants as far as how they were projecting their image to others. Lynn's encounter with a nurse when her father was hospitalized reinforced that these gestures that the

NG/RNs felt imparted a positive image of the self, did accomplish just that. Lynn shared her experience: "*And I remember her petting my Dad's hair, and it was just those little things... she was so wonderful. And I just thought, 'I want to be that person.'"*

Participants also came to realize that these ***Little things*** were noticed by patients, even if the participants themselves were not aware of them at the time. Feedback offered by their clients enabled participants to see the connection between these ***Little things*** and the participant's goal of making a difference. Coreana described how patients seemed to be more appreciative than she expected: "*I can think, 'Well I didn't really do all that much'. But you become associated with a happy outcome and sometimes is just the little things, just making them feel a little bit better…that makes a difference."* Raven had also been surprised when patients expressed appreciation though she did not feel she had given them a great deal of her time. Raven concluded that patients appreciated some basics of respectful human interaction and said, "*But I guess just being open, honest, treating them like the human beings that they are, is what makes a difference at the end of the day."* However, the organization of the work was still seen as a primary obstacle for some even when trying to focus on the little things. Nicole said, "*Saying how much you have to talk with the patient and focus on all these little things. But in the real world you just don't have time for that."*

Disconnecting. Though the participants themselves did not often experience issues with feeling disconnected from clients, they did reflect on why this can happen to nurses. Coreana believed that when nurses or other healthcare providers become very comfortable with certain procedures, they were less likely to consider the patient's perspective. "*Just realizing, 'Oh yeah, they don't do this every day.' To remember we have to explain what we're doing and it's not just …just every day work for them."* Coreana was asked if she thought she would be able to remember to take the patient's perspective as she too gained more experience and these procedures became routine for her. She stated that she had not considered a strategy to maintain her ability to relate but shared, "*I hope it's not going to happen to me…I think as I get more comfortable I'll just have to remember this is not everyday life for them…this is new for them and they're probably really scared right now."*

Others noted that the cumulative effects of working with patients and families could result in nurses "burning out" and this contributed to having less patience, less ability to relate to the patients over time, and a feeling of being disconnected. Nicole explained it this way:

> *Where I work there are a lot of patients with dementia and a lot of nurses are finding it more difficult…and yes, [with] families for sure and the stress of everything. All those things, they just add up.* (Nicole)

Like Nicole, Marie saw that working with some patients could accelerate the process of burnout and that as a nurse you need to consider where your energies will be effective. "*You realize where you need to put your energies….Maybe sometimes you can't make everyone comfortable… Some people are very difficult to work with."* (Marie)

The participants acknowledged a need for balance between the goal of connecting with and caring for others and self-protection for the nurse. Marie described being cautioned by more senior nurses about the risks of working with patients and caring "*too much*." "*A lot of them at work say that I'm too sensitive… you care too much. I think they just want me to be tougher so I last in the profession I guess."* One solution for the "burnt out" nurse was moving to a different area of nursing as expressed by Raven- "*If you're there too long, then you need to change. If you're miserable and you don't like what you're doing, move [laughs]. Go somewhere else."*

Another contributor to feeling disconnected from patients was being unable to understand a patient's perceived lifestyle choices. While a Nursing Student, Elle was told she that as an RN she would be *"obligated to provide the same quality patient care to a criminal versus a good citizen"* and that she was expected to care for all clients without judgment. Though still cognitively aware of this expectation, caring for people whose conditions could be attributed to poor lifestyle choices versus people who were sick "*through no fault of their own*" challenged Elle's ability to empathize. She felt her personal values conflicted with this message from her nursing education, thus, she had not internalized the associated values promoted during nursing education as her own personal values. Now, experiencing caring for clients as an RN Elle *"found a balance between* [her] *own personal values and those taught during education."*

Lynn, who worked in a busy emergency room also distinguished between patients she judged to be more deserving of empathy compared to patients with substance abuse and psychiatric issues that caused them to be loud and disruptive.

> *My other poor patients were just being ignored because we're trying to manage the symptoms of these two, who are essentially healthy… I have little 90-year-old ladies who were in there with a hip fracture, and I have these two goofballs yelling at each other.* (Lynn)

Lynn maintained that she was non-judgmental and accepting of patients with different or challenging lifestyles, but still did distinguish between patients who were more deserving of her empathy.

Janice described herself as trying to live out her values of relating to patients, connecting with them, and meeting their needs. However, when the needs of the system conflicted with those of a particular patient, Janice was influenced by the actions of her preceptor to prioritize in favour of the needs of the system and furthermore, felt this was an approach she would continue to use in her nursing practice. While there was some acknowledgment that the patient's situation was "difficult" the patient's needs did not influence the choices made by the preceptor or Janice, and the organizational need to discharge the patient was prioritized. Although this would seem to contradict the ideal values described by Janice, she did not seem to see any conflict between her professed values of relating to patients and the actions taken. Thus, despite a commitment to certain values, the fact that she did not create a Meaning from this experience that made this obvious to her, resulted in an action that may not have been aligned with her Ideal NI.

> *For example one lady didn't want to leave because she was having diarrhea and I said to my preceptor, "I didn't know what to do with her." Because she's going home and the discharge is waiting for her but I didn't know what to say. And she said, "Oh just come, I'll do it." She just said, "This is how it is. I understand you're frustrated and you don't want to go home and that this may be harder, but this is how it goes." And even to this day I think of that conversation and I go, "you know yeah it was a tough conversation but that's how you have to do it. Just be straight up, straightforward, honest, get the point across.*" (Janice)

Summary

The theory FINDING MY OWN WAY explains how the journey from layperson to RN is an individualized one, notwithstanding the phases, categories, and subcategories being collectively experienced. The process of NI development is influenced by the contexts of Personal Identity, Environment, Meanings and Choices and Actions. These contexts modify each of the four phases of NI development by influencing experiences. By *ALIGNING* her Personal Identity including values, attributes, and characteristics, with the image of RN, the person enters the first phase of FINDING MY OWN WAY: **CHOOSING NURSING**. This *ALIGNING* is based on an Ideal NI or how the person believes a nurse SHOULD BE. Once she has chosen to enter nursing, she enters the second phase, **BEING THE NURSING STUDENT**. While in this phase, preconceptions about what nurses DO are challenged and the Nursing Student begins *REFINING* her conceptions of what a nurse IS and DOES while keeping her Ideal NI of who the nurse SHOULD BE intact. This *REFINING* is limited by the fact that the Nursing Student Identity is different from that of RN Identity, as the Nursing Student is still on the outside of the RN identity. The Ideal NI they entered nursing education with is sustained and further developed during this phase but is challenged in the next phase, **BECOMING AN RN**. The change in Environment from education to practice during this third phase means that the Senior Student and New Graduate is experiencing the full extent of the RN's reality for the first time and as a result, she begins *REDEFINING* HOW she will live out her NI in practice. New experiences generate new Meanings, Choices and Actions at this time, which may or may not align with her individual Ideal NI. Once the full responsibilities of the RN are assumed during the last phase, **BEING THE NEW GRADUATE RN**, the NG/RN engages in *CUSTOMIZING* her Lived NI by finding what works for her within the context of a given situation. In so doing, her Personal Identity and Lived Nursing Identity become enmeshed.

CHAPTER V

DISCUSSION

In this chapter, the emerging theory of FINDING MY OWN WAY is compared to the literature about Nursing Identity (NI) development, with additional comparisons to literature about identity development from other disciplines such as medicine, psychology, and social psychology literature. Existing theories and research about nursing identity and the influence of Baccalaureate Nursing (BN) education on the process of developing a nursing identity are examined in order to demonstrate how the proposed grounded theory of NI development correlates with, adds to, or differs from, current knowledge. Finally, limitations of the study and implications of the findings are addressed.

The purpose of the current study was to delineate the process of NI development from the perspective of new BN graduates. New Graduates (NG) go through a process comprised of four relatively linear, interrelated, overlapping, and somewhat recurring phases: (1) **CHOOSING NURSING**, (2) **BEING THE NURSING STUDENT**, (3) **BECOMING AN RN**, and (4) **BEING THE NEW GRADUATE RN.** The contexts influencing this process include a) Personal Identity (personal values, attributes, and characteristics), b) the Environment c) Meanings assigned to experiences, and d) Choices and Actions taken based on these meanings.

FINDING MY OWN WAY: Contributions and Comparisons

The emerging theory, FINDING MY OWN WAY describes a complex and highly individualized process of NI development. The topic of NI development has traditionally been discussed in nursing literature under the rubric of professional identity development (Cowin, Johnson, Wilson, & Borgese, 2013; Grealish & Trevitt, 2005; Ohlén & Segesten, 1998), moral/ethical development, (Callister, Luthy, Thompson, & Memmott, 2009; Goethals, Gastmans, & de Casterlé, 2010; Kelly, 1998; Krawczyk, 1997) or competency development (Chernomas, Care, McKenzie, Guse, & Currie, 2010; Edwards, Smith, Courtney, Finlayson, & Chapman, 2004; Wangensteen, Johansson, Björkström, & Nordström, 2012). Researchers examining these various aspects of nursing development frequently express that one goal of nursing education is the socialization and assimilation of students into RN practice so that the NG/RN shares common professional values and

competencies (Stockhausen, 2005). The current study adds to the extant literature by suggesting as well, that NI development is a highly individualized process.

The individualized process at the core of the emerging theory FINDING MY OWN WAY is generated by the contexts of Personal Identity and Environment which come to create experiences, the perceptions of which are unique to an individual and thus, generate unique Meanings. Based on these Meanings, the Nursing Student or NG/RN makes Choices or takes Actions. This process is described as translating her Ideal NI into her Lived NI. It was discovered that although NGs describe the abstract values associated with NIs such as caring and compassion in similar ways, the aforementioned influence of context results in variation in the enacting of these values. While this was not found to be reported in nursing research specific to NI, this finding is supported by findings in sociology research such as those of Jenkins (2008) who reported, "It is possible for individuals to share the same nominal identity, and for that to mean very different things to them in practice, to have different consequences for their lives, for them to 'do' it differently" (p. 24). Sociology identity theorists have highlighted the difference between professional identity at the collective level, which can provide definitions for values and norms associated with a professional role and the identity formed by how an individual *interprets* these concepts and associates them with certain actions and behaviours (Ashforth, 2000).

Another finding from the current study not noted in the nursing literature to date is that even if a NG/RN is unable to enact values as imagined, this does not change how she describes herself or the values she holds. This ability to maintain a more abstract sense of Ideal NI while not necessarily living out this ideal is understood in FINDING MY OWN WAY as being accomplished in part by REDEFINING what actions are accepted as evidence of enacting this ideal. This is an important finding that offers a new perspective for examining previous studies in which quantitative measures of self-reported abstract values or professional identity concepts were used. Even if such quantitative tools have strong psychometric properties, they still cannot offer data about HOW these measured abstract concepts are translated into concrete Meanings and Actions for individuals. Interestingly, Cowin et al. (2013) recently reported that there was a lack of strong support for the reliability and validity for any of the five psychometric

tools for measuring professional identity that they examined. Ginsburg, Regehr, and Mylopoulos (2009) posited that "professionalism, as a subtle and complex construct, does not reduce easily to numerical scales" (p. 414).

Another contribution of the current study to the extant literature is the finding that there is a distinction between ***Belonging*** to the collective RN identity versus *fitting in* with one's work group, as they relate to the effects of socialization on NI development. This distinction was not one found in current nursing literature and it was noted that studies on socialization and sense of belonging focused on the concept of fitting in with the work group. However, organization identity theorists discuss that professional identity can be conceptualized at individual, interpersonal, or collective levels (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Brewer & Chen, 2007).

One grounded theory study conducted with Canadian (CA) BN graduates was found for comparison with the current study - MacIntosh's (2003), *Reworking Professional Identity*. It should be noted that MacIntosh's participants graduated from an RN-to-BN program and therefore, had worked as Diploma-prepared nurses prior to re-entering education for their BN degree. However, MacIntosh's theory does share some commonality with the phases of NI development presented in FINDING MY OWN WAY such as NGs realizing BN education did not provide them with all the knowledge and skills needed as professional nurses. However, the foundation of Nursing Identity and the time frame of identity development is quite disparate between MacIntosh's theory and the theory proposed here. MacIntosh found that NGs did not develop a sense of professional identity until the second phase of their theory, *Reworking Professional Identity* which focuses on socialization to nursing post-graduation. In the proposed theory, FINDING MY OWN WAY, NGs have a strong sense of who they want to be as nurses prior to entering education and this guides them in their subsequent experiences.

