# THEORISING *in* EVERYDAY NURSING PRACTICE

## A critical analysis

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# Theorising in practice through workplace recontextualisation

**Chapter objectives**

- Discuss workplace recontextualisation (WR)
- Introduce *activity* and *context* act as triggers of learning for nurses as they practise
- Draw on data from studies 1 and 2 to show how these triggers prompt learning in the workplace. We refer to learning in the workplace rather than clinical placements which is more routinely used in nurse education literature.

## Introduction

There is a long history in professional and occupational learning of considering workers as lifelong learners (Vähäsantanen et al., 2017), although this is not common in the nursing literature. It may seem odd to refer to learner recontextualisation when talking about qualified and experienced, even executive nurses, as we do in this book. We do so because nurses are lifelong learners who engage formally in continuous professional development and informally in adapting to changing workplace practices, or organisational restructuring. The data in this book illustrate their

commitment to lifelong learning. After all, a feature of professionalism is the ability to adapt to change; developing identities as a professional is evidence of the individual's ability to be agentic, and we consider this further in Chapter 7 (Vähäsantanen et al., 2017). While they form their professional identities early on in their careers (Bentley et al., 2019) many will choose to move to clinical specialisms and roles and therefore develop a further identity embedded in the new area of clinical practice. For many nurses, this will be part of positive career development. Many will be forced to move specialisms due to workforce reorganisation and restructuring and may find adapting to change difficult. Hence, we recognise that registered nurses are adaptable, agentic, flexible professionals who have developed lifelong learning skills.

## Workplace recontextualisation

As presented in Chapter 3, each of the four expressions of recontextualisation (workplace, learner, pedagogy and content) sheds light on the challenges of connecting theory with practice and relating subject-based and work-based knowledge in professional learning and practice development. Learners draw on their prior disciplinary knowledge and on their prior and current work experiences in the ways in which they engage with the teaching, learning and assessment strategies and eventually their new work roles (LR). They make connections work for themselves individually as individual learners and develop a sense of the whole work process along with agency and identity as a professional. Learner recontextualisation (Chapter 7) is facilitated when learners develop meta-cognitive strategies and when learning partners work together to help the learners to see connections and make sense of the whole process.

Workplace recontextualisation takes place through workplace practices and activities that support knowledge development, and through the mentorship, coaching and other arrangements that enable nurses who are in situations which require learning (so we might call them learners) to engage with and learn through workplace environments. WR is also about the quality of the workplace teams and the types of and quality of the relational learning and activity in teams shaped by the clinical context. These practices are fundamental to undertaking standard workplace activities effectively and to developing the confidence and capability to work with others to change those activities where the situation demands it. These practices are the way individuals and teams 'progressively recontextualise' concepts in activity. This form of learning is triggered by the activity and the context.

## Workplace learning in nursing

Of course, workplace learning in clinical settings has always been hugely important in nursing internationally (Forber et al., 2015) and continues to be so despite arguments around:

- placement capacity in relevant settings (Smith et al., 2010)
- a lack of a proper evidence base for practice learning hours (Barker et al., 2016)

- the role of simulated learning, its effectiveness and whether simulated learning can substitute for learning with real patients (Ricketts et al., 2013)
- the relative merits of short or long clinical placements (Levett-Jones et al., 2009) including other configurations of placement allocation such as 'hub and spoke'
- the varying quality of clinical placements, which depends on patient throughput and the 'busyness' of clinical areas, the relationships between learners, mentors and teams and the learning opportunities of particular placements as well as the ability, interest, and time for teaching among qualified staff (Cooper et al., 2015; Rebeiro et al., 2015).

Research into workplace learning in nursing has been focused latterly on competences rather than learning; with how nurses perform skills rather than the knowledge on which these skills are based and how both knowledge and skills are integrated through supported learning. Understanding how students and registered nurses learn to theorise in practice is another way to unlock our understanding of the complexities inherent in workplace learning and move beyond narrow concerns (even obsessions) with competence-based learning; and importantly, as the data from studies 1–5 show, to understand how nurses continue to learn until late in their careers and develop lifelong learning skills. Such understanding is crucial as society expects nurses to develop increasingly sophisticated levels of practice as healthcare systems evolve while at the same time employers expect nurses to become increasingly responsible for their own continuing professional development and learning. Our approach to theorising in practice demonstrates the limitations of this focus on competences and skills.

Workplaces fundamentally affect how knowledge is put to work, and they vary in the nature and quality of learning experience that they afford (Guile and Evans, 2010). WR takes place through the workplace practices and activities that support knowledge development, and through the mentorship, coaching and other arrangements with which learners/employees can engage and learn through in workplace environments. These practices and activities are fundamental to learners as they learn to vary and modify existing workplace activities or to develop the confidence and capability to work with others to significantly change those activities. Any worker must 'progressively recontextualise' concepts in activity. For example, the concept of blood pressure measurement takes many different forms in workplaces hence pedagogic, content and workplace contextualisation requires a range of supports to allow students to understand and thus theorise blood pressure measurement when confronted with patients who do not present with textbook symptoms.

## How does workplace recontextualisation take place in clinical nursing practice?

Knowledge recontextualisation takes place in the workplace setting when:

- a learner recognises a new situation as requiring a response and uses knowledge – theoretical, procedural and tacit – in acts of interpretation in an attempt to bring the activity and its setting under conscious control (van Oers, 1998);
- the interpretation involves the enactment of a well-known activity in a new setting, an adaptive form of recontextualisation, which takes place as existing knowledge is used to reproduce a response in a parallel situation.

And where

- the interpretation leads the learner to change the activity or its context in an attempt to make a response; a productive form of recontextualisation takes place, as new knowledge is produced (Allan et al., 2018).

In Table 5.1, we illustrate how a nurse might demonstrate these three sets of knowledge recontextualisation in the workplace.

