SHAPING CLINICAL IMAGINATION IN MATERNAL-CHILD SIMULATION: THE LIVED EXPERIENCE OF NEW GRADUATE NURSES

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Doctor of Philosophy
Nipissing University

2018

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SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

NIPISSING UNIVERSITY
SCHULICH SCHOOL OF EDUCATION
NORTH BAY, ONTARIO

NIPISSING UNIVERSITY
Charter Anniversary 1992-2017

SCHOOL OF GRADUATE STUDIES
MRP/THESIS/DISSERTATION CERTIFICATE OF EXAMINATION

Certificate of Examination

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entitled

Shaping Clinical Imagination in Maternal-Child Simulation: The Lived Experience of New Graduate Nurses

is accepted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

July 19, 2018
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Abstract

Simulation-based experiences have been introduced in nursing education as experiential learning strategies to integrate theory with practice. The purpose of the phenomenological study was to uncover the lived experience of new graduate nurses transitioning into nursing. van Manen's phenomenology of practice was used to understand the essence of being a new graduate nurse entering practice following a traditional practicum and preceptorship with maternal-child simulation experiences. Narrative methods included a three-phased phenomenological approach with two semi-structured interviews and one member-checking contact with ten participants. Thematic analysis revealed four emerging themes: performing like a nurse, forming a clinical imagination, embodying the role of the novice nurse, and embracing life-long learning in simulation. The participants shared their journey into nursing practice and presented simulation as intertwined in their own discovery of the ethics of caring, reflective practice, and imaginative thinking. Study findings suggested a need to further examine the impact of simulation in entry-to-practice in nursing and to establish a review of current practices in maternal-child simulation in Canadian nursing curriculum. The stories offered first moments in clinical practice, in which the new graduate embraces the role of the novice nurse and shapes a clinical imagination of being a nurse.

Keywords: simulation, new graduate nurse, maternal-child, transition, simulation-based experience, lived experience, phenomenology

Acknowledgements

I am grateful for the guidance of my thesis committee, Dr Carole Richardson, Dr Tara-Lynn Scheffel, and Dr Sandra DeLuca. These scholars have helped me understand that ideas that are messy and unclear are worth pursuing. Through their expert revisions, I discovered the artistry in sharing the complex stories of nursing practice. I also acknowledge the contributions of the examiners, Dr Allan Pitman and Dr Susan Elliot-Johns.

I have profound gratitude for my thesis supervisor, Dr Sharon Rich for her endless support and her unwavering belief in my abilities as a researcher that kept me moving forward. She has given me the gift of her knowledge and practical wisdom, inspiring me to find my voice as a woman, as a nurse, as an educator, and as a researcher.

My doctoral experience was a transformational journey with people most deeply connected to my own sense of being. The ideas originated and grew in our family home. To my husband Steve, I express my heartfelt gratitude for being attentive to the details every step of the way, as well as to my children, Taylor and Nathan, whose young minds inspire me to make positive contributions in my everyday life. Seeing my daughter become a nurse during this experience was an honor as a mother and as a fellow nurse. She was also the force behind my writing about the ethics of caring that she represents so beautifully. The philosophical conversations with my adolescent son shaped my own imagination as we talked about the meaning of being in this world. I am grateful for the gift of our dialogue.

I am also appreciative of the Nipissing University Graduate Scholarship funds, of the support of the Dean of Applied and Professional Studies, and of my colleagues in the School of Nursing for taking interest in my research. A special thank you to Wendy and Tammie for the ideas we shared in our travels as we learned about clinical simulation. I share this success

with good friends: Chantal, Julie, and Ylise provided endless conversations about my research while reminding me to get outdoors to restore energy and enthusiasm. I cherish the memories with the group of ten: thank you Amanda, Kathryn, Michelle, Carmen, Adam, Sarah, Kerry, Carmen, Sunaina, and Nafisa for helping me achieve this goal.

I am most grateful to the participants in this study. They are new graduates; they took time from their lives as they transitioned into this beautiful nursing profession to share their experience. It is a humbling experience to listen to the first days of a nurse's life and the participants allowed me to reflect on the adventures of becoming a nurse.

Dedication

I dedicate my work to my parents and to my husband's parents. They have taught me that being in this world means striving to live a good life.

Table of Contents

List of Tables and Figures

Tables

Figures

Reflexive Prologue: Uncovering my Own Journey

As a new graduate nurse, I was interested in the theoretical components of relational practice and curious about how to develop the clinical judgment required in nursing practice. A novice, I took comfort in being a clinical educator as I interacted with childbearing families realizing that the refinement of clinical reasoning would come with practical knowledge. Although I was proud of becoming a perinatal nurse in a small northern Ontario hospital, I was easily overwhelmed by the expectations for a nurse in maternal-child nursing in a northern and rural setting. In my first year, I wondered how I would discover what I needed to know to care for women and children and how self-directed learning would be different from the formal learning I enjoyed in university.

I began my career in a town close to the Far North boundary, in a forty-four-bed hospital servicing a population of approximately a thousand people divided by a radius of fifty kilometres east, one hundred and thirty kilometres west, and eighty kilometres north-south. My work as a perinatal nurse was marked by a temporary part-time and casual employment status which resulted in disillusionment and ultimately, a pursuit of more permanent and stable roles. The desire to specialize in perinatal nursing was combined with my employer's need for cross-training between paediatric and perinatal nursing, a common requirement for maternal-child nurses in the northern region. My first year in practice made me question whether I would become proficient, as in this northern and rural experience, I was required to apply the skills and knowledge gained from nursing school while deepening my understanding of the profound implications of caring. I observed, listened, and talked to families as I provided care and felt the pressure of accountability for their wellbeing. I

learned that as a nurse in a northern and rural hospital, I would have to make decisions rapidly, communicate within the interprofessional team, and collaborate with other centres.