MacIntosh (2003) also found that new nurses focused on task completion and did not reflect on how others' perceived their performance in their initial phase of identity development which began after convocation. In the current theory, Nursing Students and NG/RNs are consistently concerned about receiving feedback and being viewed in a positive way in terms of their performance, by other nurses and by clients. In FINDING MY OWN WAY values are central to NI but MacIntosh did not present values or other

motivators for making judgments and choices in her theory. Although *connecting with others to make a difference* was viewed as central to the Ideal NI in the current study, clients, or the meaning gained from interacting with clients was not a finding reported by MacIntosh.

Context of NI development: Personal Identity and Environment

In the proposed theory FINDING MY OWN WAY, Personal Identity and Environment influence the process of NI development. Meanings assigned to experiences, and the Choices made and Actions taken based on these Meanings, exert further influence on the process. The finding in the current study that Personal Identity influences perceptions and Meanings created from experiences is supported by research examining how personal values alter perceptions (Feather, 1995; Goodwin, Costa, & Adonu, 2004; Sagiv & Schwartz, 2000) and helps explain the findings in the current study where NGs who have had similar experiences will have differing perceptions of these experiences.

In the current study, individuals have a sense of nursing and who they would like to be as a nurse before they experience nursing education and practice and this sense creates expectations and preconceptions that serve as the measure against which they evaluate their educational experience and the people they encounter. The fact that students enter nursing education with preconceptions is well-supported in the literature (Adams et al., 2006; Grainger & Bolan, 2006; Cook et al., 2003; Gallagher, 2007; Spouse 2000; Thorpe & Loo, 2008). Gallagher (2007) found that these preconceptions "were the standards against which the worth of the formal, practical, and personal theories to which students were exposed during their nursing degree was evaluated" (p. 878). Similarly, Andersson (1993) reported that "new information offered by the education programme has to 'filter' through the student's perceptions of nursing. Information, knowledge or values, which are not in line with the ideal image of nursing, are rejected or induce perspective transformation" (p. 814).

In the current study, it was revealed that NG/RN's identities prior to entering nursing education are rooted in values and perceptions that first attracted them to nursing and that these values are stable over time. Other researchers have reported similar

findings (Andersson, 1993; Björkström, Athlin, & Johansson, 2008; Bolan & Grainger, 2009; Eley, Eley, Bertello, & Rogers-Clark, 2012; Fagerberg & Kihlgren, 2001; Newton, Kelly, Kremser, Jolly, & Billett, 2009; Pedersen & Sivonen, 2012). This finding is important in terms of the timeline for NI development as it demonstrates that it is because individuals already believe themselves to be caring, compassionate, and other-oriented that they choose nursing. Individuals are more apt to choose nursing if they perceive nurses belonging to a group with values they share and will fit well.

There has been previous research which emphasized the role of values in generating a NI (Fagermoen, 1997; Ohlén & Segesten, 1998). Fagermoen (1997) also concluded that "values are inherent in developing and sustaining professional identity and are expressed in nurses' actions in relation to others" (p. 436). In the current study, NGs feel most fulfilled when they are able to apply the values inherent in connecting with their clients and this need to apply values to extract meaning from nursing work has been cited in other studies (Fagermoen, 1997; Öhlén & Segesten, 1998; Perry, 2005). The proposed theory, FINDING MY OWN WAY furthers the understanding of finding meaning in nursing practice by explaining that the nurses' abstract values of caring and making a difference must be translated into definitions by the individual and then into corresponding actions they believe would represent these values to others. This internal process becomes highly individualized as it is influenced by existing perceptions, personal experiences, and unique Meanings assigned to these experiences. The application of these individually conceptualized values-as-actions is further modified by the external context of the various Environments of education and healthcare systems which can facilitate or impede their application.

In the proposed theory of FINDING MY OWN WAY, the Environment in which a Nursing Student learns and the NG/RN practices has a direct impact on experiences while developing a NI. Chreim, Williams, and Hinings (2007) reported similar findings regarding the influence of micro to macro Environments on professional identity development of physicians. Several other researchers have reported Environmental influences that both facilitated and hindered the enactment of an ideal identity in practice Environments (Hartrick Doane, 2002; Quality Worklife-Quality Healthcare Collaborative, 2006; Rhéaume et al., 2011; Laschinger et al., 2003; Zurmehly et al.,

2009). When **BEING THE NEW GRADUATE/RN**, practicing in an Environment which facilitates practicing her own values, increases the NG/RN's sense of positive NI and work satisfaction. This is a finding similar to those of previous studies examining factors contributing to nursing satisfaction (Brennan & Timmins, 2012; Gaudine & Thorne, 2012; Pauly, Varcoe, Storch, & Newton, 2009; Perry, 2008).

Phase 1: CHOOSING NURSING

The finding of the current study that *ALIGNING* one's ***Personal Values***, ***Preferences*** and ***Attributes*** are the primary factors weighed when choosing a career is supported by researchers examining how adolescents come to make career choices (Eccles, 2009). Specific to nursing, researchers have noted as well, that *ALIGNING* ***Personal values*** of caring or helping, with one's perception of nursing, are instrumental in **CHOOSING NURSING** (Adams et al., 2006; Brodie et al., 2004; Cook et al., 2003; Fagerberg & Kihlgren, 2001; Kirpal, 2004; Newton et al., 2009; Mackintosh, 2006; Mooney, Glacken, & O'Brien, 2008; Price, 2012; Thorpe & Loo, 2003).

In the proposed theory of FINDING MY OWN WAY the ideal image of nurse is first generated by a combination of life experiences, family member influences, and to a lesser degree, the media. All of these influences have been cited in previous studies as well (Mooney et al., 2008; Price, 2012; Sand-Jecklin & Schaffer, 2006)

There are many similarities in the reasons people viewed nursing as a positive alternative to other careers found in both the current study and past research. Fagermoen's (1997) examination of the values underlying nursing identity revealed that there are both other-oriented and self-oriented values involved in choosing nursing. This is a finding of the current study where motivations for choosing nursing related to helping others as well as to personal achievement and security. Based on Price's (2012) study with CA NG's, nursing was viewed by her participants as more interactive and less routinized than an office job and when comparing medicine and nursing, nursing was viewed as offering more personal interaction. These were findings in the current study as well.

It is noteworthy that, although being an RN is a career that pays relatively well, financial motivation was not cited by current study participants as a significant factor

influencing the choice of nursing as a career, nor indeed, was it mentioned in any other studies reviewed. Is some stigma attached to choosing nursing for financial reasons as was hinted by participants in the current study who criticized others whom they believed entered nursing for financial gain? Could this be a function of gender to some degree? Interestingly, security in the sense of always having employment options was an acceptable motivation, although it too is directly related to stable income. As found in the current study, Kirpal (2004) also reported employment portability and the variety of areas that nurses can work as motivations for choosing nursing as informed by European RNs.

A central motivation to becoming a nurse revealed in the current study was the desire to "make a difference" and this is supported by a number of studies from a variety of countries (Maben et al. 2007; Newton et al., 2009; Pask, 2003; Perry, 2008; Price, 2012; Usher et al., 2013). This desire to "make a difference" has been cited as providing a source of meaning to the nurses' work (Pask, 2003; Perry, 2008). Wanting to "make a difference" could be interpreted as a self-oriented motivation since it could be viewed as a way of exerting one's influence over another and thus, carries connotations of power-seeking in nurse-client relationships. By contrast, it could also be viewed as an other-oriented value if the differences that are made are aligned with the goals of the client the nurse is working with. Therefore, it is posited here, that it is in the *applying* of "making a difference" that this motivation becomes aligned with either other or self-orientations.

Phase 2: BEING THE NURSING STUDENT

In Phase 2 of the proposed theory of FINDING MY OWN WAY the person is **BEING THE NURSING STUDENT**. At this time, a Nursing Student is discovering new things about nursing that cause her to *REFINE* her original image of nurse. Primarily, the Nursing Student develops a deeper understanding of what it is RNs DO, but the more abstract concept of Nursing values, i.e. who a Nurse SHOULD BE which forms the basis of the Ideal NI, remains stable. The *REFINING* of NI occurs during this phase through ***Experiencing formal learning***, ***nurses***, and ***clients***. Sand-Jecklin & Schaffer (2006) reported similar quantitatively-derived results; although measures of perceptions related to nursing values did not change over a six-month period of nursing education, the students' ideas about the duties and responsibilities of nurses changed considerably.

Björkström, et al. (2008) in a longitudinal study with Swedish nursing students and RNs, also found that measures related to humanistic values remained stable for both students and practicing nurses.

Pratt, Rockmann, and Kaufmann (2006) argued that because what we DO as work partly defines our identities, the work itself can lead to changes in identity. This offers evidence to support that nurses working in differing roles and areas can have a different image of what it is a nurse DOES. However, it is the understanding revealed in the data and presented in the proposed theory of FINDING MY OWN WAY, that what a nurse DOES is described on a fundamentally different level from WHO a nurse is. The WHO speaks to values, commitments, and the WAY in which tasks would be carried out. The DOES speaks to responsibilities and prioritized tasks and duties. In FINDING MY OWN WAY, DOING and BEING are more separate mental constructs. What the nurse DOES is more directly affected by the immediate Environment than WHO the nurse is. This understanding of identity is supported by the framework related to medical student identity development proposed by Swanwick (2005) who posited that developing into a professional is "a process which itself is more about *being* than *doing*" (p. 862).

Experiencing Formal Learning, Nurses, and Clients

In the current study, refinements were made to NI during BN education in varying degrees and resulted from ***Experiencing formal learning, nurses, and clients***. The primary refinements made were that nursing involved a more complex level of knowledge as well as a greater degree of responsibility than originally perceived. This is consistent with what has been reported in studies in CA (Bolan & Grainger, 2009), the United Kingdom (UK) (Brodie et al., 2004), and the US (Sand-Jecklin & Schaffer 2006) in relation to BN students' changing perceptions. Findings from the current study demonstrate that the role of nurse as client advocate is an aspect of NI Nursing Students develop during their education, and was also the aspect of the nurse's role which increased most in a group of US BN students in a quantitative study using the Nurses Professional Values Scale by Leners et al. (2006).

In the proposed theory of FINDING MY OWN WAY, the impact of formal learning on nursing values development is minimal. This was a somewhat surprising

finding as it has been largely taken for granted that nursing education instills a sense of values in the Nursing Student. In nursing literature the causal relationship between Nursing graduates' values and their education is sometimes stated as fact without evidence to support this relationship. Maben et al. (2007) concluded that because the participants in their study, "emerged from their education programme with a coherent and largely consistent set of nursing ideals and values" (p. 109) this was the effect of being taught these ideals in the program. However, as there was no investigation of the graduates' ideals prior to their education, it cannot be known if these ideals were already present.

The findings of the current study indicate that formal learning has limited influence on changing personal values and the consequent NI developed, findings supported by a number of researchers from Canada (CA) (Bolan & Grainger, 2009), Sweden (SWE) (Björkström et al., 2008; Fagerberg & Kihlgren, 2001), the US (Sand-Jecklin & Schaffer, 2006) and Finland (Vanhanen & Janhonen, 2000) who found NI to be stable throughout the education experience. Interestingly, studies with medical students regarding moral identity development have also shown little change during education (Branch, 2000; Patenaude, Niyonsenga, & Fafard, 2003; Self, Schrader, Baldwin, & Wolinsky, 1993).This stands in contrast to the findings of several other researchers who concluded that nursing education did significantly influence NI development as investigated by quantitative (du Toit, 1995) and qualitative (Reutter et al., 1997) studies examining socialization, quantitative measures of professional identity (Leners et al., 2006) and qualitative measures of self-concept (Ware, 2008).