**Table 5.1** Knowledge recontextualisation in a workplace setting – the IVF clinic

| | |
|---|---|
| A nurse recognises a new situation as requiring a response and uses knowledge – theoretical, procedural and tacit – in acts of interpretation in an attempt to bring the activity and its setting under conscious control. | An example might be a fertility nurse recognising that a non-donor IVF couple seem anxious after a consultation with their doctor in the IVF clinic and may need assessment. Tacit knowledge here might be the trigger (the couple's body language) and the nurse draws on theoretical knowledge (familiarity with an anxiety and depression scale perhaps) or procedural knowledge (referral to the clinic counsellor). The new situation is the anxiety the nurse notices in a *non-donor IVF couple* as opposed to a donor couple who are required to have counselling about their donor IVF. Non-donor couples don't automatically get referred to the clinic counsellor.<br>Note the nurse may draw on a wide range of knowledge and theory to recontextualise knowledge to bring an activity and its setting under conscious control. |
| The interpretation involves the enactment of a well-known activity in a new setting. An adaptive form of recontextualisation takes place as existing knowledge is used to reproduce a response in a parallel situation. | Continuing this example, the nurse realises that while she hasn't met this situation before, this non-donor couple are as anxious about IVF as a donor couple who routinely have access to counselling. They should be referred to the clinic counsellor even though this isn't usual practice. This is the adaptation which is provoked by the interpretation of new knowledge above. |
| The interpretation leads the learner to change the activity or its context in an attempt to make a response. A productive form of recontextualisation takes place, as new knowledge is produced. | As a result of this observation and the referral to counselling for this infertile, non-donor couple, the nurse begins to informally assess all couples in her clinic for anxiety and potential requirement for referral to counselling. She brings this up at a clinic meeting and all couples (non-donor and donor) are asked to complete a self-assessment for anxiety and depression at their first appointment prior to IVF. This is the new knowledge which changes both the activity (the assessment of IVF couples' anxiety and depression) and the context (the team meeting and orientation to the need for a broader assessment of anxiety and depression in new couples). |

In the workplace, knowledge is embedded in activities which are themselves performed as routines and protocols using different symbolic and meaningful artefacts. An example here might be the 'patient observations' which are taken routinely at certain times a day according to a protocol (the scoring system called the modified early warning score or MEWS) using necessary but at the same time, hugely symbolic artefacts like the sphygmomanometer or the stethoscope. The key challenges include (1) learning to participate in workplace activities and use artefacts, and (2) learning to use work problems as a further 'test-bench' for 'curriculum' knowledge. This is facilitated when:

- workplaces create stretching but supportive environments for working and learning
- learners take responsibility for 'observing, enquiring and acting'
- WR is shaped by mechanisms or factors which either enhance or mitigate against WR happening: time/predictability, gradual release and enacting new knowledge.

## Factors enhancing or working against WR

Gradual release, time/predictability and enacting new knowledge are factors or mechanisms which work across WR to enhance or work against recontextualisation.

### Gradual release

In pedagogic and content recontextualisation forms, i.e. before and alongside the student learning in workplace or clinical placement, mentors or lecturers (those who are responsible with the student for planning learning) can carefully:

- sequence modules to build and integrate knowledge
- support learners to move between different spaces of learning; from the university to the working or clinical placement environment and back again.

Likewise, mentors and senior colleagues in clinical practice can structure learning activities for students to facilitate coherent learning. The gradual release of responsibility from teacher to learner involves learners being given incremental opportunities across two axes: predictability and time.

### Time and predictability

Examples of time and predictability might be when students:

- strengthen and develop knowledge through extended time and exposure with familiar equipment, such as the stethoscope or wound dressing equipment
- are allowed to make mistakes in a controlled environment, closely supervised such as in the clinical skills laboratories or simulation, and increasingly, as students become more confident in skills in clinical practice
- feel confident when they move from predictable to more unpredictable tasks.

Feedback during a period of learning under supervision with a mentor or supervisor which is tailored to workplace and academic criteria further assists the learner in developing confidence to the point where the student is working under time and (un)predictability pressures of the workplace.

### Enacting new knowledge

One of the biggest criticisms of the use of 'reflective' strategies in work-based learning programmes is that they are primarily designed to assist learners to gain accreditation or recognition for their existing knowledge, rather than to support them in generating and using new knowledge. The 'learning conversation' approach, which was an important feature of management development in the glass industry described by Evans and her team in the original work on *putting knowledge to work*, offers a way to escape this dilemma. Its key premise is that someone with extensive industry and facilitation expertise can design a conversational approach that not only recognises, but also expands, employee learners' knowledge and puts it to work. These conversations will assist the student/learner to put knowledge to work.

Learning conversations can be with formal mentors but also informally with key people occupying boundary roles for student learning such as (in nursing and midwifery) ward managers, senior colleagues, healthcare assistants, doctors, other healthcare professionals and fellow students or peer learners (as above in the example of the preceptor peer learning group). Activities for learning conversations might include:

- Shadowing
- Mating up
- Peer support
- Planning incremental responsibilities
- Debriefing that focuses on developing confidence in putting knowledge to work

## Illustrations of workplace recontextualisation in clinical practice

We shall now use data from studies 1 and 2 to illustrate recontextualisation, starting with the following extract from study 2 which illustrates an *act of interpretation* leading to recontextualisation for a mentor who describes mentoring a student to do a medication round at lunchtime on her own but supervised by herself. She does this to allow the student to gain familiarity with the activity safely, i.e. with her remote supervision: in her words, to *build up confidence* in the activity (the medications, the computer) by bringing the activity under conscious control through doing something which is safe, i.e. lunchtime medications. But interestingly, she also describes through this act of interpretation, her own learning: bringing the activity of mentoring '*supervising a student undertake a medication round*' under conscious control '*allowing herself to tolerate the student do something she's assessed as safe*':