Reflective practice helped me during the times when I felt underprepared as a new graduate. Through my reflection or intuitive thinking, I came to understand that the relational skills would eventually blend with the instrumental technical skills emphasized in practice readiness. I valued my time learning from patients, nurses, midwives, physicians, social workers, nurse practitioners, porters, housekeepers, and administrative clerks. At every opportunity, I observed my fellow nurses' grasp of everyday clinical situations and noted that most practicing nurses were pursuing additional education such as hospital-based training, national certification, post-diploma programs, and graduate studies. I soon recognized that formal and informal learning would nurture my professional development as a novice nurse.

As decentralization of the maternal-child program occurred in the northern and rural hospital, I relocated to become a nurse educator while still working as a staff nurse in direct practice in perinatal nursing in a larger hospital. In my first year as a clinical instructor, I felt blessed to see the first graduating class of nurses at the baccalaureate level in a new nursing program. A collaborative program between colleges and universities seemed perfectly positioned to prepare nursing graduates for the realities of nursing practice and I valued a formation approach aimed at a smooth transition into clinical practice. From my perspective, the integrated collaborative program offered the ideal blend of the technical skills with the theoretical aspects required in nursing.

Over more than a decade, I progressively developed a scholarship of teaching as I used simulation to integrate theory with practice in addressing everyday clinical concerns. In my epistemology of practice, I incorporated entry-to-practice competencies, standards of

practice, and current literature in nursing to educate reflective professionals. In my course delivery, I carefully designed learning objectives aligned with experiential learning in both the simulation lab and in classroom lectures; adopting clinical simulation as a way to combine theory and practice during a period in which provincial funding was available for the design and implementation of simulation in nursing education. I collaborated with faculty in the School of Nursing to design and develop maternal-child nursing simulation activities while levelling learning objectives in maternal-child simulation across the nursing curriculum.

In my inquiry, I gathered transition stories of nurses entering practice and wondered to what extent the experiences of these nurses reflected or differed from mine. Thus, I came to this study wanting to consider and mindfully capture the lived experience of new graduate nurses entering practice following a senior-level practicum and preceptorship with maternal-child simulation.

Chapter 1: Introduction to the Lived Experience

> Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is one of the Fine Arts; I had almost said, the finest of Fine Arts.
>
> - Florence Nightingale

In this phenomenological study, I examine the lived experience of new graduate nurses entering practice after their exposure to maternal-child simulation during their senior practicum, their preceptorship, and their transition into nursing. I use narrative methods to probe into the artistry, creativity, and imaginative thinking involved in finding the essence of becoming a nurse. In this chapter, I outline the background for the study, the phenomenon of interest, the key terms, the problem statement, the significance of the study, the purpose, and the research questions.

Background for the Study

Preparing the twenty-first century learner for the demands of nursing practice requires meaningful clinical experiences aimed at developing practice readiness, and fostering skills relevant to specialized settings. The nursing practicum incorporates various models of clinical practice education. In the facilitated practicum, a clinical instructor supervises a group of eight to ten students in the practice setting (Canadian Association of Schools of Nursing [CASN], 2004). In their final practicum, nursing students enter preceptorship, a one-to-one learning experience with a nurse in the practice setting designed to foster the professional socialization of the senior student to the nurse's workplace (Alexander, 1984; Dobbs, 1988; Kaviani & Stillwell, 2000).

The transition of professional roles from student to staff nurse after graduation is characterized by the changes that occur in the socialization to the clinical setting. The

transition into practice is a period marked with growth and transformation in the nurse's professional identity, role, relationships, skills, and pattern of behaviors (Registered Nurses' Association of Ontario [RNAO], 2016). New graduate nurses describe the transition from being a student to becoming a nurse in practice as challenging, and identify transition shock, the dramatic stage in which the new nurse experiences the arduous process of professional role adaptation (Boychuck Duchscher, 2009; Kramer, 1974). The senior-level clinical placements, which include a facilitated practicum followed by preceptorship, need to appropriately prepare graduates for the "dynamic, highly intense, and conflict-laden context of professional practice" (Boychuck Duchscher, 2009, p. 1111).

Incidentally, professional programs in Canadian universities are experiencing a shortage of practicum placements required for learners to gain practical knowledge (Ralph, Walker, & Randolph, 2010; Smith, Corso, & Cobb, 2010; Smith, Spadoni, & Proper, 2013). The scarcity of placements is significant in specialty nursing such as maternal-child nursing where there are limited availability of mentors, few sites accepting learners, and competition between professions (Spadoni & Proper, 2013). While each discipline organizes the final placement experience before entering the workforce differently, Ralph, Walker, and Wimmer (2009) report that programs in professional education share a common goal of providing students with learning opportunities that require them to apply their knowledge and assume greater professional responsibility.

To respond to these needs and to remodel practical learning, classrooms need to carefully integrate practical experiences with theory (Ralph et al., 2010). Traditional placements in hospitals and in the community continue to hold importance in nursing; however, the design of on-campus simulation labs offers practical learning strategies and

relieves the pressure on the over-capacity traditional practicum sites more appropriately reserved for the practiced learner (Issenberg, McGaghie, Petrusa, Gordon, & Scalese, 2005; Ralph et al., 2010). Despite the emerging use of simulation in nursing curricula, a standard substitution ratio for the use of simulation and traditional supervised practicum remains undetermined (Breymier et al., 2015; Gore, Van Gele, Ravert, & Mabire, 2012). As I strive to understand the lived experience of learners who have engaged in maternal-child simulation during their senior facilitated practicum and also in preceptorship, I examine their transition into nursing practice.

Phenomenon of Interest

The phenomenon of interest is the transition into practice of new graduate nurses. Phenomenology is used to seek answers to the question of "what is it like?" when probing into the lived experience and gathering existential accounts of entering practice following a senior-level practicum and preceptorship combined with maternal-child simulation.