The finding of the current study that courses related to values or ethics are viewed as "common sense" and not valued by students is supported by research from Australia (AUS) by Birks et al. (2011) and Hughes (2005). Belgian researchers Milisen, De Busser, Kayaert, Abraham, and Dierckx de Casterlé (2010) discovered that courses on ethics, research, and philosophy were least valued by students while clinical and science-based courses were most valued. In the current study, topics and skills which had obvious relevance and concrete applicability to clinical practice were most valued. It was found in the current study that Nursing Students feel they must *apply* knowledge and skills to be able to truly learn them. Research has also demonstrated different interpretations of ethics

courses between students and instructors, i.e. students may not experience courses as the instructors believe they are delivering them (Numminen, Leino-Kilpi, Arie, & Katajisto, 2011). In the current study Nursing Students shared a similar disconnect; feeling that the answers to ethical case study questions were black and white and that the "correct" answers essentially belonged to the instructor. They felt "preached to."

A finding in the current study is that though NI development is a social process, it also requires interpretation and during this interpretation, the experiences of socialisation are modified by Personal Identity to result in unique Meanings being created. This influence of the individual's Personal Identity on NI development stands in contrast to socialization discussions within healthcare literature which have generally focused on the top-down effects of role modelling by more experienced nurses to Nursing Students and NGs (Bisholt, 2012; Brown, Stevens, & Kermode, 2012; Coudret, Fuchs, Roberts, Suhrheinrich, & White, 1994; du Toit, 1995; Reutter et al., 1997; Ware, 2008).

As mentioned previously, each person has an existing perception of how a nurse SHOULD BE. This perception influences how she will judge the nurses she encounters. In the current study, this judgment of other nurses is based primarily on how that nurse's treatment of the Nursing Student or NG/RN is perceived and on whether that nurse is perceived as a strong patient advocate. When a Nursing Student or NG/RN feels mistreated by a nurse she views this nurse as a negative role model and makes efforts to avoid this nurse. Though some encounters with staff nurses can be negative, more negative relationships are experienced while **BEING THE NURSING STUDENT** with clinical instructors which result in the Nursing Student feeling unsafe and misunderstood. This is in keeping with the finding of Clarke et al. (2012) where Canadian BN students cited their clinical instructors as the primary sources of bullying behaviours witnessed. However, it was noted in the current study that the clinical instructor also had the ability to make the student feel supported and safe and was sometimes viewed as a better source of support than faculty in lecturing or administrative roles. It was also noted in the current study that messages imparted by negative role models are more easily dismissed by the Nursing Student and therefore less influential on NI development than the messages of positive role models.

So, while some researchers from the UK (Brodie et al., 2004) CA (Day, Field, Campbell, & Reutter, 2005; Reutter et al., 1997) and the US (Wear & Zarconi, 2008) have put forth that the effect of negative role models is to "teach" the newcomer how "not to be" a finding of the current study is that the student *already* has values and beliefs in place which cause her to categorize this role model as negative and therefore, *already* knows "not to be" like this person. Thus, the positive spin assigned to negative role models as far as their value to NI development may be misplaced.

Though it is generally accepted that learning in nursing education is facilitated by mutual respect between educator and learner (Gaberson & Oermann, 2010; Gillespie, 2005; Mogan & Knox, 1987) the effects on NI development that may result from not respecting an instructor because they represent a negative nursing role model could not be found in the literature. However, in a study with U.S. medical students Wolf, Randall, Von Almen, and Tynes (1991) discovered that feeling mistreated in medical school increased cynicism in graduates. In the current study, it was found that if Nursing Students feel mistreated by nursing instructors they may question the values of RNs as a group. However, the Nursing Student and NG still holds on to her belief about how the nurse SHOULD BE even if first-hand experiences contradict this imagined ideal.

The Ideal NI is conceptualized in FINDING MY OWN WAY as *connecting to make a difference* and experiences with clients serve to deepen the student's belief that empathy, or the ability to relate to the client's situation is an important part of the nurse she wants to be. Thus, these experiences while **BEING THE NURSING STUDENT** reinforce or further develop existing values associated with Ideal NI. While the participants rarely used the term "empathy" it is understood as "an ability to communicate an understanding of a client's world" (Reynolds & Scott, 1999, p. 363). The finding that caring for others enhances Nursing Students' understanding of their values is reinforced by the findings of other studies examining the student experience in delivering care to clients in the US (Warelow, Edward, & Vinek, 2008; Pearcey & Draper, 2008)

Brunero, Lamont, and Coates (2010) conducted a literature review about the effects of empathy education in nursing and examined 17 quantitative studies. The majority of these studies demonstrated an increase in empathy. Most of these studies were focused on specific educational interventions and on pre-test and post-test measures

to determine effectiveness. Other studies have found a decrease in empathy measures during nursing education over time (Nunes, Williams, Sa, & Stevenson, 2011; Ward, Cody, Schaal, & Hojat, 2012). Murphy, Jones, Edwards, James, and Mayer (2009) conducted a quantitative cross section survey of UK students, one group at the start (N= 80) and one at the end (N= 94) of a BN program, and discovered a statistically significant decrease in caring behaviours as indicated by students' self-reports on the Caring Behaviours Inventory Index. Mackintosh (2006) discovered a loss of idealism in students during nursing education, which they felt negatively affected the students' ability to care.

Being on the Outside

The finding of the current study, that Nursing Student identity is very different from NI, casts doubt on the value of asking students about NI as have many researchers (Day et al., 2005; Grealish & Trevitt, 2005; Leners et al., 2006; Andersson & Edberg, 2010; Milisen et al., 2010; Ware, 2008). In the current study participants offered information based on having recently been Nursing Students and contrasted this with how they now experienced nursing. Therefore, they could fully appreciate the contrast between the nurse they thought they would be while **BEING THE NURSING STUDENT** and the nurses they were now being.

The Nursing Student experiences ***Being on the outside*** of the collective RN identity due to ***Dressing differently***, ***Nursing differently***, and are ***Feeling in the way and less-than.*** These differences that exist during the Nursing Student Identity are viewed in FINDING MY OWN WAY as having an important impact on NI development. Kirpal (2004), a social scientist, conducted a qualitative study with nurses from various European countries and reported that nursing education did not greatly influence NI development and attributed this finding to the differing levels of responsibility and autonomy between the student and nurse roles.

Based on the current study, Nursing Students in clinical feel distinctly separate from other nurses, in part because of the student uniform, referred to as their "whites." This finding is supported by Irish researchers Brennan and Timmins (2012) who suggested that the previous hospital education system created a stronger Nursing Student identity partially tied to symbols such as uniforms or badges, than did the university

system which served to segregate students from the hospital culture and therefore, made them outsiders.

The organization of student work around total patient care was found to hinder BN graduates' ability to learn about delegation and teamwork in the current study. The former finding was reported by Hasson, McKenna, and Keeney (2013) in the UK, and the latter by Besner and Lait (2011) in CA. Based on the findings of the current study, being assigned only one or two clients influences the way NG/RNs interact with clients. Spouse (2001) had earlier noted that U.K. students could work at a slower pace and think about their actions, had time to speak to their clients, and came to know them as people. Michalec, Diefenbeck, and Mahoney, (2013) who studied U.S. BN students added that

> the mantle of "the student" provides a safety net for the student to perform the tasks and duties expected of them while remaining somewhat shielded from the negative side-effects of such activities (i.e., burnout and compassion fatigue). (p. 319)

The students' highly positive sense of NI that is partially a result of being protected from some of the realities of nursing practice, may contribute to the transition shock experienced by NGs (Duchscher, 2008; 2009). This idealism of students was summarized by Milisen et al. (2010) in relation to senior Belgian nursing students' views of important nursing care

> individualizing patient care, detecting care problems and potential complications, and promoting patient well-being; within a care environment with open interdisciplinary communication, where care problems could be discussed with nursing colleagues, where one cares for the same patient regularly, and [is] led by a team leader with vision. (p. 688)

This idealism provides further evidence that education maintains much of the initial values present when **CHOOSING NURSING** and further contributes to the Ideal NI with which the Nursing Student enters her senior practicum. The participants in the current study recognized that nursing education could not prepare them for everything they would experience in practice. Similarly, the participants in Hickey's (2010) U.S. study stated that, "the real world is different, and 'little can prepare one to take care of 8 patients' and manage the 'problems that occur during a shift'" (p. 40). In FINDING MY OWN WAY, students feel "lowly" as compared to others with whom they interact in healthcare settings. Participants in the current study tended to be relatively forgiving of

staff nurses' behaviours toward Nursing Students, citing that the student could be a burden and therefore add to the nurses' stress. This perception of students about their place in the clinical learning environment has been cited in other studies from AUS (Jackson et al., 2011) and the UK (Brodie et al., 2004).

Getting Through

The fact that the Student Identity is by and large a finite one, makes it unique from the RN identity. The knowledge that the identity is temporary influences Choices made while **BEING THE NURSING STUDENT** as they focus on ***Getting through***. In the current study, Nursing Students Choose avoidance and silence and this results from a sense of powerlessness coupled with a need for ***Protecting self*** while ensuring they are successful in ***Passing courses and the nursing program*** and that this was accomplished by not "rocking the boat." Similar findings have been reported repeatedly in nursing literature (Coudret et al., 1994; Day et al., 2005; Grealish & Trevitt, 2005; Jackson et al., 2011; Levett-Jones & Lathlean, 2009; Reid-Searl et al., 2010).

Several researchers have examined the impact of power hierarchies on student learning and development (Allan, Smith & O'Driscoll, 2011; Brodie et al., 2004; Grealish & Trevitt, 2005; Jackson et al., 2011; Myrick et al., 2006; Pearcey & Draper, 2008; Reid-Searl et al., 2010). Both Allan et al. (2011) in a study with U.K. students and Jackson et al. (2011) in a study with AUS students found students were subjected to disempowering behaviours which set up barriers to learning. Similar to the findings related to experiences of Nursing Students in the current study, Nursing Students tolerated these disempowering behaviours with relative degrees of silence and avoidance (Bradbury-Jones et al., 2011; Myrick et al., 2006).

Phase 3: BECOMING AN RN

The phase, **BECOMING AN RN** is situated within the transition from the Nursing Student identity to the RN identity. This phase begins to take place in senior practicum and continues into **BEING THE NEW GRADUATE RN**. The finding in the current study that individuals are negotiating two identities during this time, that of student and of practitioner, has been previously described both in the nursing literature (Holland, 1999) and in literature related to professional identity development of clinical psychologists (McElhinney, 2008). In FINDING MY OWN WAY this is the phase when the Senior

Student and NG are ***Beginning to belong*** to the RN collective identity and seek to *fit in* with in the work group.

While **BECOMING AN RN** the Senior Students/NGs' Ideal Nursing Identities are challenged and one finding of the current study is that they are faced with needing to ***Let go*** of some of the idealistic images of HOW they would enact their Nursing Identities. They become more realistic. In a study conducted with medical residents' professional identity development, Pratt et al. (2006) described this phenomenon of changing perceptions as developing a more "nuanced" (p. 254) sense of identity and they believed this contributed to identity enrichment. This idea of identity enrichment fits well with the findings of the current study, as it captures the movement from black and white images the participants had of nursing while Nursing Student, to a more complex or *nuanced* understanding of the role of RN now that they were ***Experiencing RN reality***. Being that these participants had less than one year of experience at the time of the interview, the complexity of RN practice was likely not yet fully appreciated.

Experiencing RN Reality

Although researchers have largely focused on transitions to the RN reality post-graduation, the finding of the current study indicates that the greatest adjustment to NI occurs during both senior practicum and the initial months of practice as new BN graduates when students *REDEFINE* their NI based on ***Experiencing RN reality.*** Numerous studies about transition to practice support this finding related to the "shock" many NGs experience after senior practicum (Cowin & Hengstberger-Sims, 2006; Newton & McKenna, 2007). However, the importance of the senior practicum experience (or capstone course) for identity development, adjustment to practice reality, and nursing skill development, as identified in the current study, is supported by numerous other researchers as well (Anderson & Kiger, 2008; Casey et al., 2011; Cooper, Taft, & Thelen, 2005; Curtis et al., 2012; Hickey, 2010; Schroetter & Wendler, 2008), as has the importance of hands-on experience (Chappy, Jambunathan, & Marnocha, 2010; Hartigan-Rogers et al., 2007; McAllister et al., 2007; Ralph et al., 2009; Papp, Markkanen, & von Bonsdorff, 2003).