> Last year … [a] student and she was absolutely brilliant and I let her do a lunchtime medication with my computer and I was feeding somebody and watching her doing it … so in that way I trusted that student and she built up a confidence by, but you need to know if that student is confident and know what she's doing, I'll never ever let a student do morning medication without my supervision [working directly with student], absolutely not. Lunchtime medication yeah, it's more paracetamol and maybe some [thing] for the sickness if there is any but it's mainly the paracetamol so …

Acts of interpretation can be activities which are facilitated in groups, as in another extract from study 2. In this NHS trust, newly qualified nurses (NQNs) participate in a peer learning group once a month. In the next extract, an NQN speaks about her learning in one of these groups. She talks about how she uses tacit knowledge '*having a little trick*' to utilise empirical knowledge '*when to give hypertensive drugs pre-operatively*', which comes about by sharing learning with and learning from her peers:

> It was great being there with newly qualified nurses … to go 'I just don't get it', 'which anti-hypertensive can you give before theatre', 'which ones [you] can't' and everyone else going 'ah, I've heard a little trick for that' or 'yeah, the way you want to think about that' …

In the following example from study 2, an everyday act of interpretation is illustrated in the NQN's description of working in teams of NQNs and HCAs. The act of interpretation has led the NQN to learn that getting to know an HCA you work with and what she can and can't do will assist her in planning care as she learns to manage teams:

> So you try to know, try to know their limitation, what they can do and what they can't do.

While recontextualisation can seem like a fairly simple everyday action, i.e. getting to know staff you work with, it actually involves sophisticated human communication and judgements in acts of interpretation where the NQN or the mentor (above) brings what they know about the situation (the student, the medications, the potential for things to go wrong, the patients' condition, the plan for care, competencies of the staff she has working with her to deliver that care) into conscious thought through an assessment based on knowing what skills are needed for which task or activity and who can be expected and trusted to deliver those activities safely. In the following quote we can see how an NQN thinks or processes knowledge to arrive at this state of knowing, which she describes as '*[you] apply yourself well with doing what's important*':

> And sometime I can be nervous but I try to learn… try to think of who I want to be like, like some mentor they are very calm, like very, you need calm to reassure the patients first because you cannot get nervous and you cannot panic on the actual thing so if you panic you stress out everyone and if you panic as well you don't know what's the next plan, you can't plan for the next, so we try to calm yourself, reassure the patient and apply yourself well with doing what's important, the next step is, so…

Acts of interpretation are smoothed by establishing a routine, as described by this NQN:

> I did struggle first, like maybe [a] month, two months nearly, until I got myself around routine and then, then it's gone better and better now, now it's, if we've got enough staff then if the staffing levels are good, then yeah you can get a job done, without too much stress and I can actually finish on time.

This NQN describes how seeing the '*nursing point of view*' through listening to patients helps her identify and assert her role as a nurse:

> Like multi-disciplinary team planning, so you can, you can raise your concern because you are the one with the patient most of the time so you know them better ...
>
> **Yes.**
>
> Sometimes doctor[s] just see the medical point, they wouldn't see the nursing point of view so and some other issues the patient tell you quietly so.
>
> **Exactly, and I saw, I mean you seem to be very good at that.**
>
> We try to listen.
>
> **And I'm sure not all nurses are like that, you know with communicating those things.**
>
> I try to listen what they say and what their main concern is and their worries.
>
> **The patients.**
>
> The patients, their worries and so try to raise the concerns with the doctors, even though sometimes they, they just see only the medical point of view they wouldn't see other point of views, it's nice to go round with them and tell them your suggestion and they can decide how we can make a better plan for the patient.
>
> **And do you think generally they listen?**
>
> Yes, they do, yeah. I try to sometime you have to be assertive and advocate [for] the patient.

In the quote above, the NQN shows she's theorising in practice as she claims her unique nursing role through:

- listening to patients as they tell her privately what their worries are
- identifying these worries as different to medical concerns and as nursing concerns – as part of nursing and therefore her responsibility
- reframing patients' worries and communicating them to the doctors as a nursing point of view – again seeing this as part of nursing and her responsibility.

Her use of the phrases, '*medical point of view, nursing point of view*' is also interesting because it suggests that she is conscious of more than one viewpoint or worldview which are, until she reframes them in her role as patient advocate, in conflict and 'unseen' by the doctors: '*they wouldn't see the other point of views*'.

Sometimes acts of interpretation arose out of negative situations where learning hasn't been a positive experience. The student's act of interpretation in the following quote is to understand the reality of learning on a particular ward where she has felt excluded from learning:

> You know what am I doing here? I qualify in a month and not even drugs yet. I won't be able to do anything as a nurse. What have I done today? Caring not nursing; I know we have to do that, it's okay. Washes, beds, breakfasts, observations – but when they do drugs they should call me to look and learn. But they don't, so another shift wasted! (3rd year student, surgical ward)

## Complexity of recontextualisation

As we've shown, recontextualisation is a complex learning activity partly because different stakeholders have different expectations and understandings of learning; it can be effected by the interplay between learner and mentor. Here the ward manager (WM) explicitly argues that knowing doesn't mean that all nurses (in this case NQNs) can nurse; in other words, that putting knowledge to work or recontextualisation is not always successful. She says this is down to the individual nurse's personality:

> ... you read sort of some of their work that they've done it always seem very and all very in depth and they know the knowledge, it's putting that knowledge into practice and it depends on the personality whether they're good at seeing what they're seeing and putting into practice what they're doing, everyone can talk a good speak about pressure area care but its whether they do it in practice.