Definition of Terms

Simulation-based experience. A simulation-based experience is defined by the International Nursing Association for Clinical Simulation and Learning (INACSL) Standards Committee (2016c) as "an array of structured activities that represent actual or potential situations in education and practice and allow participants to develop or enhance knowledge, skills, and attitudes or analyze and respond to realistic situations in a simulated environment" (p. s39). I search for the meaning of simulation as strategies leading to the socialization and development of knowledge and skill acquisition of the new nurse graduate.

Formation. Benner, Sutphen, Leonard, and Day (2010) present formation as a philosophy of learning that includes experiences beyond the classroom to develop

knowledge, skills, and ethical notions of nursing practice. Rather than occurring in a specific course or in a set timeframe, professional formation occurs over time through multiple experiences in nursing (Benner et al., 2010). In the study, I examine the learning moments where graduate nurses imagine themselves in relational practice providing safe, competent, and ethical care and how simulation-based experiences may also shape professional identity.

Practical wisdom. Wisdom is distinguished by Aristotle as an intellectual virtue in which scientific knowledge termed 'episteme' and practical knowledge, referred to as 'techne', appeals to excellence and to acting virtuously (Aristotle & Ross, 2009). Practical wisdom concerns itself with choice, options, and deliberation in human actions (Kinsella & Pitman, 2012; McKie et al., 2012; Runes, 1960). I reflect on the instances in practicum and preceptorship, whether traditional or simulated, where the new graduate may develop practical wisdom.

Clinical imagination. An integrated approach to nursing education develops clinical imagination, a term used by Benner et al. (2010) for rehearsed situations potentially faced by nurses in practice. The degree of believability of a simulated experience is described by its resemblance to reality. As reality increases, the level of fidelity ranges from low, medium, or high (INACSL Standards Committee, 2016c). Fidelity is dependent on physical factors in the environment such as the resources and the equipment, and the psychological factors of emotions, beliefs, and self-awareness. The degree of realism is influenced by the social factors of learning that affect motivation, goal attainment, group dynamics, and the level of trust in this learning modality (INACSL Standards Committee, 2016c). In the presented study, I seek to understand the imaginative thinking and clinical imagination in nursing.

Problem Statement and Significance of the Study

Nursing practice is largely shaped by transformative professional experiences in practicum (Ralph et al., 2010). This qualitative study gathers information on the new graduate nurse's transition into practice following traditional practicum, a preceptorship, and simulation-based experiences. Consequently, there is discourse on the implementation of simulation in Canada as a result of mandatory clinical practicum time incorporating the use of simulation in many nursing programs. While CASN (2015) has developed a framework for effective utilization of practicum and simulation, the emphasis on quality practical experiences in Canadian nursing education is most significant to this study. Discovering the new graduate nurses' perceptions of both their practicum and simulation experiences may serve to understand a sustainable twenty-first century practicum in professional education. To date, few qualitative studies describe the lived experience of new graduate nurses using maternal-child simulation in their traditional instructor-led practicum and into preceptorship.

Purpose and Research Questions

The purpose of this study is to develop an understanding of the ways in which new graduate nurses perceive their transition into practice following their experiences in maternal-child simulation. The study is guided by an overarching question with three sub-questions. The overarching question is: What is the lived experience of new graduate nurses transitioning to practice after a practicum with maternal-child simulation? The sub-questions are: In what ways does the lived experience in maternal-child simulation prepare for reflective practice? In what ways does the lived experience in maternal-child simulation develop the ethics of care? In what ways does the lived experience in maternal-child simulation support the development of clinical imagination?

In summary, I use phenomenology of practice to uncover the lived experience of new graduates as they transition into nursing practice following a final practicum and preceptorship that incorporated maternal-child simulation. To understand the lived experience, I aspire to listen to new graduate nurses' stories of their transition into nursing.

Organization of the Research

In this chapter, I have outlined background for the study, the phenomenon of interest, the key definitions, the problem statement, the significance of the study, the purpose, and the research questions. In chapter two, I approach the theoretical framework using Dewey's theory of experiential education, Schön's reflective practice theory, Bandura's social cognitive theory, and Benner's stages of clinical competence. In the literature review, I trace four major areas of knowledge informing this study as I present current evidence relating to practice education in professional programs, nursing formation, practice readiness, and simulation-based experiences. In chapter three, I describe the methods used in phenomenology of practice to turn to the nature of the lived experience, recruit participants, conduct phenomenological interviews, capture the essence of the lived experience, and transform experiential description into textual representation. In chapter four, I share the story of each participant while revealing four emerging themes: performing like a nurse, forming a clinical imagination, embodying the role of the novice nurse, and embracing life-long learning in simulation. In chapter five, I take an in-depth look at the findings and return to my origins to uncover phenomenological meaning.

Chapter 2: Theoretical Framework and Literature Review

I am enough of an artist to draw freely upon my imagination.
Imagination is more important than knowledge.
Knowledge is limited. Imagination encircles the world.
–Albert Einstein

In this chapter, I describe the theoretical underpinnings and the literature informing the research. I employ a social constructivist viewpoint to depict the complex artistry of learners in clinical simulation as they imagine themselves in the role of the nurse entering practice. In the first section, I incorporate educational theories to situate my inquiry in the lived experience of nursing graduates. In the second section, I present the literature informing the study in four areas: (a) practice education in professional programs, (b) nursing formation, (c) practice readiness, and (d) simulation-based experiences.

Approaching the Theoretical Underpinnings of the Study

In this section, Dewey's philosophy of education provides a major theoretical underpinning for my understanding of experiential learning in practice education. To complement the constructivist viewpoint, Schön's reflective practice theory serves as a framework for the new graduate nurse's experience in becoming a reflective practitioner. Bandura's social cognitive theory (SCT) helps me discern the social interactions that shape the imaginative thinking required in clinical simulation and in clinical practice. Finally, Benner's nursing model of novice-to-expert stages of clinical competence provides a theoretical framework for professional formation.