Maben et al., (2007) have discussed NG idealism, as have Duschsher (2009) and Kelly (1998). MacIntosh (2003) further noted that this challenge to ideals during NG transition often resulted in the acceptance of ***Letting go*** as unavoidable and necessary for developing a more realistic professional nursing identity. Spouse (2000) had earlier suggested that students "sublimate" (p. 732) their ideals, while Kelly (1998) described the "reworking" of ideals to cope with moral distress through rationalizing. Randle (2002) actually found that students "failed to preserve their moral integrity" (p. 251). These findings are in contrast to those of the current study where ***Letting go*** is not viewed as an abandoning of ideals or nursing values. Instead, these ideals and values persist but Senior Students/NGs are able to ***Let go*** of some idealistic *enactments* of these ideals, i.e. the HOW of nursing. For example, the Senior Students/NGs let go of the ideal of taking time to sit and talk to clients but do not abandon the ideals associated with connecting with clients. They "do the best they can." Thus, there is a personally mediated *REDEFINING* of the Ideal NI into a less ideal, Lived NI. And since the realities of practice are often accepted as unchangeable, Senior Students/NGs focus on strategies to circumvent the competing demands of the workplace and still connect with clients.

However, it was noted in the current study that Personal Identity and one's perception of their Ideal NI also had an important influence on how the Senior Student/NG perceived congruence between her Ideal and Lived NIs. Thus, two graduates may profess the same abstract values associated with their Ideal NI, practice in the same Environment, and still have differing interpretations of how well they are able to live out their Ideal NI. Some Senior Students/NGs more readily accept the need to *REDEFINE* HOW they will enact their NIs and others experience distress. In FINDING MY OWN WAY, the level of distress is related to the Senior Student/NG's understanding of her Ideal NI, her level of commitment to this ideal, and the characteristics of the Environment.

As was reported by Kelly (1998), if the mismatch between how the person is able to enact her NI in the Environment and her Ideal NI is too great, NGs contemplate or act on changing the Environment. Thus, findings from both the current study and Kelly's were that there is a limit to how far one can *REDEFINE* the actions associated with the ideals of what nursing SHOULD BE before one is unable to accept the dissonance.

Organization science research also informs us about the effects of dissonance between an Ideal versus Lived identity. Foreman and Whetten (2002) found the degree of cognitive dissonance between ideal identity and that which an individual was able to live out within an organization significantly affected the individual's commitment to the organization.

The finding of the current study that Senior Students/NGs are ***Realizing gaps in knowledge*** related to interpersonal dynamics, delegation, and leadership skills once immersed in the practice setting, has been previously reported by researchers in CA (Bolan & Grainger, 2009; Duchscher, 2009), SWE (Björkström et al., 2008; Kyrkjebø & Hage, 2005), Finland (Suikkala & Leino-Kilpi, 2001), and the US (Cooper et al., 2005; Rebeschi, & Aronson, 2009). Etheridge's (2007) examination of how U.S. NGs learn to "think like a nurse" (p.24) exposed many of the same experiences of transitioning to RN practice as were revealed in the current study, including her finding that "accepting responsibility, adapting to changing relations with others, and thinking more critically" (p. 24) were skills that had to be developed once experiencing the RN's practice reality.

Beginning to belong. In the phase, **BECOMING AN RN**, there is a distinction made between ***Beginning to belong*** to the collective identity of RN versus *fitting in* with the workplace group. The former identity is based on the individual feeling more aligned with the RN identity by ***Gaining competence and confidence*** and thus, is more of an internal process. Fitting in with the workplace group is determined by ***Feeling supported*** based on feedback from others and is modified by expectations of the Senior Student/NG. This distinction was not one found in literature describing professional socialization in nursing but identity theorists present varying levels of identity associations at personal, relational, or collective levels (Brewer & Chen, 2007).

Nursing-related research which aligns with the concept of *fitting in* in the current study typically focused on socialization to the working group (Malouf & West, 2011; Mooney et al., 2008; Levett-Jones & Lathlean, 2008) while research findings that parallel those of the current study related to belonging to the collective RN identity focused on self-confidence or competence measurements (Anderson & Kiger, 2008; Cooper et al., 2005; Wangensteen et al., 2012). So in FINDING MY OWN WAY "fitting in" with the work group can be separated from "feeling like an RN" but both can be described as types of ***Belonging*** in NI development.

MacIntosh (2003), in a study with practicing nurses in Canada, also theorized that stages of socialization exist and nurses continue to "rework" their NI long after graduating, with acceptance from others being a key component of this process. Hotho (2008) explained that it is natural for people within organizations to seek an alliance with the more powerful, or "in-group" (p. 728). This supports the finding of the current study that the desire to detach from the lower-level group of Nursing Student motivates the Senior Student/NG to adopt the practices of the more powerful RN group. The importance of being accepted and fitting in during transition from Nursing Student to RN identity and the influence on Choices made has been well explored in the nursing literature (Deppoliti, 2008; Duchscher, 2008; Kelly, 1998; Kyrkjebø & Hage, 2005; Newton & McKenna, 2007; Randle, 2002).

However, despite the need to belong being a motivator for Choices and Actions, it was found in the current study that, as individuals, a Senior Student/NG exerts her own limits while adjusting her Ideal NI in order to belong. Kirpal (2004) explained that this variation results from group influences being filtered through the individual's own values and perceptions. Thus, if there is a perceived conflict between the group expectations and the NG's self-expectations, she will Choose HOW to Act based on her own Personal Identity, Ideal NI, and the Meanings she assigns to the experience. This helps explains why Senior Students/NGs and RNs may interpret similar practice situations differently, make different Choices and demonstrate different Actions.

In the current study it was found that socialization could exert positive or negative influence on Senior Students/NGs. Positive messages from some senior nurses about advocating for clients inspired participants and bolstered their courage to "put the patient first" while negative messages discouraged them from addressing practice issues and contributed to seeing themselves as powerless to effect change. In a grounded theory study with Irish NGs, Mooney (2007) also found that the efforts of NGs to address practice issues were met with dismissive comments such as "it has always been done this way" (p. 77). Researchers have reported that wanting to fit in encourages conformity and conformity increases the likelihood that an individual will behave in a way that is inconsistent with his/her values (Bardi & Schwartz, 2003; Bardi et al., 2009; Bernard et al., 2003; Farmer & Dyne, 2010; Levett-Jones & Lathlean, 2009; Lonnqvist et al., 2006)

and thus, the effects of wanting to "fit in" have an important modifying effect on Lived NI.

In FINDING MY OWN WAY, if the Senior Student/NG perceives colleagues as displaying nursing values that are disparate from her own, this diminishes her desire to fit in with this group. Spouse (2001) also discovered that if participants disagreed with the approaches modeled by nurses, this made them less likely to seek support from these nurses and diminished a sense of belonging. Still, the Senior Student/NG wants to belong to the collective RN identity as envisioned in her Ideal NI but may find a lack of support in the current Environment to realize this goal. Thus, the findings of this, and other studies support the work of Duchscher (2008), whose transition shock theory illustrates that NGs struggle to construct a NI that still adequately represents their ideals within the realities of certain practice Environments.

The ability to relate to others was a prerequisite for offering support in the current study. Senior Students/NGs in the current study describe support primarily as the security of knowing other nurses will "have your back" as well as validation in the form of positive feedback. Both contribute to feeling accepted. It was discovered that participants in the current study often felt that more experienced nurses were less able to relate to the needs of the student and less likely to be positive forms of support. Although nursing instructors reading this are likely familiar with the student refrain, "They forget what it is like to be a student", there is very little to be found in the literature about this phenomenon. In a study conducted with CA nursing students and staff, Besner and Lait (2011) also found that participants believed older nurses were less able to relate to students. Rather than a generational issue, this seems to be an issue of *relating* as a precursor to being able to provide support. Thus, if an older or more experienced nurse has the ability to put herself "in the student's shoes" she will be equally as capable of offering support as a younger nurse.

An important modifier of access to support and feedback in FINDING MY OWN WAY was the context of Environment with areas of higher client-nurse ratios interfering with access to support. Other researchers from CA (Sedgwick & Harris, 2012), SWE (Kyrkjebø & Hage, 2005) Ireland (Mooney, 2007), and AUS (Parker, Giles, Lantry, & McMillan, 2014) have discovered that access to support and feedback for NGs can be

inadequate due to competing demands within the Environment that can interfere with supporting new nurses.

In the current study, an important goal for Senior Students/NGs while **BECOMING AN RN** is ***Carrying a full load.*** They find organizational skills and multitasking in combination with becoming familiar with routines as ways to meet this goal. This focus on multitasking and mastering routines is similar to Kelly's (1998) findings in her work with U.S. NG nurses. Bjerknes and Bjørk (2012) found that SWE NGs would accept stressful workloads so as to be seen as doing a good job. Maben et al. (2007) also found NGs in the UK felt they had to do their fair share of the "dirty work" (p. 103) to avoid reprisal from colleagues. On the other hand, Senior Students/NGs in the current study also had to be encouraged to take breaks and delegate tasks, indicating that they may sometimes overestimate the expectations of others in their attempt to do a "good job" and be accepted or may be trying to live up to self-expectations which exceed those of their colleagues.

In the current study, a strategy used by NGs to *fit in* is ***Avoiding ward politics***. This could be conceptualized as rising above the gossip and petty interpersonal conflicts witnessed or as avoiding dealing with conflicts that should be addressed. It may be that avoidance was learned as a strategy during education, as was noted previously by Pines et al. (2012), or that this is a coping strategy common to persons who choose nursing (Thorpe & Loo, 2003). Avoidance of conflict has been reported to be self-protective (Chang et al., 2006; Duddle & Boughton, 2007; Laabs, 2011) and has also been seen in the actions of other healthcare provider groups such as Speech Language Therapists (Kenny, Lincoln, Blyth, & Balandin, 2009) and Clinical Psychologists (McElhinney, 2008).

Phase 4: BEING THE NEW GRADUATE RN

In the final phase of the process of NI development, the person is assuming the role of New Graduate RN (NG/RN). The NG/RN is in a period of transition that has been well-studied in the nursing literature and this period is accepted as a time of great and sometimes difficult adjustment (Andersson & Edberg, 2010; Deppoliti, 2008; Draper, Sparrow, & Gallagher, 2009; Duchscher, 2008, 2009; Kelly, 1998; Newton & McKenna,

2007). In FINDING MY OWN WAY, this fourth phase is when the person is ***Separating from the Nursing Student Identity*** through ***Assuming RN responsibility*** and by ***Describing herself as nurse***. The NG/RN is now *CUSTOMIZING* her NI and discovering what works for her within the context of her Personal Identity and her current Environment. She discovers ***Nursing My way.*** The original value-based beliefs about WHO a nurse SHOULD BE remain, and the NG is finding ways of ***Connecting to find meaning.***

Separating from the Nursing Student Identity

While transitioning to the new identity of RN, results of the current study revealed that the NG can still feel like a student and must separate from this prior identity in order to embrace her new one. New Graduates in a study by Draper et al. (2009) described similar feelings of coming to terms with their new credentials and the associated identity, almost forgetting at times that they were now the RNs and responsible for their clients. The increased autonomy of the RN compared to that of the student has been noted in other professions as part of the transition. School life is experienced as more prescriptive with less freedom and this also separates the student identity from the practitioner identity (McElhinney, 2008).