The interviewer, Karen Evans, probes why these differences may occur in NQNs' performance. The WM replies that in her view, the difference in '*putting knowledge into practice*' is due to *personality* and *common sense*. However, looking carefully at what she says in this extract, she describes the NQN putting knowledge to work the next time the patient has a fall in the context of '*knowing who to escalate the incident to*'. This last statement suggests that the WM has recognised that by the second patient fall, the student has put her knowledge to work and is able to act appropriately:

> **KE: is it anything to do with the extent to which they go over what they've done and think about it and seek feedback and so on, is that an element of it at all do you think or not?**
>
> No I don't think.
>
> **KE: it's just there or not.**
>
> I keep coming back to sort of pressure care because they're, a lot of them are, it's obviously drummed into them about their sort of pressure area care and I just think you know, some of them do talk about it actually when you say 'well have you put them on a cushion?', well no they haven't done it, but if I asked the other girl she would have done

it because it's just common sense, but, I say where you've clearly said in your writing that you know, you would do it, so why didn't you do it, I don't understand that ... One of our girls – recently qualified, had a really nasty fall, a patient had a fall, cracked the back of his head, and I said to her 'you know what you have to do if there's a fall, who, who do you escalate it to, I know you've written about this because it was one of your concerns when you were training wasn't it?' 'yeah' she said, and I said 'and yet you never sort of escalate, you never sort of did the next step on from it, but you know what you have to do ... when I've talked to you now face to face you know exactly what to do but you didn't do it in practice and you know, and that sort of patient suffered sort of a head injury'. But now the next patient that had a fall, she did an absolute brilliant [escalation], so yeah, I don't know whether they think that you know, that people on that [academic] paper that they're writing about is a person today, you know [the] most frustrating thing about when you work with some students as they're qualifying and then you know what they're capable of but they don't seem to equate it to a real life patient.

She is probed on this by the second interviewer (CM) and this time suggests that it's not just (lack of) common sense that prevented the student from knowing how to escalate the fall/incident. She now says the student is not able to move beyond her academic knowledge to put that knowledge into practice when faced with a live patient:

**CM: and why, that's something in their training that?**

I don't know.

**CM: what is it?**

I suppose it's in their training, I don't know whether they don't get enough hands on, I don't, I have no idea, I don't really know why, why that is, because you, you know, you think back to your training, mine was very, very hands on training so it was completely different, we didn't have much of the sort of learning behind it and we wished we did so I don't know whether it is something about experience and just looking at patients I think, that's probably where you learn a lot from isnt it, I don't know, from their relatives and their patient themselves, I mean a lot of them can write very very, very good essays don't they and you just think 'oh come on' you need to think about it and put it to [work] as a patient.

She then goes on to suggest that the NQNs who are able to put knowledge into practice may have more experience with patients gained as HCAs, i.e. through having had more experience and developed confidence in workplace practices. In other words, by being exposed to practice experience and having had experience of putting knowledge to work.

Actually X was very good, she's got a good balance of what she writes and what she puts into practice, she, she's, you know, I think probably because she's been qualified a little bit longer when I got her so I think she had quite a bit of experience already under her belt, but she, because she's only been qualified I don't think all that long is it – less than a year ... She might have been March, yeah, anyway came with a little bit, maybe because she'd been a care assistant before as well so she just sort of seemed to sort of have a bit of both really.

As well as prior and continued exposure to clinical practice, putting knowledge to work may improve performance as continued experience of recontextualisation may assist in processing new knowledge in future instead of being *blinded* by new knowledge and situations. The ward manager in the following quote describes a scenario where having recognised this, the HCA might begin to use gradual release, and a learning conversation '*bring[s] them back to base*' to assist the learner to become more confident in future:

> ... so that they can direct them to some degree but in a nice kind of way, it's not telling them to do something but they will prompt them of what they need to do next to help them to manage the cares that are needed in that bay ... [NQNs] know that they have to some degree take the lead, shall we say because, although the student nurse will say 'I've done a lot of hands on care on the ward', when it comes to physically running a bay on their own, you do become very blinded very fogged shall we say because all you're thinking is 'I've got this to do, I've got that to do, I've got a million and one things to do' and 'actually my head's spinning already and I don't know where I'm going'. So sometimes the support workers will manage to bring them back to base and say 'right okay', say for example 'lady in bed one is self-caring, the lady in bed two we need to two of us to wash, the lady in bed three and four they will only need one for us to help them with personal cares, right okay, you do that one and I'll do that one and then we'll team up again afterwards'. We try to encourage that way of working.

## Poor learning environments where recontextualisation struggles

The data from the five studies we draw on were collected between 2008/2009 and 2017 during a period of change and flux in the NHS (see Chapter 2). Common to all the studies are the references and descriptions of the busyness of the NHS; this is referred to by all interviewees and understood to shape learning in the NHS. Busyness was seen as detracting from learning across all studies but particularly in study 1 and recontextualisation did not figure strongly in participants' accounts in that study. Much of the learning seemed to the observer (Helen) to be about how to perform nursing rather than why a nurse was delivering care in a particular way. Helen observed that staff were orientated to allowing students to learn through doing but did not challenge them to expand their knowledge and skills or explore ideas cognitively. Indeed, much of study 1 data described when learning *didn't* take place. As this extract from Helen's field notes shows:

> Lots of learning what to do and how to be but not much why. It's as though embodied knowledge is hugely important – acquiring skills through doing – as one staff said today 'They'll have to be doing that soon'. (Field notes day surgery morning shift)
>
> Staff nurse and student doing drug round (2nd year student). Staff nurse letting student pour out tablets and give them to the patients; she didn't explain the drugs at all. She seemed to guide and facilitate the doing rather than understanding. At one point, she leant back, stretched her back and arms and looked for the world like she was bored. She didn't

> teach or challenge ... at coffee, student said she felt 'taken care' of by her mentor who she always worked with. (Field notes day surgery morning shift)

While the student's feeling of '*being taken care of*' in her relationship during this drug round with her mentor was comforting for her, it appeared to Helen as if the mentor was role modelling how-to (procedural) and tacit knowledge at the expense of content or know-that knowledge which would be important on a drug round as patients need to receive the correct medications in the correct dose. This emphasis on procedural and tacit knowledge led to a few incidents where the researcher observed students caring for patients without knowing what their medical diagnosis was, as described in the following extracts from field notes:

> The staff nurse allocated to work with the student that shift had not known what a [particular] scan was or how to explain a pulmonary embolus when asked by the student. So the staff nurse suggested we [Helen and student nurse] went up to see the scan. Helen then explained about the scan and what a pulmonary embolus was. (Field notes Accident and Emergency [A and E] late shift)