Dewey's Theory of Experiential Education

Education is a process of leading, shaping, and forming through social activity (Dewey, 2005). In health education, learners construct knowledge and reality through

professional interactions that form their views of the social world of clinical practice (Kinsella, 2009; Scotland, 2012). If past experiences shape future learning opportunities, design strategies need to consider the student's prior social learning (Dewey, 1938). Learners come into health professions with their own experiences and their personal stories about health and illness. In experiential education, competence develops through practical experience; Dewey's postulations thus have a large impact on the ways in which practicum is constructed across many professions. In nursing, continuing competence tends to develop over time and through an array of practical experiences (Benner et al., 2010). Ideally, the link between theory and practice is a substantial focus in practicum exposure and has been a major concern within health professions (CASN, 2015; Ralph et al., 2010, Smith et al., 2010; Smith et al., 2013). Nursing practice is founded on a multitude of experiences that require an integrative approach between the classroom, which is often more about theory, and practical education, which facilitates hands-on learning (Benner et al., 2010). Simulated experiences may provide opportunities for learners to think about their practice and apply classroom theory in a safe, protected environment (Jeffries, 2005). Inquiry into the use of simulation in clinical practicum, preceptorship, and more broadly into the nursing transition calls for consideration of professional formation, the development of knowledge, skills, and ethics of nursing practice; this requires imaginative and integrative thinking to interpret the inherent possibilities that arise in practical reality (Benner et al., 2010). Such professional formation necessitates thoughtful practice that goes beyond trial and error by requiring learners to think carefully about the ways in which they approach their actions (Tanner, 2006).

Schön's Reflective Practice Theory

Dewey (2005) suggests that experiential learning fosters reflexivity between the learner's actions and consequences, thereby providing the element of thought as bringing meaning to experiences in education. Schön's theory of reflective practice builds inherently on Dewey's work and suggests that thought is central to the acquisition of practical wisdom. In simulation, nurses use reflective practice to contemplate the perceptions and emotions triggered while they are being coached in the development of skills and the ethics of caring (Gardner, 2013). Reflexivity represents a progressive direction for professional schools once characterized by a dominant positivist technical rationality stemming from the advancement of science and technology (Argyris & Schön, 1974; Schön, 1987). The move from a positivist approach to a movement of integrating practicum experiences with theoretical learning fosters the application of the artistry and the aesthetics of relational practice (Kinsella, 2009; Smith & Kinsella, 2009). The reflective practice theory in which Schön (1983) presents reflexivity as a form of practical knowledge incites learners to spend time thinking about their actions. Drawn from Michael Polanyi's concept of tacit knowledge, Schön (1987) delineates the professional artistry in reflective practice, which leads to knowing-in-action. As I search for professional artistry in the transition into practice following the use of simulation as a component of learning, the literature on reflective practice helps me to understand learners' perspectives as they face the uncertainties of complex health situations. Practitioners gain tacit knowing from reflecting professionally on their own patterns of actions to gain a sense of knowing-in-action in professional practice (Schön, 1983). For example, the simulation debrief provides an opportunity for learners to reflect and critique the tacit understanding of the elements of repetition in practice to make sense of the ambiguity, the similarity, and the contrasts within the clinical situation (Fanning

& Gaba, 2007; Gardner, 2013). As a reflective practitioner, the nurse assumes responsibilities to provide competent, safe care using reflection on-action and reflection in-action. The intuitive thinking of the nurse represents a form of processing of information in clinical situations (Schön, 1987). Knowing-in-practice is organic to the social interactions of a community of health providers as they are motivated to assume the role in their scope of practice (Schön, 1983). Knowing-in-practice also shapes the aesthetics of relational practice in moments where the new graduate nurse gains an awareness of the skills and knowledge required to develop therapeutic relationships.

Bandura's Social Cognitive Theory

Practicum experiences are frequently designed to draw from both Dewey's (2005) and Bandura's (1995) theories of development. While Dewey (2005) notes that the experiences obtained in social learning helps to form social groups with similar ideas, beliefs, and goals, Bandura (1995) suggests that self-efficacy, a self-perceived belief in the ability to set priorities and execute action in a given situation, affects the way individuals view their thinking, their feelings, and their level of motivation. In a nursing practicum, students learn from practitioners as they observe and learn by doing, and over time the nurse in formation develops an ability to function more independently. In simulation-based experiences, small groups of learners come together to rehearse a clinical situation designed to promote self-regulation of behavior and to foster self-efficacy (Burke & Mancuso, 2012). Learning occurs when there is a transformation in behavior initiated by engaging in an activity and experiencing the consequences of actions (Zimmerman & Schunk, 2009). In adopting a new scope of practice in nursing, the nursing student and the new graduate nurse require

imaginative thinking and vicarious learning to shape cognitive perceptions about their abilities (Bandura, 1993; Benner et al., 2010).

In clinical practicum and in simulation, learners describe physiological responses, emotional triggers, and visceral reactions to develop their self-concepts as nurses (Jeffries, 2005). Self-concept, as a phenomenon, includes self-reinforcement and the pre-disposition to view positive and negative aspects of our own behavior (Bandura, 1971). In simulation, for instance, nursing students indicate a greater connection with the role of primary nurse rather than with that of observer and report that roleplaying the nurse's responsibilities requires them to carry out the actions of the nurse (Harder, Ross, & Paul, 2013).

Learners internalize their self-efficacy and competence in a task through their beliefs of personal capability (Bandura, 1995). Vicarious experiences in simulation provide experiential opportunities for learners that enable them to envision themselves in real-life situations and in so-doing create self-efficacy beliefs (Bethards, 2014). As nursing students are socialized in their practicum, there is pressure to undergo personal and professional change to respond to practical situations. Bandura's SCT is relevant in simulation-based experiences since self-regulation of learning and the social interactions may affect student nurses' ability to imagine being in a clinical situation. Vicarious learning and self-regulatory processes are essential components of professional practice. Practical learning, cultivated through social interactions, is characterized by individuals instinctively imitating others in their surrounding (Bandura 1995; Dewey, 2005; Kinsella, 2009).