As found in the current study, other research with NGs has highlighted the effects of responsibility on delineating the difference between Nursing Student and RN identity. As described by Bjerknes and Bjørk, (2012), "One nurse, who considered herself well acquainted with the ward from her student days, noticed a marked difference between being a student and bearing the responsibility of being a nurse. She said that 'the main difference between training and being on the job is in fact the responsibility'" (p. 4). Other researchers also reported increased responsibility as central in the transition from student identity to RN in CA (Duchscher, 2009), SWE (Andersson & Edberg, 2010; Fagerberg & Kihlgren, 2001), AUS (Cowin & Hengstberger-Sims, 2006; Newton & McKenna, 2007; Parker et al., 2014) and the US (Deppoliti, 2008; Etheridge, 2007)

Despite ***Assuming RN responsibility*** being a commonly cited finding in the literature related to transition to the RN identity, what stood out in the current study was the finding that individual participants interpreted the responsibilities related to their

NG/RN role differently. Some participants focused on doing the best for their assigned clients, increasing their own competence, and avoided any extra responsibility. For others, additional group level responsibilities, such as addressing staffing issues, were accepted and viewed as part of their RN responsibility. Factors associated with the variation found were the amount of support the person felt they had from others should they choose to act when confronting workplace issues and the amount of control they believed they had over the situation. These Meanings being assigned were generated by past experiences and if a NG/RN is discouraged by others, or if she has been ineffective when trying to take action in the past, she is less likely to view taking action for issues such as unsafe practice conditions or interpersonal conflicts, as worthwhile. These past experiences help shape the new Meaning for the NG/RN, that trying to address practice issues is futile. Studies examining ethical decision making support the finding of the current study that Nursing Students and nurses interpret situations differently, i.e. have unique Meanings, and Choose different Actions with perceptions of risk, competence, and confidence being the primary factors influencing these Choices (Callister et al., 2009; Goethals et al., 2010; Hartrick Doane, 2002; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012).

In FINDING MY OWN WAY, NGs begin to customize HOW they practice to best suit themselves in their current Environment and are discovering ***Nursing My way***. Teachings from formal educators and senior RN peers are less influential, as the NG/RN decides what "works for me". They become more "creative" in finding what works. This allows for increased influence from their individual Personal Identities, which were somewhat suppressed while **BEING THE NURSING STUDENT** and **BECOMING AN RN** due to educational expectations. The effects of increasing experience and feelings of competence, and the concomitant flexibility and creativity being applied to the NG's practice, are congruent with Benner's (1984) Novice to Expert theory of nursing development. For example, the movement from task focus to the "bigger picture" correlates with movement from the Novice phase to the Advanced Beginner phase and is the result of increased experience with clinical situations (Benner, 1984).

MacIntosh (2003) also proposed in the final stage of her theory *Reworking Professional Identity*, that RNs are infusing more of their Personal Identity into the

professional identity. Pratt et al. (2006) conducted research about constructing professional identity with U.S. medical students, which led them to posit that one customizes to match the work to one's preferred self and that "work is meaningful to an individual to the extent that it reflects who the individual is" (p 255). In research with psychology and political science graduates transitioning to working life, Nyström, (2009) discovered that individuals negotiate between personal and Environmental expectations while forming their work identity.

When interviewing began for the current study, the open-ended request for the participant to "Tell me about your Professional Identity as a nurse" was met with silence or awkward hesitation. This response in itself was telling. Due to the "rough start" this opening request produced, when the interview guide was revised the questioning began with "Thinking back to when you decided to enrol in a BN program, what made nursing seem like the right choice for you?" This question resulted in immediate responses.

In the current study the concept of what it means to be a *professional* RN was not easily articulated by participants. Akhtar-Danesh et al. (2013) in a Q-sort study with Canadian nursing students and faculty found that differing interpretations of the term *professionalism* existed between nurses and students and concluded that there were numerous contextual variables that affected individuals' perceptions of this term. Goodrick and Reay (2010) conducted a discourse analysis of nursing texts from the 1960's to the 1990's and discovered a shift in the way the word *professional* was used. While it originally referred to level of training, *professional* was later defined in the broader sociological context (Goodrick & Reay, 2010). Despite the existence of a definition based on social science criteria, Watson (2002) goes as far as to question whether social scientists should avoid the word *professional* in research altogether, given the ambiguity associated with this term as used by laypersons. Researchers with other healthcare professionals have also revealed disparate interpretations of *professionalism* (Hafferty & Castellani, 2010; Martimianakis, Maniate, & Hodges, 2009; Monrouxe, Rees, & Hu, 2011).

Finding Meaning by Connecting

Despite ***Letting go*** of some of the idealistic images of themselves as nurses while **BECOMING AN RN**, NGs in FINDING MY OWN WAY still believe themselves to be caring and compassionate people who want to *connect to make a difference*. Other researchers have supported that aligning one's values with one's chosen work increases a sense of meaning, fulfillment, and satisfaction with work life (Fagermoen, 1998; Ibarra, 1999; Kahn, 1990; Perry, 2008; Pratt et al., 2006). The degree to which a NG is successful in finding meaning depends in part on how idealistic her original perception of "connecting" is and how much she is able to *REDEFINE* this ideal as a representative action before she becomes aware of the incongruence with her Ideal NI. The NG/RN finds strategies to fulfill the act of connecting such as ***Stealing moments*** and ***Attending to the little things***. As mentioned earlier, if the Environment facilitates the application of the NG/RN's values and promotes connecting with clients, she will be more satisfied in her work. This link between Environment, enacting nursing values, and job satisfaction has been previously reported (Atree 2005; Canadian Health Services Research Foundation, 2006; Gaudine & Thorne, 2012; Kirpal, 2004; Kramer et al., 2009; Laschinger et al., 2003). However, the NG/RN also discovers that connecting may be associated with risk to self and sometimes ***Disconnecting*** is a way to protect herself from these risks and that ***Disconnecting*** may be recommended by senior nurses.

While the current study focussed on the NG's experience of NI development, this importance of "connecting" stood out as a finding about the nurse-client relationship. Thus, literature examining the meaning of connecting *for clients* was also examined. The importance of the nurse being able to empathize and create meaningful encounters has been cited by several researchers examining what the clients seeks in their relationship with nurses in the UK (Griffiths, Speed, Horne, & Keeley, 2012) and SWE (Berg & Danielson, 2007; Eriksson & Svedlund, 2007; Gustafsson et al., 2012; Halldorsdottir, 2008). Also, clients do appear to notice that sometimes nurses face less than ideal working conditions that can interfere with their ability to connect in meaningful ways (McCabe, 2004). The importance of connecting with clients is supported by study findings from researchers examining what clients want most from nurses: understanding

and patience were key to a positive nurse-client relationship (Griffiths et al., 2012; Gustafsson et al., 2012). The participants in the current study expressed the need to be able to relate to, i.e. understand, the client's situation, and to demonstrate patience by putting the client's needs before the nurses' need to "get things done". Thus, research findings related to the client perspective of connecting are consistent with the findings from the perspective of NG nurses in the current study.

In FINDING MY OWN WAY, NG/RNs employ the technique of ***Stealing moments*** to be able to connect with clients within the constraints of time and competing demands. This technique involves making a conscious effort to connect with a client while performing the tasks, and similar approaches have been identified in a number of studies wherein researchers examined how nurses created meaning or enacted caring in practice in CA (Perry, 2005; Boyce, 2007) and SWE (Lindh, da Silva, Berg, & Severinsson, 2010). This acceptance of a new way of connecting evolves from ***Letting go*** during the previous phase of **BECOMING AN RN**. Though aware that it is not the "ideal," ***Stealing moments*** comes to be an accepted way of accomplishing a value-based goal the NG possessed even when she was **CHOOSING NURSING**. Thus, by accepting this less ideal version of connecting, the NG is more able to satisfy ***Finding meaning*** in her work while still meeting the demands of the workplace priorities.

In the current study, feedback from clients helps NGs realize that meaning in the nurse-client relationship can be found by ***Attending to the little things***. In FINDING MY OWN WAY, *little things* include showing basic respect, providing a comforting gesture, or remembering to acknowledge a client's birthday. Findings from previous studies examining nurses' delivery of care support that client-centered care was sometimes captured in small actions and "little extras" (McGarry, Aubeeluck, Simpson, & Williams, 2009). The ability to attend to details was found by Perry (2009) to have the two-fold effect of improving clients' quality of life and nurses' job satisfaction.

Because the NG, often caught up in the business of nursing, may not realize how these *little things* affect the client, she relies on client feedback to know she has made a connection. It was evident that the participants in the current study felt validated when their efforts to connect and make a difference was acknowledged by patients or families. This can be perceived as being motivated to help in order to feel good about one's self or

to elevate one's sense of importance and this interpretation has been criticized as incongruent with a nursing ethos (Rognstad, Nortvedt, & Aasland, 2004; Solvoll & Heggen, 2010). Participants in the current study cited being thanked by clients as instrumental in making them feel like they were being the nurse they wanted to be, i.e. evidence that they were living out their Ideal NI. While appreciation from patients and families may not always be a good indicator of technical nursing competence, it should help the nurse know if they have made a positive connection with a client.

Rognstad et al. (2004) expressed concern that generational differences in how one conceptualizes "helping" may mean that younger nurses expect thanks and may not deliver optimal care should this gratitude not be offered. This stance is in keeping with the hierarchy of motives described by Paciello, Fida, Cerniglia, Tramontano, and Cole, (2013) wherein approval-oriented moral reasoning is explained as an individual being motivated only by the possibility of social recognition of the behaviour. However, this assumption that being thanked is the motivation for helping should be examined closely. As was noted in the current findings and several aforementioned studies on the motivations for **CHOOSING NURSING**, helping and caring for others are the primary values cited. So while enacting these pre-existing motivating values may result in an expression of gratitude from the recipient of care, the expression of gratitude is simply an outcome generated by acting on the pre-existing *values-based* motivations. Thus, the client's expression of gratitude is interpreted in the context of the current study not as the motivation for the behaviour. Rather, the client's expression of gratitude simply reinforces the values that contributed to the action in question and serve as validation for the NG/RN of having successfully enacted the value-based goal of ***Connecting to find meaning***.

While **BEING THE NG/RN**, the concept of psychological and emotional self-protection is introduced and the NG/RN discovers that although she wants to create meaning in her practice by connecting, doing so can put her at risk. As was discovered in the current study, Kirpal (2004) also reported that nurses must find a balance between "their own psychological need to care about their clients but, at the same time, the dangers of 'caring too much'" (p. 293). This finding was echoed in a study of nursing

identity by Deppoliti (2008) where she determined that NGs experience a "conflict of caring" (p. 258).

It was revealed in the current study that clients considered by the NG/RN as not caring for their own health or who were deemed "difficult", challenged the NG/RN's empathy and ability to connect. Also, participants felt that greater exposure to these clients and families over time increased the need for the RN to distance herself. This phenomenon is described here as ***Disconnecting***. It was also found in the current study that certain populations of clients were more easily related to, and empathized with, by participants. Clients who were viewed to be ill "through no fault of their own" were more apt to elicit feelings of empathy versus those who suffered from conditions perceived to be related to lifestyle choices. Similarly, Paciello et al. (2013) found that for one's other-centered values to be enacted at times when there was risk to self, empathy was the primary moderating factor. If the person, i.e. NG/RN, was able to relate to the person, i.e. client, and feel empathy, the NG/RN would be more likely to take action that supported the client even at the expense of the NG/RN's self-interest. However, it would also be necessary for the individual, i.e. NG/RN, to correlate this encounter with one of his/her values. In the current study, although the NG/RN has a desire to connect with clients and relate to them, barriers such as diminished empathy for the client, tasks being prioritized, being advised not to care too much, and not fully internalizing certain nursing-related values as her own values, served to influence the individual's Meanings related to ***Connecting*** with others and alters the Actions taken.

López-Pérez, Ambrona, Gregory, Stocks, and Oceja (2013) in a series of studies conducted in Spain and the US found that nursing students exhibited more empathy than experienced nurses and that experienced nurses tended to approach suffering of clients with more objectivity. Kirpal (2004) also described a redefining of caring that moved the nurse away from being too emotionally invested, and an acceptance that he/she should not care "too much", suggesting that ***Disconnecting*** increases over time. This reduction in closeness was described by the participants in Kirpal's study as "developing a more professional approach" (p. 294). While ***Disconnecting*** can be viewed as a means of protecting the self from moral distress (Hartrick Doane, 2002), researchers and theorists also discuss the dangers of becoming distanced from, or cynical of the clients for whom

nurses must care (Paciello et al., 2013; Pask, 2005; Rudolfsson & Berggren, 2012; Thorup, Rundqvist, Roberts & Delmar, 2011; Varcoe et al., 2012; López-Pérez et al., 2013).