> Student and I [Helen] were preparing a lady for operation; I asked student if she knew what the operation was; she didn't know and hadn't asked. Later mentor and student at the station looking at notes for the same patient going for parotidectomy that morning; mentor had arranged for student to prepare a patient and follow her through to theatres and watch the operation and care for her post-op. So again facilitative and meeting her identified learning needs. However she didn't check student knew what the operation was; so I asked the staff nurse in front of the student and she gave a brief explanation. (Field notes day surgery morning shift)

Helen's observations on the lack of know-that knowledge in the mentoring relationships that evolved as trained staff worked with students were validated in an informal interview with a ward manager, as recorded in this extract from field notes:

> Sister told me that she thought students learnt how to do things but not why. 'We don't have the time. Don't know where they learn why'. (Field notes mixed surgical ward late shift)

In rather a negative way, these data show that the context in which learning takes place is hugely important and frequently, *it* was simply too busy to assist students to learn.

## Factors which shape recontextualisation

It is known that certain factors can move recontextualisation from acts of interpretation to adaptive and then productive recontextualisation: time and predictability, gradual release and enacting new knowledge.

## Time and predictability

Data showed how time and predictability were consciously and structurally planned to help the NQN learn. In the first quote, an HCA describes how systems like a structured handover are designed to help the NQN adapt and learn routine in order to enhance patient safety and effective team working:

> So that's like a structured one [handover], so it will prompt like the staff nurses to give a really good handover, a thorough handover, so most things should be handed over.

Other ways to facilitate time and predictability happened more informally through the performance of routine responsibilities as an NQN. Here an HCA in study 2 describes NQNs' learning triggered by an activity, i.e. being in charge for a group of patients and having to use the computer to keep accurate records. She describes NQNs gradually gained confidence through the performance of routine activities:

> They seem to be like, they're doing the same thing you know, took a long time on that, but I think it, I don't know, that's what I feel, that they just seem to be like lost on the computer sometimes and you know, it just takes them a while to do a certain thing but I suppose as they get more experienced they'll be a lot quicker at doing the care plans and stuff you know.

Time and predictability are therefore key to understanding how NQNs learn to recontextualise or put knowledge to work for themselves across different situations, as this ward manager explains:

> ... we always say it will take you all of that time for you to sort of get to where you think, you know – you won't think twice about picking up the keys or you know, taking the ward or whatever, so that's the nice thing about the preceptorship.

In another example, shown in Box 5.1, an HCA is frustrated that an NQN doesn't know how to take out a patient's drain on a surgical ward. She sees this as an example of how unprepared the NQNs are for practice. There's also some frustration that she's expected (because of her experience as an HCA) to show/tell the NQN what to do. However here we can also see that intuitively the HCA knows that repeated exposure to the activity (removing a patient's surgical drain) is necessary to perform an activity in practice – in the HCA's words '*because I've observed … I knew how to do it*'. She describes how repeated exposure has allowed her to feel confident enough to tell an NQN who has never done it before how to do the activity. Yet she denies the NQN the opportunity for the same learning process, '*she should know already*'. Sadly without repeated exposure, the activity will not become predictable and the NQN unable to move to unpredictable performance.

## Box 5.1 Time and predictability

I was with another staff nurse who'd been here for a while as well and this newly qualified nurse was taking out a patient's drain and she wasn't sure how to do it, but I knew how to do it anyway because I've observed, I don't do that myself but we were telling her and I was telling her 'this is how you do it', I'm not even, I'm not even qualified to do that because I don't do that but when I'm telling her this is how you do it – I shouldn't be telling her like she should know already.

A little later in the interview she seems to acknowledge that the NQNs are learners although she'd rather they didn't rely on her as the more junior (and poorly paid) in the hierarchy:

Yeah, and there's always other people here that they can ask, but I just think that they need to know everything really about their patient and when they don't it's a bit [frustrating] cos they ask me ... I don't know whether it's they're slightly embarrassed about asking what that kind of thing is, so they've come to me 'oh what is this', because they think I'm below them it doesn't matter if they ask me, rather than ask someone of their own level because they might feel a bit embarrassed I don't know.

Even seemingly well-known tasks and activities require time to produce adaptive and hopefully (finally) productive recontextualisation:

... they spend a lot of time on medication which I know I'm not qualified, but I've been here for three years and I know it don't take like 45 minutes to draw one [injection] fluid up, which some of our new ones are doing and it's not fair on us you know, we get, we get left with the confused, we get left with the risk of falls and trying to work all of that out as well as your daily jobs it's really hard, it is really hard.

However time and *predictability* as factors in facilitating recontextualisation are not always possible given the unpredictable nature of learning in clinical practice, as the WM suggests in relation to cardiac arrest:

The other big is that a lot of student nurses have never been exposed to sometimes is cardiac arrest, so in that situation that the nurses struggle because it is a difficult situation and it's not one that you have a lot of the time however now on the preceptorship course here they have started doing the intermediate life support so we are preparing for them for that situation in the future as well.

But the same could follow for any number of complex nursing tasks because recontextualisation is *dependent* on the placements NQNs have been exposed to in their programme:

> ... placements they've had within their training and where their exposure has been and you can certainly tell the nurses that are being exposed to places like A and E, Medical Admissions Unit, Early Diagnosis Unit, you know, surgical wards, because they know a lot of the background information and they can think about is that, should that patient be nil by mouth, have we filled in the surgical pathway, so a lot depends on where they've been.

The need for time and predictability is captured in this ward manager's description of NQNs' learning as a '*big learning curve, a big, big, learning*' which they don't have because they have two weeks from qualifying to learn. This lack of time has consequences, as she describes, in their drop in confidence:

> ... it's a huge difference isn't it from when the day that they qualified they have two weeks sort of supernumerary and then they're on the wards in charge of wards, right from the very early on, a big learning curve for them, I think it probably takes them about a year to really get their confidence built up again ... and it's just a big big learning thing.