Benner's Stages of Clinical Competence

The stages of clinical competence developed by nursing theorist Benner provide a framework for the new graduate nurse experience in this study. Benner (1982) formulates a

descriptive educational theory in nursing, a framework based on the Dreyfus model of skill acquisition with five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Influenced by an epistemology of practice, Benner's novice-to-expert model emphasizes the importance of clinical knowledge and practical wisdom through the development of clinical expertise. In Benner's framework, nurses develop expertise through integrative thinking, technical skills, and ethical behavior in a manner that brings them to imagine and rehearse clinical situations to approach practical problems (Benner, Tanner, & Chesla, 1996; Tanner, 2006).

Clinical competence is achieved through practical experience, and novice nurses move from seeking rules in their nursing practice to developing a sense of intuition to solve clinical problems (Benner, 1982; Benner et al., 1996). Through various experiences, novice nurses spend time considering every element in a situation in order to seek patterns and, although initially detached observers, become a part of the system in their acquisition of knowledge and skill, ultimately using explicit knowledge until tacit knowing is developed (Benner, 1982). As a starting point for practice, novice nurses rely on formal learning to approach a clinical situation while the competent, proficient, and expert nurses incorporate informal learning moments to improve nursing practice (Benner, 1982). In Benner's model, nurses experience professional growth to move from novice to competent, proficient, and expert practice. The new graduate enters nursing practice with novice to competent levels of clinical skill and knowledge.

Literature Review

To complete the literature review, I searched for background literature related to practice education in nursing, new graduate nurse transition, entry-to-practice requirements for the Registered Nurse (RN), clinical simulation, and maternal-child simulation. I used the electronic databases of ProQuest Nursing and Allied Health, OVID Medline, OVID Evidence Based Medicine Reviews, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL). I found one hundred and seven relevant articles dating from 2007-2017, which included eight systematic reviews relating to simulation in healthcare. While seventeen studies were identified as using qualitative methods in simulation research, five studies used phenomenology to describe the perceptions of learners in simulation. The qualitative studies dated from 2012-2017 and seemed to indicate a shift from a more quantitative paradigm in simulation studies over the period. Most of the articles retrieved were published outside of Canada. I also searched for relevant clinical practice guidelines from international, national, and provincial associations informing nursing education and entry-to-practice in nursing.

In this section, I present the literature relevant to practice education in professional programs, nursing formation, practice readiness, and simulation-based experiences.

Practice Education in Professional Programs

Most programs in professional education have a process of evaluation involving feedback from several sources combined with a program review conducted predominantly by professional credentialing, regulatory, and accrediting bodies (Ralph et al., 2009). A practicum, common to all programs, varies across disciplines, but generally consists of a teaching-learning relationship between faculty, a mentor, and a learner collaborating on the

process of summative and formative evaluation of performance in the practical component in professional education (Ralph et al., 2009). Information relating to practicum is often obtained from graduates' employers, their practice mentors, the faculty, the program administrators, and to a lesser degree, from the students enrolled in the programs (Ralph et al., 2009). Thus, more studies may reveal student perceptions of practice education.

To understand the use of practicum in Canadian universities, Ralph et al. (2010) present the results of a three-year multi-disciplinary study of practicum experiences in professional education. Using mixed methods, Ralph et al. (2010) expose findings from document analysis, site visits, focus group interviews, individual interviews, and surveys to explore the level of preparation for learners in professional education as they enter the workforce. The researchers describe practicum experiences from students in their final practicum in nursing, engineering, dentistry, forestry, law, medicine, veterinary medicine, pharmacy, social work, theology, and education in nine Canadian universities. Participants identify the practicum as reducing the theory-to-practice gap through a mentorship experience, a supportive environment where students are team members, and an exposure to practical problems that build self-confidence. Negative aspects of practicum include poor relationships within the mentorship experience, ineffective placement in relation to learning needs, unrealistic time constraints for learning goals, unfair evaluations, and financial difficulties related to the cost of the practicum (Ralph et al., 2010).

Showing the range and types of pre-licensure placements for nursing and other health professions, Smith et al. (2013) provide an inventory of the hospital, community, long-term care, and innovative settings utilized by various disciplines. Study findings reveal that nursing and other health professions face similar issues relating to placement and Smith et al.

(2013) question if past practicum practice reflects the needs of health education in the twenty-first century. A closer look at the simulation-based experience in this study is pertinent to seek the new graduate's perspective on the utilization of practicum combined with simulation.

Simulation in practice education in nursing. Learning in simulation goes beyond the impressive technological components and the funds acquired to design innovative, state-of-the-art simulation labs (Gaba, 2007). It also provides an opportunity to take learners outside of the traditional lecturing space to learn practical skills and to engage in reflective conversation on fundamental concepts in nursing such as patient safety, role clarification, communication, and collaboration (Kneebone, 2009). Gaba (2007) depicts simulation as "a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion" (p. 126). Gaba's interpretation of simulation as a technique reflects the perspective of twenty-first century educational sustainability in which technological strategies provide opportunities to enhance the preparation of learners to respond to important real-life matters. Simulation requires facilitation by a skilled, trained simulation educator to ensure the design meets the needs of learners, and to assist them in achieving expected outcomes (INACSL Standard Committee, 2016b; Jones & Hegge, 2008). The facilitator's role is to foster the development of skills through careful coaching toward critical thinking, problem solving, and clinical judgment while bridging theory with practice (INACSL Standards Committee, 2016b).