Limitations

A major limitation of the current study is the homogeneity of the sample. All nine participants were female, with little variation in age, educational experience, or among a range of other characteristics (see Table 1). This resulted in limitations to the variation in properties and dimensions to be analyzed. Given that there were no truly negative cases, the strength of the emerging theory is compromised. Although no new information was emerging from the analysis, i.e. nothing new was being heard, the lack of variety, and in particular the lack of male participants, may have artificially created the appearance of saturation.

Given the purpose of the study was to examine aspects of identity, recruitment via self-selection with no incentive for participation meant the "types" of persons who might make the effort to participate could have shared similar values and attributes, thus skewing the finding associated with the context of Personal Identity.

Espoused aspects of one's NI, including values, do not necessarily offer accurate data about how these values are enacted in practice. As a result, questions were posed to participants in relation to how they enacted their nursing identity or values in practice. Unfortunately these questions did not yield very rich data, again weakening the theory related to this concept. The lack of concrete examples of values-in-action is likely the result of a novice interviewer coupled with a lack of reflection by participants on how their actions represent the values they possess. Observations of values-in-action would have strengthened the findings and resultant theory.

Implications for Practice, Teaching, and Research

Findings of the current study challenge the prevailing assumption that nursing education has an important modifying effect on the internalization of nursing values (Leners et al., 2006; Ohlén & Segesten, 1998; Reutter et al., 1997; Ware, 2008; Woods, 2005) and suggest that nursing instructors need to consider more closely the influence of student Personal Identity, including personal values, on the eventual NG Ideal and Lived Nursing Identities developed.

The finding of the current study that Personal Identity exerts a strong modifying effect on eventual Choices and Actions, is supported by research examining how values

influence behaviour, which indicates that the internalization of a value into the core concept of one's Personal Identity increases the likelihood the person will recognize value-relevant events in the future and behave in value-consistent ways (Bernard et al., 2003; Feather, 1995; Maio, 2010; Verplanken & Holland, 2002). Nursing educators may enlist the research of social psychologists to help enhance the internalization of nursing values so as to promote the NG/RN's ability to practice in ways congruent with their Ideal NIs. For example, Maio (2010) reported greater congruence between voiced and enacted values if concrete arguments as to why the value is important to the individual were discussed, along with whether the individual had strong mental representations of the values as actions in a variety of contexts. Known as instantiations, these representative actions enable the person to move beyond stating they believe in the value as an abstract, toward being able to consistently enact the value as behaviours (Maio, 2010).

This correlates with a theory by Greenwood (1993) that explains how speaking about nursing values as "fuzzy concepts" (p. 1478) can leave too much open to individual interpretation and facilitates acting in ways incongruent with these values. Maio et al. (2001) helps us understand why values are so "fuzzy" by explaining that the non-contemplative process of being told what to value such as being fair and kind, begins in parent-child relationships. Rationales and cognitive reasoning are not generally applied in the teaching of these pro social values (Maio et al., 2001). This trend appears to continue in nursing education where nursing values are accepted as "common sense" and thus are accepted as *truisms*. Unfortunately, these are the types of values that have been demonstrated to be the easiest to abandon if challenged (Maio & Olsen, 1998). Thus, this is an important finding that should be taken into consideration when determining how to best teach nursing values and encourage the internalization of these values in BN graduates.

Findings in the current study reinforce the importance of the organization of nursing work and the impact of the environment on the eventual Lived NI. Whether NG/RNs can live out their Ideal NI is greatly influenced by ***Feeling supported*** and **G*aining competence and confidence*** in what they view as a stable environment. Thus, the current study lends further evidence to the importance of creating healthy nursing

work environments and being attentive to the transitional needs of NGs. Despite previous research in the area of NG transition to practice in Canada and resulting recommendations such as providing students with theory about role transition, exposing undergraduates to the contextual and "conflict-laden" aspects of professional practice, and extended orientation periods with access to support and feedback (Duchscher, 2009), it would appear that the participants in the current study did not experience such approaches but may have benefitted from them. Additionally, several of the NGs in this study worked in highly acute areas and were hired into float-nurse positions which contradicted the recommendations for NGs to be "placed in consistent and relatively stable clinical settings [and] be encouraged to increase their exposure to advanced clinical scenarios gradually and strategically" (Duchscher, 2009, p. 1111). New Graduates in MB, therefore, do not seem to be benefitting from interventions based on current research.

Based on the finding that the actions that come to represent abstract values are *REDEFINED* when **BECOMING AN RN**, the question raised is, if the *REDEFINING* is taken too far to accommodate competing demands of the Environment, will this result in the NG/RN living a NI incongruent to her spoken values and yet be unaware of the incongruence? It has been found that people, including nurses and nursing students, tend to view themselves in a more favorable ethical, moral, and professional light than those around them (Brown, 1986; Emeghebo, 2012) indicating a lack of personal insight related to ethical development. Additionally, when confronted with barriers to acting in value-congruent ways, research examining identity and self-awareness has shown we will use rationalization and self-deception to diminish the effects of this incongruence and thus, are unaware of the incongruence of our actions (Caldwell, 2009). Thus, nursing instructors could enhance NI development in students by challenging actions that are incongruent with ideal nursing values. Coupled with the use of critical self-reflection, this may help these developing nurses to examine how their actions reflect their values. Critical self-reflection has been advocated as necessary for transforming of perspectives during education (Cranton, 2002; Mezirow, 1978) and has specifically been advocated as a way to promote ethical development during nursing education (Kyrkjebø & Hage, 2005; Mann, Gordon, & MacLeod, 2009).

Another educational approach which could encourage actions which positively reflect nursing values is the use of a framework for nurse-client interactions. An example of such a framework is the Nursing Support with Families (NSWF) framework developed by Vandall-Walker (2002). In this framework, instructors and students have access to more concrete translations of abstract concepts, thus making them more accessible and consistently represented. For example, in the NSWF framework, "connecting" is deconstructed into "subjective referents" such as empathy, respect, or concern (p. 184). These subjective referents are further deconstructed into "objective referents" that exemplify an action. For example, one way to demonstrate respect for the client is represented as providing information (Vandall-Walker, 2002). Giving students examples of actions associated with abstract values has the potential to create more positive student-client experiences. As demonstrated in the current study, these positive interactions often produce reinforcing expressions of gratitude from patients and families, thus providing evidence for the student that they have enacted a nursing value in a positive way. Captured by Vandall-Walker as "reciprocity" (p. 177), this experience of mutual benefit is also found to be a positive outcome of nurse-client interactions in the current study reinforcing commitment to nursing actions which benefit clients. Such frameworks could be used in combination with the aforementioned critical reflection approaches to improve the development of nursing values in BN graduates.

Ethnographic studies examining the actions of Nursing Students and RNs and comparing these to the values the individuals felt that motivated these actions, could offer some valuable evidence about interpretation of nursing values-as-actions. Also, such studies could enhance the understanding of the individualized process of creating Meanings from experiences. Given the important role Meanings have in guiding Choices and Actions, research exploring this process is warranted. Deconstructing events to understand the Meanings behind Choices and Actions could also be a reflective exercise challenging Nursing Students to offer value-based rationales for their Choices and could then highlight to them, their current Lived NIs.

Findings in the current study and previous research from CA (Day et al., 2005 Myrick et al., 2006), the US (Coudret et al., 1994), AUS (Grealish & Trevitt, 2005; Jackson et al., 2011; Reid-Searl et al., 2010) and the UK (Levett-Jones & Lathlean, 2009)

has indicated that Nursing Students choose silence, conformity, and "not rocking the boat" as valid strategies for ***Getting through*** nursing education. This likely contributes to the difficulties encountered with negotiating interpersonal encounters and practice issues once ***Experiencing RN reality*** as found in this, and previously cited studies. Though contemporary pedagogical approaches tend to promote student-centered approaches (Forbes & Hickey, 2009; Giddens & Brady, 2007), there is a power imbalance inherent in educational systems (Anthony & Landeen, 2009; Friere, 1970) that, coupled with the tendency for persons who enter nursing to value security and conformity over assertiveness (Thorpe & Loo, 2003), make correcting the disempowering effect of **BEING THE NURSING STUDENT** challenging. Nonetheless, nursing instructors must rise to this challenge if future BN graduates are to possess the assertiveness and skills needed to enact a Lived NI congruent with ideal nursing values.

On the surface, teaching to an ideal in nursing education seems of benefit to NG/RNs, by raising expectations for nursing practice. However, if the NG/RN enters practice unaware of the challenges he/she may encounter, the result for some can be shock and disillusionment upon transition to practice (Cowin & Hengstberger-Sims, 2006; Newton & McKenna, 2007). It was a finding of the current study that lack of knowledge about the RN's reality and the lack of skills for addressing the challenges to ideal practice combine to make the NG feel ineffective, and at times, mislead by their nursing instructors. This unchallenged idealism of nursing education is partially maintained by the fact that **BEING THE NURSING STUDENT** is so vastly different from **BEING THE NG/RN.** Such educational approaches leave BN graduates with gaps in knowledge and skills needed to help them practice in ways congruent with their individual Ideal NIs.

A finding in the current study was that clinical learning models that are disparate from the role of RN do little to aid in NI development and hinder the development of skills needed for teamwork, including resolving interpersonal and practice issues. This has been a previously reported consequence of traditional BN education (Benner, 2012; Clouder, 2005; Cooper et al., 2005; Etheridge, 2007; Maben et al., 2007; Newton & McKenna, 2007). Though it was a finding that students learn best from experience, and that they retain knowledge and skills best if they have been *applied*, it was also apparent

that Nursing Students and SS/NGs are not always able to *apply* their Ideal NIs in practice and thus, are missing opportunities to develop the associated skills and knowledge.

Pedagogical approaches which focus on NI development via *applying* values in practice have their roots in virtue ethics (Begley, 2006; Crigger & Godfrey, 2011; Vanlaere & Gastmans, 2007). Based on Aristotelian virtues theory, virtue ethics contends that virtues can and should be taught and that just like other skills, virtues require application in practice if they are to be developed.

> … we acquire the virtues by having previously exercised them, as also in the case of the skills. For what one has to learn to do we learn by doing, e.g. people become builders by building, and lyre-players by playing the lyre; and so too we become just by performing just acts and temperate by temperate acts and courageous by courageous acts. (Aristotle, trans. 2006, p. 2)

Given the contextual influence of Personal Identity to the eventual NI developed in the current study, one could argue that nursing education cannot influence nursing values or identity formation. However, Begley (2006) cautions against educators simply claiming we cannot influence the characters of those we teach, or to accept that it falls outside our roles. Begley countered such assumptions as being "an abdication of responsibility on the part of the teacher and clinical mentor" (p. 260). While Begley concedes we may not adequately influence all students to a satisfactory level of ethical practice, we must still govern ourselves in a way that gives the student the best possible opportunity to do so. In virtue ethics this begins with role modeling of desired behaviours, but it cannot end there. Aristotle's emphasis on practicing the application of a virtue in order to become skilled at this application is clear. In addition, we must help Nursing Students connect their Ideals to their Actions and enhance knowing one's self as a developing RN. Ethical abstractions must be taken out of the classroom, translated into actions, and applied in practice. Opportunities to make Choices and take Actions must be provided to Nursing Students while they are caring for clients. It is in this Environment that experiences create Meanings and influence future Choices and Actions. Nursing Identities will be formed in the *doing.* As Pellegrino (1989) stated in relation to medical education, "No course could automatically close the gap between knowing what is right and doing it" (p. 492).

Questions for Future Research

Findings in the current study raise several questions for future investigation including:

- How do new male BN graduates view their NI development?
- Does experiencing different BN programs with differing pedagogical approaches alter how graduates describe their Ideal NI and/or how they enact their Lived NI?
- How do self-assessed descriptions of RNs' Lived NIs compare to the observations of these RNs' Lived NI?
- What components of Personal Identity and Environment most influence how an RN interprets the congruence between his/her Ideal and Lived NI?