## Gradual release

NQNs were well aware of how activities, if unsupported or introduced too quickly in an unplanned way, could feel unsafe and prevent learning. In other words, how gradual release could enhance their learning, as this quote shows:

> **Do you feel you've had that all the time you've been here or?**
>
> No [laughs], at the beginning I hardly had, I haven't had a really good set up at the beginning, truthfully. They were always short staffed and I was sort of a supernumerary first three days, then day four I was thrown in to the bay on my own and on day six I was co-ordinating a ward with agency staff. And because my background is from the private hospital, I've never worked for NHS so it was difficult at the beginning. I wrote a statement obviously because I was not happy with the shift and anything could happen. And they said 'why, why don't you ring site co-ordinator?' Well my question was 'who is site co-ordinator?' I didn't even know there was a person called site co-ordinator because nobody told me.

NQNs' need for gradual release was well recognised by ward managers, although they acknowledged it could be difficult to implement. It also required investment and planning by a wide, supportive, clinical team (see Box 5.2).

### Box 5.2 Gradual Release: Challenges for ward managers in busy settings

> [NQNs] struggle with a change, the big change that we all have to go through from being a student to being a newly qualified nurse. And what they find is as soon as they put the blues on [registered nurses' uniform]

*(Continued)*

they're ... all of a sudden people want them and they can't say 'I don't know something' or they're expected to give doctors answers.

Time management we do have a practice trainer that will come and work with them, they do attend an in-house preceptorship for six months where they will attend one day a month and then also there's myself and we also have a co-ordinator X which is normally is band six or an experienced band five who are there to support them who are now supernumerary on this ward and that's something new that we've only implemented in the last month to be honest.

In many cases, gradual release is not always possible or planned for on a busy ward, as the NQN is at pains to describe in Box 5.3.

## Box 5.3 Gradual Release: Challenges for NQNs in busy settings

And so, then when you started, could you tell me a little bit about those first months after you qualified.

For me, for me, my first month was really trying because I came onto this ward really, really busy ward, you've got to learn very fast, it runs at a very fast pace. And I felt like it was really [?? 08.19] for me and I felt like 'oh my God, is this what I was putting myself into' because, I mean the first, the first two weeks because you work with someone for the first two weeks.

**Supernumerary.**

Supernumerary, so that's fine, things going well, you don't know what you're, how it's going to be, when you're thrown out into it yourself and you've got to manage 13 patients, you've got to manage your own time and within those 7½ hours you are meant to attend to the patients, attend to the relatives, do your documentation, attend to the doctors as they need to know things about their patients, you know, [??] how it is, do your writing, do your medication, within those 7½ hours.

If this gradual release to exposure combined with support doesn't help the NQN perform to the level expected, then further support is introduced which places more burden on the clinical team. The skills NQNs struggle with most commonly cited by NQNs themselves, HCAs and ward managers are time management skills. The following WM describes the steps which are put in place for the NQN to acquire them: *working one-to-one, identifying gaps in skills and planning how to improve their performance*.

**And when you say that 'in theory' and that some of them struggle with it, what do you do, how do you help them if they struggle with that?**

The, we will work with them on a one to one basis and try to look where they are, not managing their time correctly and put action plans together.

**And what would, what would be included in an action plan like that?**

The action plan would look at the allocation of medications, how long it takes to do a medication round, how long it would take to do a ward round, what risk assessments they have to do that day, they would look, we would look at the overall care of a patient and whether there's some training needs more than anything because that [is] what it tends to be, training needs, to then free up some time for nurses to provide hands on one to one care with patients.

Despite the busyness and the challenges of transitioning from senior student to NQN, many ward managers recognise how important gradual release is to learning and successful transition. In the data extract in Box 5.4, a ward manager illustrates her awareness of the challenges NQNs face and how activities can be structured: *paced* to facilitate recontextualisation or learning to *forward think*, *forward plan*.

## Box 5.4 Gradual release and successful transition

Ward manager speaking:

It's just physically learning the [computer] system and then the other thing is you know, a lot of training days are advertised on the hospital intranet. So it's learning how to and having the forward thinking, the forward planning to, to look on the learning development website as well to find those study days for themselves

Yes, it's a lot to begin with, that's why I think in the 3rd year student, they should be given some autonomy and their mentor should under observation let them manage to begin with one patient, then two patients ...

**And would you expect that, them to be able to do that from day one or would it be?**

No, no, no, no, I think it's unfair – no, not from the day one, even though they're 3rd year ... because it's a responsibility ... it has to be a really certain pace. You have to think constantly, have to think 'what's next, what's next'. So that's why I think they should be introduced you know, let them see how we work, and gradually preparing them for what's next and you say next week you could look after a patient, the following day two patients, and the following week perhaps, this is a middle of placement here I think, to get used to the environment and to sort of, we also have a lot of discharges, admission[s] and it's very fast and sometimes it could be a bit exhausting for us, never mind for a student who has a lot to take in to be honest.

## Enacted new knowledge

A team approach to putting knowledge to work can be structured when the individual NQN works with a senior nurse who can probe and challenge the NQN:

> think that's another big learning thing for them really our walk round handovers with a good person that does it, a senior nurse that does it and just goes through it step by step and I think you know, and you question, why is their blood pressure like that, you know, and is there something that's happened, what are you thinking about their low blood pressure, are you going to sort of escalate that up and, I think that's another sort of learning thing really in the very early days really. (WM)

Here the NQN says she participates in enacted knowledge as she watches those nurses who are slightly her senior and listens to their tips on how to become more confident:

> **And how have you learnt to prioritise do you think?**
>
> Through practice, and practice, watching how other people do their thing and really through practice and asking and also watching how other people do it really. Because like for example I remember one of the girls telling me 'if you really want to manage for example in the morning when the doctors are doing their rounds, you could write what they, what they have decided about the patient then, because you're standing there with them, if you have the time scribble what they have written then if anything comes up like if there's any change you can add it to that'. So then you know you've done that otherwise if you leave it to the end then there's a possibility that you're going to forget what they have said.