Although the use of technology is emerging in nursing education, simulation-based experiences have existed in professional education for centuries. In order to develop

innovative simulation strategies into the twenty-first century, it is important to uncover its history in healthcare. Before the 1950's, nurses initially learned in class and then by observation while often performing nursing skills for the first time on the patient in the hospital under strict supervision (CASN, 2015). In maternal-child nursing, dolls and pelvic torsos are illustrated as a fundamental practical learning tools since the seventeenth century to emulate the technical aspects of childbirth (Cooper et al., 2012; Jeffries, Bambini, Hensel, Moorman, & Washburn, 2009). Throughout nursing history, role-playing, story-telling, and predetermined acting scripts have been commonly used to practice clinical skills (Harder, 2009). These strategies are still used today.

The first movement toward simulation in healthcare was marked by the development of Resusci-Anne, a mannequin created by toy maker Laerdal (Harder, 2009). At that time, simulation mannequins were affordable and accessible, which produced a new wave in teaching nursing skills. The convenience of these mannequins brought a second movement of simulation created by advancements in equipment and a focus on teaching critical care skills using higher technology in the mannequins and task trainers, mostly designed for learners in medical anesthesia and critical care nursing (Harder, 2009). The focus on patient safety and job readiness resulted in the third movement of simulation originating in the 1980's and has triggered a widespread use of simulation in health education to provide a safe learning environment. In this third movement, educators are interested in teaching technical tasks and complex scenarios using constantly improving technologies. Harder (2009) proposes a fourth movement in simulation driven by the interest for research into the development of best practice in clinical simulation. The fourth movement may be poised to explore the imaginative component necessary for simulation design to be effective. Hence, Kneebone

(2009) suggests a reframed movement of simulation in which solutions to problems are potentially explored where "the essence of simulation is a purposeful design, based on an active process of selection from an originary world, abstraction of what is criterial and re-presentation in another setting for a particular purpose or audience" (p. 1). Through this lens, simulation reframed offers the possibility of teaching current practices, creating connections, embodying the actions in therapeutic relationships, and finding solutions to clinical problems (Kneebone, 2009). Now more than ever, research into simulation is piquing interest in evidence-based practice to support the use of simulation in bridging theory and practice. However, there is a gap in the literature in delineating the effectiveness of simulation in entry-to-practice in nursing despite the documented advances and the development of guidelines. The fourth movement of health care simulation is timely for this inquiry.

Guidelines for clinical practicum and simulation. CASN (2015) provides guidelines for the selection of the practice learning and recommends careful consideration of the learning outcomes, the nature of the learning, and the types of issues involved to effectively use simulation as an enhancement or substitution for clinical placement. For some learners, simulation is an extra-curricular activity, while for others, simulation is part of a course expectation. Ideally, the selection of the practice learning experience depends on appropriate use of fidelity (CASN, 2015). The INACSL Standards Committee (2016c) provides a best practice guideline to define the range of fidelity, also referred to as realism, and to attribute the level of authenticity and believability in simulation in comparison to the real situation. A high-fidelity simulation (HFS) is defined as the use of computer-operated patient simulators, virtual reality, or standardized patients to mimic a realistic clinical situation using a high level of interaction and realism in the learning experience (INACSL

Standards Committee, 2016c). Low fidelity involves an immersion into clinical practice through the use of case studies, role-playing, task training, and stationary mannequins to experience a specific clinical situation and practice the acquisition of a specific skill or competency. As the level of fidelity increases from low to medium and high, the level of realism increases (INACSL Standards Committee, 2016c). The level of fidelity is affected by several factors in the learning environment, such as the equipment used and the resources available for the simulation. While psychological and social factors relating to emotions, beliefs, awareness, motivation, and goal setting alter the level of fidelity, the culture of the group and their degree of trust in each other in simulation also adjust the level of realism of the experience (INACSL Standards Committee, 2016c).

When comparing the effectiveness of traditional and simulation practicum, Adamson (2015) calls for careful identification of learning needs, proper selection of the level of fidelity in the appropriate situation, and a mapping of evidence-based educational practices. The author also questions whether the current literature identifying simulation with skill-performance, learner satisfaction, clinical judgment, and self-confidence is adequate evidence of the effectiveness of simulation. This suggests a need for more literature to explore the learner's perspective of how simulation-based experiences affect their entry-into-practice.

Selection of the practice learning experience. The traditional setting, often described as an apprenticeship-like model, would benefit from innovative approaches to help new graduate nurses achieve entry-to-practice competency (Smith et al., 2010; Wolff, Regan, Pesut, & Black, 2010). Blending traditional placement with simulation may help to integrate theory with practice. However, selection, planning, and implementation of the practice experience remains unsystematic in nursing education (CASN, 2015; RNAO, 2016, Smith et

al., 2013). According to CASN (2015), the use of simulation as a substitute or enhancement of the traditional placement is a topic of discourse in nursing education and a national nursing education framework provides recommendations on effective consideration for length, frequency, and continuity of a practice experience that uses simulation. In Canada, nursing educators would benefit from best practices guidelines to support the framework for the use of simulation in practice education in nursing. Adopting American nursing simulation approaches may not be effective for the transition into Canadian context. In a multi-site randomized control trial, Hayden, Smiley, Alexander, Kardong-Edgren, and Jeffries (2014) have examined the effectiveness of using clinical simulation as practicum in nursing. The study, informing policy decisions on the use of simulation as practicum in nursing, represents ten pre-licensure programs in the United States (U.S.) where participants were categorized into three groups: a control group with no more than ten percent of clinical practicum spent in simulation, a group in which students replaced twenty five percent of their traditional practicum hours with simulation, and a group in which students replaced fifty percent of traditional practicum hours with simulation. Hayden et al. (2014) have reported no statistical significant difference in clinical competency prior to licensure, in the licensure success rates or in manager ratings for overall readiness for practice at three months and at six months after graduation. Their study results suggest that new graduates are effectively prepared for nursing practice with both or either traditional practicum and simulation. As a result, Hayden et al. (2014) provide national guidelines to support the substitution of practicum hours with simulation for up to half of the required, mandatory practice hours. Incidentally, the study has omitted the student perspective that could indicate the ways in which simulation may

foster practice readiness and the researchers have, alarmingly, left out the new graduate nurse's voice on the utilization of new strategies as senior-level undergraduate students.