Summary

In this chapter, the emerging theory FINDING MY OWN WAY as a proposed preliminary explanation of Nursing Identity Development was compared with existing literature. The four phases of FINDING MY OWN WAY and the contexts of Personal Identity and Environment, along with the Meanings created from these experiences and how these Meanings inform Choices and Actions, were compared to relevant nursing, sociology, organizational science, and social psychology research. This comparison revealed that various findings of the current study reinforced, challenged, and contributed new information to the current knowledge relevant to NI development. The proposed theory FINDING MY OWN WAY offers a new way of conceptualizing NI as two constructs, the Ideal NI and the Lived NI. Additionally, the finding that ideals or values associated with an Ideal NI which can be similarly described but uniquely translated into the eventual Lived NI, offers a new perspective to be applied when investigating NI and NI development in the future. Primary limitations of the study included homogeneity of the participants' characteristics that weakens the emerging theory. The current study contains findings relevant to nursing practice, administration, and education, and brings to light areas and approaches for future research such as ethnographic investigations to gain insight into how Nursing Students and RNs understand and act on their values in action.

CHAPTER VI

CONCLUSION

The provisional grounded theory FINDING MY OWN WAY emerged from the data provided by 9 female NGs in 14 individual interviews and serves as a proposed explanation of NI development. The findings challenge the assumption that nursing education exerts significant influence on NI development, by demonstrating that BN education as currently experienced by students in Manitoba plays a relatively minor role in this process. Rather, the pre-nursing identity of each individual plays the dominant role. FINDING MY OWN WAY then, is proposed as a provisional explanation of the individualized journey of NI development from layperson to RN, where one is seeking a balance between one's initial layperson-imagined Ideal NI and the eventual new graduate Lived NI. This journey involves four interrelated, overlapping, and at times recurring phases: (1) Choosing Nursing, (2) Being the Nursing Student, (3) Becoming an RN, and (4) Being the New RN, each phase influenced by the context of Personal Identity and Environment which together generate Meanings, Choices, and Actions. During these phases, the person is first, aligning, then refining and redefining, and finally customizing how this NI will be enacted.

The homogeneity of the participant characteristics limits the strength and transferability of the resultant emerging theory. Nonetheless, the current study adds to the extant research and offers new insights for assessing existing approaches to the study of NI development, curricular approaches in nursing education, and future research investigations.

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Appendix A

Letter Outlining Third Party Mailing Service by CRNM

COLLEGE OF REGISTERED NURSES OF MANITOBA

EXECUTIVE DIRECTOR POLICY

Policy Type: Print and Communication Standards **Number:** PC-8

Policy Name: Third Party Mailings **Date Approved:** July 12, 2006

Third Party Mailings

This Administrative Standard applies to all external requests for bulk mailing services to College members. Typically these types of requests come from: researchers wishing to solicit information from registered nurses; commercial and non-commercial enterprises wishing to market to registered nurses and district chapters wishing to send printed material to their chapter members. Requests for mailings should be forwarded to the Director of Communications.

The College will endeavour to fulfill requests provided that:

1. the purpose of the mailing provides a benefit for either the member or the profession of nursing;
2. they are not inconsistent with the College's Vision, Mission and Strategic Directions;
3. the timing of the request can be accommodated within existing operational priorities;
4. a sample copy of all materials to be mailed is provided to CRNM for prior approval;
5. the privacy of CRNM members is protected at all times;
6. a cover memo is added to the material to be mailed indicating the College is mailing on behalf of an outside party;
7. the request is approved by the Director of Communications.

Requests from researchers for surveys must be accompanied by the approval of the ethical review of the sanctioning organization (ie: university).

Rates

Consistent with the College's policy on Revenue Generation, the rates charged (net of taxes) for providing this service will be as follows:

Non-profit and Educational Organizations

The initial database query will be billed at $50.00 for a routine or simple request and $100.00 for more complex requests. The Director of Communications will make that determination in consultation with the Director of Finance.

Stuffing envelopes, applying labels and affixing postage will be billed at $25.00 per person hour – in quarter hour increments. Postage is billed on a cost recovery basis.

Printed laser mailing labels (2 5/8" X 1") are billed at $2.00 per 100. Envelopes are $10.00 per 100 for #10 envelopes, $20.00 per 100 for 9" X 12" envelopes and $30.00 per 100 for 10" X 13" envelopes.

The College can also offer to send bulk emails to members as an alternative to postal mail. The price charged for this service reflects the cost of the email software, set-up charges and staff time. The cost is $10.00 per 100 addresses with a $10.00 minimum charge. Staff time is billed at $25.00 per person hour – in quarter hour increments.

Commercial Requests

The initial database query will be billed at $100.00 for a routine or simple request and $200.00 for more complex requests. The Director of Communications will make that determination in consultation with the Director of Finance.

Stuffing envelopes, applying labels and affixing postage will be billed at $25.00 per person hour – in quarter hour increments. Postage is billed on a cost recovery basis.

Printed laser mailing labels (2 5/8" X 1") are billed at $5.00 per 100. Envelopes are $20.00 per 100 for #10 envelopes, $40.00 per 100 for 9" X 12" envelopes and $50.00 per 100 for 10" X 13" envelopes.

The College can also offer to send bulk emails to members as an alternative to postal mail. The price charged for this service reflects the cost of the email software, set-up charges and staff time. The cost is $25.00 per 100 addresses with a $25.00 minimum charge. Staff time is billed at $50.00 per person hour – in quarter hour increments.

District Mailings

The database query will be no charge.

Stuffing envelopes, applying labels and affixing postage will be offered at no charge. Postage will be billed on a cost recovery basis.

Printed laser mailing labels (2 5/8" X 1") are billed at $2.00 per 100. Envelopes are $10.00 per 100 for #10 envelopes, $20.00 per 100 for 9" X 12" envelopes and $30.00 per 100 for 10" X 13" envelopes.

The College offers bulk email service to members as an alternative to postal mail. The cost is $5.00 per 100 addresses with a $10.00 minimum charge. Staff time is provided to Districts on a no charge basis.

Invoicing

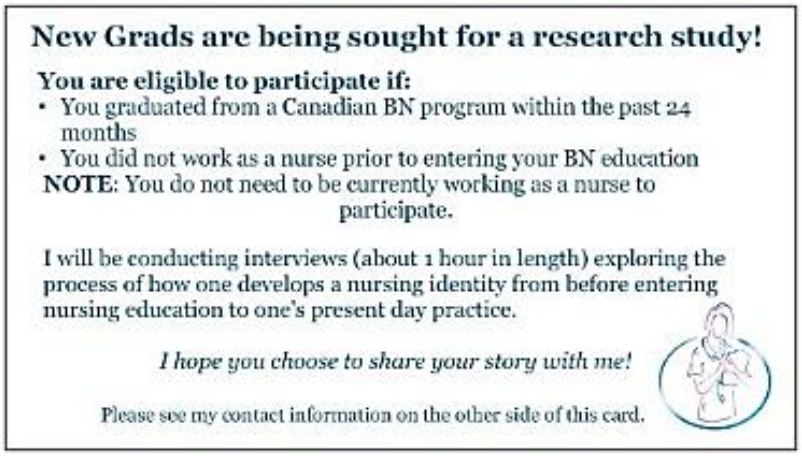
A request for invoicing outlining the details of work and applicable rates will be prepared and sent to Corporate Services for invoicing.

Appendix B

Business Cards for Recruitment

Standard Business Cards: Front side

Standard Business Cards: Reverse side



Appendix C

Participant Letter of Information

Principal Investigator:
Brenda Enns
MN Graduate Student
Athabasca University
Home phone: (204) 866-4296
Cell phone: (204) 782-3263
Email: identitystudy@live.ca

Project Supervisor:
Dr. Virginia Vandall-Walker
Associate Professor
Faculty of Health Disciplines
Athabasca University
Work phone: 1-800-801-2572

Email: virginia@athabascau.ca

Dear Potential Participant,

My name is Brenda Enns and I am a Masters of Nursing student with the Faculty of Health Disciplines at Athabasca University. I am inviting you to take part in a research study to examine the process of professional identity development in baccalaureate nursing education, being conducted as partial fulfillment of a Masters of Nursing degree.

Purpose of this study

The findings of this study will reveal the process students engage in that results in their Professional Nursing Identity i.e. how they come to see themselves as Registered Nurses. This information can help contribute to the adoption of educational strategies that promote and support students as they consolidate their nursing identities.

What you can expect as a participant

Should you agree to participate in this study, you will be asked to meet me for a one to one interview lasting about one hour, held at a location and time convenient to you. If we cannot meet face-to-face, a telephone interview can be arranged. I will be asking you questions about yourself and your experiences related to developing a sense of professional nursing identity and your related nursing values from the time you decided to enter a nursing program to the present day. It is intended that this interview will have an informal, conversational tone where you share the story of your journey to becoming the nurse you are today. The interview will be digitally audio-recorded and I may take a few notes.

Exploring and reflecting on one's experiences, professional identity, and values can be rewarding but it can also be uncomfortable. If at any time you find you are not comfortable, you may decline to respond to questions or request a change in topic without offering an explanation. My priority is your comfort and well-being during this interview. Once again, participation in this research is voluntary. You can withdraw at any time from the study without consequences. Your data will be removed from the study unless analysis of your data has begun.

Measures to protect your identity

Every effort to protect your confidentiality will be made. Your name will be replaced with a pseudonym known only to myself, and your identity will not be linked to any of the information you provide. Interviews will be digitally audio-recorded and stored in a password-protected computer owned by

myself, Brenda Enns, and I am the only person who has access to the password locking this computer. However, as the project is conducted, some confidential information will likely be shared with Dr. Virginia Vandall-Walker, my thesis supervisor (see contact information above). Your employer, professional body, or other parties associated with your professional designation or employment will not be aware of your participation in this research project.

A written summary of this study in the form of a Master's thesis will be available through Athabasca University's digital archive. As well, results will be presented in journal publications and conference presentations. In none of these instances will there be any identifying information provided. Demographic and interview data will be presented only in aggregate form other than some participant quotes, but again, no participant will be identified.

Results

If you would like a summary of the findings, I will provide you with these.

In closing

If you would like to participate in this study or if you would like more information before agreeing to do so, please contact me using the above contact information. Feel free to share this Information Letter and the recruitment poster with colleagues, if you wish. I am more accessible via email but also have voicemail on my cell phone. If needed, you can also contact the project supervisor, Dr. Virginia Vandall-Walker using the contact information above, should you have any concerns at any time during the study.

I appreciate you taking the time to inquire about this study and hope you choose to share your story with me.

Brenda Enns,

Appendix D

Informed Consent

Principal Investigator:
Brenda Enns
MN Graduate Student
Athabasca University
Home phone: (204) 866-4296
Cell phone: (204) 782-3263
Email: identitystudy@live.ca

Project Supervisor:
Dr. Virginia Vandall-Walker
Associate Professor
Faculty of Health Disciplines
Athabasca University
Work phone: 1-800-801-2572

Email: virginia@athabascau.ca

Title of Project: "Professional Nursing Identity Development in Baccalaureate Nursing Education"

Before you sign this consent (in duplicate), I will review the purpose of the study, the research process, including procedures to enhance confidentiality, and I will do my best to answer any questions you may have. Consent should only be given if you are satisfied that you understand this information and are comfortable with being a participant in this study. Once you are satisfied that you understand what you can expect as a participant in this study you may complete the sections below. You will be given one copy of this signed consent for your records.

Declaration

Statements of Consent	Initial here indicating agreement with each statement
I am aware that the interview will be audio taped.	
I am aware that my name will be replaced with a pseudonym known only to the Researcher and that my confidentiality will be protected	
I have reviewed the Participant Letter of Information and am satisfied that I understand the contents of this letter.	
I am aware that my participation in this study is voluntary and I have the right to withdraw without negative consequences at any time.	
I am aware that I am free to contact the Researcher or the project supervisor to seek information or to voice concerns at any time during my participation.	

Signatures (written consent): Your signature (or email should you return this electronically) on this form indicates that you agree to participate as a research participant in this study.

Participant's name: (please print)_____

Participant's signature: _____ Date: _____

Researcher's Name: (please print) _____

Researcher's Signature: _____ Date: _____

Appendix E

Demographic Questionnaire Script

Please respond to the following demographic questions. All answers are kept confidential, and you may omit answering any question you are not comfortable answering.