The support for enacting new knowledge doesn't have to come from a senior nurse. The data show that HCAs are key members of an NQN's work team. HCAs described observing NQNs learning as they begin to make connections through workplace practices and activities:

> I mean sometimes you get, over the years you get into like a routine and you know what takes longer to do and I say you do get into a routine. But with newly qualified, it's like 'what shall I do first?' And it all depends on what patients you've got and what's happening you know. Well they do tend to get through it but a slower process you know, because they're not used to it. But they do fairly well and if they get stuck they do ask you know, others. (HCA)

However, NQNs don't always feel supported by their colleagues – as in this extract where the individual NQN was left on her own to establish a routine:

> I did struggle first, like maybe month, two months nearly, until I got myself around routine and then, then it's gone better and better now ... now it's, if we've got enough staff then if the staffing levels are good, then yeah you can get a job done, without too much stress and I can actually finish on time.

## Adaptive recontextualisation

When the act of interpretation involves the enactment of a well-known activity in a new setting, an adaptive form of recontextualisation takes place as existing knowledge is used to reproduce a response in a parallel situation. While the following data from study 1 don't show the greatest supportive learning environment, they do show students are active learners who show adaptive recontextualisation. In at least two episodes of observation in study 1, it quickly became clear to Helen that the students she was working with were accustomed to sorting out their allocation of work including who they worked with. They enact well-known activity (allocating the work) in a new setting or parallel situation (each morning shift with new students).

> Morning shift had handover. The ward manager comes out of the office, then staff nurses, then two students trailing behind; allocation already done. Students look hesitant but then started breakfasts. I introduced myself and was told to go and find the students. Later that shift while having coffee with these students, the 3rd year student was angry about what had happened at the start of the shift 'you saw what happened? – we just sorted it out – the other student is pregnant so I took the heavy side. The staff nurses were already busy on the phone so we had to do the work, decide what to do. No-one supervises you.' (Field notes Gynae-oncology late shift)

> Very slow start to shift with mentor appearing slow to ask students what they needed to do or indeed identifying them as students who needed to work with mentors if present – my student said to me later 'I wait to see – is she going to sort me out? Obviously not! – Then I decide what I want to do and who to be with'. (Field notes A and E morning shift)

In the following extract from study 2, the NQN's active learning appears to be quite stressful for her. The adaptive learning is conveyed in her description of her existing knowledge '*First priority is to do my medicine round and then I take it from there really*', which she enacts in a new or parallel situation '*one particular day, we were so, so busy*'. There's a sense that she has an internal mantra to get her through stressful, new situations such as when it's busy '*the basics – medicines, observations*':

> First priority is to do my medicine round and then I take it from there really. There was one particular day, I mean we're so, so busy and I knew I wasn't going to get me jobs done. So I did my medicines, I did my obs[ervations] and then I got everybody washed and cleaned, and I couldn't get much more done than that, but I was happy with that because I'd felt that I'd done the basics, so it would be medicines first, erm, then, then obs[ervations], well then anything that needed doing in between, then obs[ervations]. And obviously, because on this particular day there wasn't anybody to do the washing, so I was going round, you know, doing them.

In Box 5.5, from study 1, a longer illustration of adaptive learning is given from Helen's field notes of a long piece of participant observation. The adaptation is shown in the student's reflection on a patient she has found emotionally challenging: in her saying '*We couldn't help. That's what I found difficult when I'm not in*

*control. The other stuff is okay because we can do something*.' So the sacral sore, the repeated need to clean up the bed-bound patient were examples of where she'd learnt to recontextualise knowledge and become confident and adapt to new situations. Meeting the needs of a dying patient and doing an electrocardiogram (ECG) were aspects of the role she was continuing to struggle with.

## Box 5.5 Adaptive recontextualisation – being able to reflect in practice

It was 07.45 on an early shift and a 1st year student was working with sister on a very busy ward. Helen offered to work with the student in one '*heavy*' bay.

> ... 2nd patient was confused, had kept the bay awake by shouting, smelt of faeces and needed a full bed bath. Student went to gather things we'd need and we started. The woman had a big sacral sore, necrotic and 'dirty' with faeces. The bed bath took about 45 minutes; it was hot, smelly, and difficult to move the woman and the student was unsure of herself. However the woman kept saying 'thank you' and looked better afterwards; she then went on to be incontinent of faeces 10 minutes afterwards. After two more bed baths and an assessment of a lady who'd 'gone off' (it turned out to be a trans ischaemic attack) and doing a set of observations and calling sister who did a superb mini teaching session, we staggered off to coffee. I remarked how tired I felt and joked I wasn't used to hard work. The student said she liked to be busy and hated being bored; gets bored with two–three hour lectures. Prefers mornings so she can be busy; she likes her mentor to show her once and then leave her to get on with things (as she doesn't like not doing). But if it's something like ECGs then she's scared of them and keeps asking to observe.
>
> I then remarked I'd found the woman's sacral sore difficult to deal with – it was a long time since I'd seen one. 'Oh you just get on with it. I'd never seen anything like that before but I have now and it's fine. I just think if you can help someone, like we were, she kept saying we were, then that's okay. But before Christmas there was a man with legs that were very painful, they were falling apart and he was in pain. I couldn't do anything and I found that difficult. To see someone come in and then in a week, like that go downhill and die. We couldn't help. That's what I found difficult when I'm not in control. The other stuff is okay because we can do something.' (Field notes medical ward morning shift)

And finally, an NQN in study 2 reflects on learning in university and in placement and what facilitates learning in placement: firstly, she looks to the mentor for guidance but if the mentor isn't up-to-date, she actively ignores and recontextualises what she observes with what she's learnt in university in adaptive recontextualisation:

I try to learn the good skill that I want whoever like, in university they teach you, they guide, they teach you in the lot of very good lectures and they guide you – the books to read, those are very useful I think, those books are, and when they send me placement the mentors are, I try to learn from and [??], you try to learn the good things from mentor and like things you don't want to [??], you don't want to be like that, you don't learn.