For learners, the selection of practice learning environment depends on the degree of believability and the application to their practice. Because learners generally prefer a higher level of realism in simulation, the use of mannequins also poses limitations on the ability to measure transferability of skills in a real situation (Tosterud, Hedelin, & Hall-Lord, 2013). Several researchers have explored the effectiveness of HFS in teaching clinical reasoning skills; however, the translation of skills and knowledge in healthcare remains poorly understood (Lapkin, Fernandez, Levett-Jones, & Bellchambers, 2010; McGaghie, Issenberg, Barsuk, & Wayne, 2014). Essentially, the transfer of knowledge from simulation to clinical practice needs to be further reviewed to adopt a high percentage of replacement of clinical hours in the Canadian curriculum. Applicability of the Hayden et al. (2014) study results to Canadian practice is questioned by educators, indicating a need for further studies of the Canadian nursing context. To fill this gap for American nursing practice, Jeffries, Dreifuerst, Kardong-Edgren, and Hayden (2015) have examined the educational outcomes when simulation is substituted for clinical placement following the Hayden et al. (2014) study, which used ten nursing schools across the U.S. and reported faculty development as a main priority to ensure appropriate use of simulation. Faculty buy-in, simulation training, and ongoing professional development also remain problematic in Canadian curriculum (CASN, 2007). Inconsistencies on how simulation is utilized in curriculum will most likely continue to exist until a standard ratio of appropriate replacement of clinical practicum time with simulated experience is proposed in nursing education (Breymier et al., 2015). Using simulation as a practicum experience rather than the traditional setting is predominantly

determined by faculty, dependent on the course learning objectives, and finally, on the availability of a practicum setting. The traditional settings of hospitals and community health placements, which employ the majority of nursing graduates, represent the main choice for practicum sites (CASN, 2015; RNAO, 2016). Simulation may be suited as an enhancement for learning practical skills in nursing. Inquiry into the lived experience of nurses following a traditional practicum combined with simulation may expose how simulation is viewed in practice readiness. The new graduate's perspective on the practical approach with simulation may offer an understanding of entry-to-practice and whether they have felt that their practicum experiences appropriately prepared them for practice.

Professional Formation

In professional formation, opportunities to observe, reflect, and experience problems faced by nurses allow learners to imagine themselves in those situations whether the context is a clinical problem, an ethical dilemma, or an issue related to the scope of nursing (RNAO, 2016). As nurses develop explicit knowledge, their actions are complemented by tacit knowledge defined by a skilled know-how difficult to express but implicit in their actions (Benner et al., 2010; Schön, 1983). In nursing, clinical wisdom incorporates tacit knowledge, the unspoken ability to recognize clinical implications, and the ability to coordinate a timely response. Gaining an awareness of the theories-in-use invites reflective practitioners to examine their actions in their practice (Argyris & Schön, 1974). Sustainable nursing education provides learners with the practical wisdom to develop a sense of salience required to sort out pressing clinical concerns while continually shaping their readiness for practice (Benner et al., 2010).

Practical wisdom in nursing. Phronesis is construed by Runes (1960) as "practical wisdom, or knowledge of the proper ends of conduct and of the means of attaining them distinguished by Aristotle from theoretical knowledge or science, and from technical skills" (p. 235). Kinsella and Pitman (2012) state that practical know-how, "the second recovery of Aristotle's 'phronesis' will see the professional as having not only the (cognitive) capacity to deliberate (judge) well but also the appropriate (affective) attitude and dispositions (i.e., the virtues)" (p. 17). Clinical wisdom represents intelligent thinking bringing nurses to discern the practical actions that will shape their professional knowledge on how to act with virtue (Benner et al., 2010). Further studies may provide an opportunity to contemplate the ways in which a traditional practicum blended with simulation fosters practical wisdom. In my inquiry, I explore the reflexivity of the lived experience in maternal-child simulation as potentially leading to clinical wisdom.

Clinical imagination. Benner et al. (2010) note that there continues to be a divide between classroom and clinical placement education in nursing. The novice-to-expert framework in nursing incorporates the development of clinical imagination, clinical judgment, and the ability to link theory and practice to strive toward nursing competence (Benner, 1984; Benner et al., 2010; Tanner, 2006). Professional formation accentuates learning in the practicum setting, and Benner et al. (1996) urge educators to use situated coaching leading to practical and imaginative thinking to enhance salience in the nurse's response to clinical problems. For example, nursing students need an intricate understanding of the complexity of co-morbidities and a grasp of how the lived experience of being ill is affected by the increasing trends of technology resulting in rapid exchange of information combined with a higher level of acuity and shortened length of stay in hospitals (Benner et

al., 1996). Simulation may allow nursing students to understand the complexity as well as identify and respond to practical problems before entering the clinical setting. Furthermore, simulation may be suited for large didactic classroom settings and using HFS within the classroom may also create dialogue and encourage nursing students to immerse themselves in healthcare situations (Carson & Harder, 2016). Since new graduates are faced with the challenge of identifying and responding to urgent situations, understanding their perception of being in simulation and how it relates to the shaping of their clinical imagination present important considerations for research.