1. Education and year completed?

- ☐ Bachelor of Nursing Degree Year Completed _____
- ☐ Additional Degree student Year Completed _____
- ☐ Additional University Degree
- ☐ I have completed or am currently enrolled in additional education in Nursing since graduation (certificates, Master's, specialty courses).
  Please specify _____
- ☐ Other _____

2. Age

- ☐ 20-30
- ☐ 31-40
- ☐ 41-50
- ☐ >50

3. How many months' experience do you have as a GN or RN?

- ☐ 1-6
- ☐ 7-12
- ☐ 13-18
- ☐ 19-24
- ☐ Other _____

4. Did you work in the healthcare field prior to entering a nursing program?

- ☐ Yes Where? _____How Long?_____
- ☐ No

5. Do you work more than one job as a nurse?

6. What field(s) of nursing comprises your practice?

- ☐ Private Practice
- ☐ Community
- ☐ Tertiary Care Hospital
- ☐ Extended Care
- ☐ Rural Hospital
- ☐ Community Hospital
- ☐ Other7. In what area of nursing do you primarily practice?
- ☐ Medicine
  - Subspecialty such as cardiology or oncology? _____
- ☐ Surgery
  - Subspecialty such as neurosurgery or orthopedics? _____
- ☐ Pediatrics
  - Area of practice? _____
- ☐ Geriatrics
- ☐ Maternity
- ☐ Emergency
- ☐ Public Health
- ☐ Community Health
- ☐ Other: _____

8. How much do you currently work (all positions) and in which practice (if more than one)?

- ☐ Casual _____
- ☐ Part-time (</= 0.5 EFT) _____
- ☐ Part-time (>/= 0.6 EFT but less than full-time) _____
- ☐ Full-time _____

9. Has this been your only practice setting since convocation? _____

If no, what other area(s) did you work?_____

10. Is there any other information about yourself that you feel would be relevant to this study? Explanation below:

_____

_____

_____

Interview number:_____Pseudonym:_____

Contact information:_____

Summary Report Requested _____

Appendix F

Interview Guide

1. Tell me about your Professional Identity as a nurse.

2. Thinking back to when you decided to enroll in a BN program, what made nursing seem like the right choice for you?

3. Do you think your personal values attracted you to nursing? If so, what were these personal values which you felt made nursing the right choice for you?

4. What was your perception of nurses and the profession of nursing prior to enrolling in the program?

5. Did this perception change over time?

6. Do you think your nursing identity or how you see yourself as a nurse has changed since you first entered nursing until now?

7. Can you think of any specific experiences that affected how your identity and nursing values developed during your education?

8. Did different clinical experiences in different areas of practice impress upon you a different sense of what professional nursing meant?

9. When you graduated what would you say you believed your identity as a nurse to be? What nursing values were most important to you before and following graduation?

10. What would you say your primary or central nursing values are now as a practicing nurse? If there has been a change since when you graduated, can you explain why you think this change happened?

11. Do you feel that you are practicing according to your values and the nursing identity you wish to portray?

12. Can you offer one or two explicit examples of how you applied these central values in your practice recently?

13. What strategies do you find increase your ability to practice according to your nursing values?

14. Do you ever find yourself having to make choices in practice that make you feel as though you were not practicing according to your values and the nursing identity you wished to portray?

15. Can you offer some specific examples of times this has occurred and explain why you think it happened?

Appendix G

Revised Interview Guide

People enter nursing school as lay persons and go through a process that results in them attaining a new identity, that of RN. This process is what I am interested in understanding better and I am interested in your personal experience with becoming a nurse.

1. Tell me about your transformation in identity from lay person to your identity as a nurse?
2. What did you feel most influenced this transformation process?
3. Thinking back to when you decided to enroll in a BN program, what made nursing seem like the right choice for you?
4. In your case what did you think nursing had to offer you?
5. What was your perception of nurses and the profession of nursing prior to enrolling in your nursing program? Where did this perception come from?
6. Did this perception of nurses and of the profession change over time?
7. When you began nursing education, what did you feel were the most important qualities a nurse should possess? Why?
8. Did the most important qualities you thought a nurse should possess change since you began nursing?
9. Why? or Why not? (What do you think influenced this change?)
10. Do you remember how you felt when you noticed this change in your image of nurses and nursing? and of those qualities of a nurse that changed? How did you adjust to these changes?
11. As you progressed through your education program can you remember any specific experiences or relationships that altered or influenced how you felt about nursing or yourself as a nurse?
12. Did any clinical experiences in any particular areas of practice impress upon you a different sense of what professional nursing meant?
13. When you graduated what would you say you believed were the most important qualities you needed to possess as a nurse. What nursing values were most important to you?
14. Can you offer one or two explicit examples of how you applied these central values in your practice recently? What does “name of value” look like to you…how do you demonstrate to a patient that you are….

15. When you show up to work, what would you say are your primary goals for any given day? What have you decided are the most important priorities for you when you are working as a nurse?

16. Do you feel that you are consistently able to practice according to your values and the nursing identity you wish to portray?

17. Has your ability to practice to professional standards ever been challenged? Have you ever felt as though you were not able to practice according to your values and the nursing identity you wished to portray? How did you cope with this?

18. Can you offer some specific examples of times this has occurred and explain why you think it happened?

19. Looking to the future, do you have any specific goals or plans for your nursing career that you would like to pursue? Where do you see yourself working in the future?

Appendix H

Transcription Contract from CML Transcription

CONTRACT FOR TRANSCRIPTION SERVICES and CONFIDENTIALITY AGREEMENT

BETWEEN: CONTRACTOR:

Colette Lebeuf
CML TRANSCRIPTION
#201 - 1017 Queens Avenue
Victoria, BC V8T 1M7
cmltranscription@gmail.com

and

CLIENT:
Brenda Enns
<benns@mts.net

This contract is made and entered into on February 16th, 2013 by Brenda Enns (Client) and Colette Lebeuf DBA CML Transcription (Contractor). In consideration of the mutual promises in this contract, the parties agree to abide by all the terms of this contact.

Contractor agrees to do the following:

Transcription in accordance with Client's documentation, guidelines and forms. Services shall include:

1. Secure transfer of audio files based on 128-bit Encryption, and which is password-protected.
2. Transcription of three audio files of approximately 60 minutes each.
3. Electronic delivery to Client of the written transcripts in a Word document with specifications and formatting determined by Client (modified verbatim; single spacing; regular margins; in Calibri 12 pt font).
4. Contractor agrees to deliver each transcript upon its completion. Delivery date for the transcriptions shall be within a few days of the reception of the audio files.

5. For performing the work pertaining to the interviews as described above, Client agrees to pay Contractor the rate of $2.00 per audio minute (or $1.75 per audio minute if the total number of minutes exceeds 180 and the transcription poses no major difficulties). No HST fees will be charged on this Contract. No deposit is required on this Contract since the Contract in itself is binding.

CONFIDENTIALITY AGREEMENT

I, Colette Lebeuf of CML Transcription, Contractor, agree to maintain full confidentiality in regards to any and all audio files and documentation received from and sent to the above-named Client related to her work.

Furthermore, I agree:

1. To not disclose confidential information, including the identity of the researcher, interviewees or the content of the interviews, to other third-parties, starting from the effective date of this Agreement, including prior discussion thereof, and continuing in perpetuity;
2. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of recorded interviews, or in any associated documents;
3. To not make copies of any audio files or of the transcribed texts, unless specifically requested to do so by the above-named Client;
4. To store all materials related to this Contract in a safe, secure location as long as they are in my possession, and to not permit access to those files by any third-parties;
5. To delete all electronic files containing documents and audio files from my computer hard drive and any backup devices upon instructions to do so from the above-mentioned client.

Agreed upon on February 16th, 2013 via email by:

Brenda Enns (Client) and Colette Lebeuf, CML Transcription (Contractor)

Appendix I

Research Ethics Review Board Approval

MEMORANDUM

DATE: September 28, 2012

TO: Brenda Enns
COPY: Virginia Vandall-Walker, Associate Professor, Nursing & Health Studies
Dr. Simon Nuttgens, Chair, Athabasca University Research Ethics Board Janice Green, Secretary, Athabasca University Research Ethics Board
FROM: Dr. Sharon Moore, Chair, CNHS Research Ethics Review Committee
SUBJECT: **Ethics Proposal #CNHS-12-02.:** *"Professional Identity Development in Baccalaureate Nursing Education"*

The Centre for Nursing & Health Studies (CNHS) Research Ethics Review Committee, acting under authority of the Athabasca University Research Ethics Board to provide an expedited process of review for minimal risk student researcher projects, has reviewed the above-noted proposal and supporting documentation.

I am pleased to advise that this project has been awarded interim **APPROVAL TO PROCEED**. You may begin your research immediately; **HOWEVER, prior to contacting participants** the following documents are required to be submitted **for file purposes only**:

- There is only one minor change the committee is suggesting: there is a sentence worded in the Appedix E (Participant Letter of Information on page 23) which may be a bit confusing so we are recommending it be rephrased.

  Current reading: (under What you can expect as a participant, last sentence)
  You can withdraw at any time (your data will be removed from the study) until analysis of your data has begun without consequence.

  It sounds like there could be consequences after data analysis has begun. So splitting that sentence into two would make it clearer. Rephrased: You can withdraw at anytime from the study without consequences. Your data will be removed from the study unless analysis of your data has begun.

  The approval for the study "as presented, including additions/changes for file only" is valid for a period of year from the date of this memo. If required, an extension must be sought in writing prior to the expiry of the existing approval. **A Final Report is to be submitted when the research project is completed.** The reporting form can be found online at http://www.athabascau.ca/research/ethics/ .

This approval will be reported to the Athabasca University Research Ethics Board (REB) at their next monthly meeting. The REB retains the right to request further information, or to revoke the approval, at any time.

As implementation of the proposal progresses, if you need to make any significant changes or modifications prior to receipt of a final approval memo from the AU Research Ethics Board, please forward this information immediately to the CNHS Research Ethics Review Committee via cnhsreb@athabascau.ca for further review.

If you have any questions, please do not hesitate to contact cnhsreb@athabascau.ca .

We wish you the best with your very interesting research study.

Appendix J

Ethics Amendment Approval

MEMORANDUM

DATE: January 16, 2013
TO: Brenda Enns
COPY: Virginia Vandall-Walker (Research Supervisor)
Dr. Simon Nuttgens, Chair, Athabasca University Research Ethics Board
Dr. Sharon Moore, Chair, CNHS Research Ethics Review Committee
FROM: Janice Green, Secretary, Research Ethics Board
SUBJECT: **Ethics #12-62A – Minor Amendments to Approved Proposal #CNHS-12-02**
"Professional Identity Development in Baccalaureate Nursing Education"

On behalf of the Athabasca University Research Ethics Board (AU REB) and the CNHS Ethics Review Subcommittee, I hereby register a minor amendment and update to the above-noted proposal to acknowledge fine-tuning revisions to the previously approved interview questions, and to add research site attendance at the New Grad Day for Nurses sponsored by the Winnipeg Regional Health Authority (WRHA) and assistance with e-mail recruitment by the conference organizers.

On the basis that the changes presented by memo request dated January 15, 2013, are not substantive, and that there are no other changes to the previously approved protocols, administrative approval has been provided and your ethics file has been updated accordingly, to reflect the following **MINOR AMENDMENT/UPDATE**:

DETAILS:

1. **Recruitment Assistance & Support for Research Access** – WRHA e-mail recruitment assistance to be provided via the February, 2013 New Grad Day for Nurses organizing committee; confirmation of support for research activities being undertaken during the conference on the conference site. (Update to **Appendix G,** p.35-36 shows confirmation correspondence)
2. **Revised Interview Guide** (p.26-27) – the revised interview guide (Appendix D) shows wording changes (highlighted in yellow) to provide question clarity only (no change to focus of the questions).

The existing approval for **the study "as amended" is valid for twelve months from the date of this memo.** If required, an extension must be sought in writing prior to the expiry of the existing approval.

A Final Report (form) is to be submitted when the research project is completed. The reporting form can be found online at http://www.athabascau.ca/research/ethics/.

As you progress with implementation of the proposal, if you need to make any changes or modifications please forward this information to the Research Ethics Board Chair via the REB Secretary.

If you have any questions, please do not hesitate to contact rebsec@athabascau.ca .