**Exactly.**

So you don't, you try to learn from a book.

**Almost like bad role models or ...**

Yeah, so not that bad like a bit, not update practice, I want to take like [??].

**And what can you try and describe what those good things are then that you try and pick up from the mentors?**

Well some of them the mentor, I wouldn't say they are not up to date but like it depends.

**Not up to date with what, knowledge?**

Yes, like knowledge, the way we do things in the trust.

## Productive recontextualisation

Where the interpretation leads the learner to change the activity or its context in an attempt to make a response, a productive form of recontextualisation takes place, as new knowledge is produced. In the following extract, in an informal exchange with a mentor in charge on a day shift who was working with a 2nd year student, Helen asks the mentor whether she liked mentoring:

I had dreadful mentors when I was a student and I swore I wouldn't be like that with anyone.

The mentor shows that she's changed the activity (mentoring) and its context (her relationship with the student, engagement and interaction with the student) as a response to her experience as a student. A productive form of recontextualisation has taken place, as new knowledge is produced to work differently as a mentor. The next quote shows another example of productive recontextualisation where an NQN recognises that the activity and setting of delegation have changed in her transition from student to NQN: '*delegating as a student and delegating as a staff nurse are two quite different things*'.

**And the management skills that you're developing, did you get some insights into that in the programme?**

Yeah, we did but delegating as a student and delegating as a staff nurse are two quite different things.

**Yeah, how would you say they're different?**

They're different because it's, it's hard to delegate as a student, because erm, I did try it once and erm, they didn't, the support worker didn't like it very much. I did it in a nice

way, and I think it's, not so much easier, but you feel like you, you've got more authority to delegate as a [NQN], not that I've, I've struggled delegating ... delegating but you've got more authority as a staff nurse than you have being a student.

Even where the learning environment is poor, as in study 1, with fewer positive examples of workplace recontextualisation, productive recontextualisation was described as taking place. In the next extract (see Box 5.6), Helen has gone for a coffee break with one or two students who are interested in what exactly she's doing working with them. Helen's been working with them on the gynae-oncology ward, morning shift. The atmosphere has been quite sombre and Helen felt the students were perhaps being shielded from the distressful death of one of the patients. The students were distressed by the atmosphere on the ward. Productive recontextualisation is revealed in the 3rd year student's resistance to the possibly well-intentioned but clumsy teaching by a practice educator. *She reveals how she resents the learning activity of reflection and being asked to 'share' what a personal and painful experience has been. Her pain and anger are revealed in her descriptions 'until you explode' and 'I hate being asked "what have you learnt?"'* New knowledge is produced through her interpretation of her need to reflect alone or possibly in a small group unforced as occurred during our coffee break together.

## Box 5.6 Productive recontextualisation in a poor learning environment

There were two young patients dying, one patient who'd had a total abdominal clearance and had come back to the ward in shock and was being resuscitated; the curtains were drawn around her and one of the Sisters kept going in and out. Neither of the students were looking after these patients.

At coffee with a 2nd year and a 3rd year student nurse, the 2nd year student asked me if I'd always enjoyed nursing?

I replied 'yes' but it had been difficult. How was she finding it?

'It's been difficult; shocking coming into nursing from school; the amount of work'.

The 3rd year then said that she found the 'stress and psychological [effect] builds up and feels heavy on your shoulders until you explode which is what I did the day before with the practice educator'.

A 2nd year asked me if other link lecturers (I had told her I taught as well as researched) worked with students. 'They're not here. Sometime in other areas they're useful; I had one in my first placement, a care home. Here the practice educator comes and.'

3rd year interrupts 'it wasn't reflection. It was should! Should! Should! Not helpful. He fires questions at me and I can't think. I hate being asked "what have you learnt?"'

2nd year 'I can't think quick enough and they continue to fire questions at me. We have reflection in college'.

3rd year 'Yes but there you don't want to share with 30 others. It's difficult, gynae-oncology and you can't share this (nodded towards the ward) with others. It's the emotions of caring for them, (nodded again) that gets on top of you'.

## Conclusions

So do these data illustrating WR show that nurses theorise in practice? In our view, there's certainly evidence of thinking and reflection and as a result, adjustments to activities and practice in the acts of interpretation we've presented. The data show how nurses theorise about their professional:

- identity
- nursing roles and activities
- purpose, i.e. patient care and advocacy
- leadership built on teamwork, being calm and organised, establishing a routine, working with others.

The data also show their ability to manage ambiguity, complexity and conflict. The findings illustrate how these nurses, including ward managers, healthcare assistants, newly qualified nurses and students:

- thought about the reasons why they care in particular ways
- articulated to each other in handovers or in case conferences the rationale of what the nursing care is based on
- thought through ethical practice
- thought through their own learning preferences.

These data reveal how complex WR is and that, despite the busyness and almost constant state of change in the NHS, WR is a feature of work and learning. The NHS appears to sustain learning despite students feeling their learning needs are not always acknowledged and ward staff finding supervision of students challenging.

These data from study 1 show poor learning environments where evidence of knowing (know-how), tacit and procedural knowledge is present in clinical practice but know-that knowledge appears to be absent. However, even in these circumstances, students appear to learn and theorise through negative incidents as well as positive in response to challenging contexts of care. Whether these apparently

ingrained habits of learning can be attributed to the ways in which the organisation explicitly fosters strong learning, foundations, dispositions and identities in early career nurses and the extent to which it is generated and sustained in the unique ecologies of learning and practice (Barnett and Jackson, 2020) of the NHS is a matter for later discussion (see Chapter 9).

We will now move to the data from studies 3–5 to illustrate other situations where more experienced nurses theorise in practice through WR.