Experiences in simulation may help establish imaginative thinking on the way to reflective practice. Reflective practitioners are required to use imaginative thinking in their provision of care and Kinsella (2001) presents practical actions that seem helpful for reflective nurses to develop clinical imagination. As a reflective practitioner, the nurse must first recognize clinical experience as an avenue for continuous learning and reflect on the meaning of practice on a regular basis (Kinsella, 2001). Since the reflective practitioner needs to recognize other ways of knowing, nurses are encouraged to develop self-knowledge, political, social, economic knowledge to complement the traditional and technical scientific knowledge (Kinsella, 2001). As the nurse examines the client's context, critically thinking about the ideologies relating to the systems in place is an important element in the provision of care. Reflective nurses explore the assumptions that are tied to their practice and learn to articulate the theory of practice that they espouse (Kinsella, 2001). Reflective practitioners negotiate their espoused theory of practice with the theories they use in their day-to-day practice to compare what they say with what they do and start to develop praxis in which their actions are guided by reflection (Kinsella, 2001). In the simulation-based experience,

reflection and imaginative thinking tend to occur in the debriefing phase which occurs after the homework, after the pre-briefing and following the activation of the simulation scenario. In the simulation debrief, a planned session in every simulation designed to improve future performance, learners are guided through their reflection by recounting the emotions from the simulation experience (Gardner, 2013; INACSL Standards Committee, 2016a; Levett-Jones & Lapkin, 2014). Instructor-led debriefing in simulation offers an opportunity for discovery of skills, emotions, and attitude while preparing the learner for a similar high-stake situation in practice (Luctkar-Flude, Wilson-Keates, Tyerman, Larocque, & Brown, 2017; Jeffries et al., 2009). In debriefing experiences, learners engage in conversation and reflection through modeling, repetition, and imagery of various responses to clinical situations. Ideally, the debriefing environment is a safe place to engage in dialogue and to share ideas with other healthcare providers (Gardner, 2013). The INACSL Standards Committee (2016a) provides clinical guidelines for educators to create an optimal debriefing environment for learners as "learning is dependent on the integration of experience and reflection" (p. s21). Debriefing supports transfer of skill and knowledge while fostering an understanding of the components of patient safety and the development of professional roles (INACSL Standards Committee, 2016a). In order to be conducive for learning, the debriefing milieu is founded on a theoretical framework and is aligned with learning objectives. To foster psychological safety, the debriefing space assures confidentiality, open communication, immediate feedback, and self-reflection (INACSL Standards Committee, 2016a). Simulation-based experiences provide the psychological safety to draw on multiple perspectives and to foster reflective conversation on clinical situations that arise in clinical practice (INACSL Standards Committee, 2016a). Groups of learners in simulation debrief

look for a safe environment where there is group cohesion and effective, skilled facilitation to explore thoughts, and to gain immediate feedback from multiple perspectives (Fey, Scrandis, Daniels, & Haut, 2014). In this study, I search for experiential descriptions of practical knowledge, reflective thinking, and role rehearsal in simulation as a reflective learning environment and the ways in which these factors come into play to build the clinical imagination of the nurse in the transition into practice.

Practice Readiness

Preparing the twenty-first century nurse for practice calls for meaningful clinical experiences aimed at developing practice readiness (RNAO, 2016). The nursing practicum incorporates various models of clinical practice education from a facilitated practicum where a clinical instructor supervises a group of eight to ten students in the practical setting to the preceptorship model, in which the learner enters a one-to-one relationship with a clinical expert (CASN, 2004). In each practicum course, nursing students must meet learning objectives based on entry-to-practice competencies and the classroom and the clinical setting need to be carefully designed to integrate theory with practice (College of Nurses of Ontario [CNO], 2014; Ralph et al., 2010).

Framework for entry-to-practice in nursing. A review of the regulatory body's competencies for entry-to-practice is an important element to consider in examining new graduate nurses' experience in simulation. The Canadian Council of Registered Nurse Regulators (CCRNR) provides a conceptual framework for the development of entry-level competencies for RN practice (2012). The client, defined as an individual, a family, a group, a community, or a population is at the center of the model which accords importance to safe, competent, compassionate, and ethical care (CCRNR, 2012). The entry-level RN requires

competent application of knowledge based on four areas of the nursing process: assessment, planning, implementation, and evaluation of care (CNO, 2014). In the conceptual framework, achieving competency is not a linear process but an iterative approach (CNO, 2014). As a provincial regulatory body, CNO (2014) defines competency as "the knowledge, skill, ability and judgment required for safe and ethical nursing practice" (p. 4). Five broad competencies are presented in entry-to-practice in nursing: professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public, and self-regulation (CCRNR, 2012; CNO, 2014). These are shown in Figure 2.1.

Figure 2.1 Conceptual Framework for Organizing Competencies (CCRNR, 2012)

The competencies, which provide measures for licensure, serve to protect the public while also representing a legal practice reference to evaluate baccalaureate nursing education (CNO, 2014). Inviting new graduate nurses to share their lived experience necessitates an understanding of the entry-to-practice requirements because the new graduate nurse needs to meet these requirements. The competencies in the framework are embedded in nursing curriculum and utilized as a basis to prepare nursing students for entry-to-practice (CCRNR, 2012; CNO, 2014). Nurses are accountable to modify their practice through experience and repetition of skills and judgment (Tanner, 2006).

Fostering a culture of patient safety. Discussing the elements of patient safety in simulation may lead to identification of behaviors, prevent adverse events, and enhance the student experience toward fostering a culture of patient safety (RNAO, 2016). Fenske, Harris, Aebersold, and Hartman (2013) report that nurses with less experience are often more interested in accomplishing task-related activities in nursing and may miss salient information while the more seasoned nurses may be ideally positioned to predict, imagine, and identify potential outcomes in a situation. Thus, careful self-appraisal of professional abilities in nursing is important for safe provision of care of our population. Such self-appraisal is more appropriately performed in simulation than in a patient care setting (Pelletier & Kneebone, 2016). Teaching strategies in simulation may serve to help learners understand the concepts of patient safety, bringing them to gain an awareness of the severity and devastating consequences of medical errors, near misses, and adverse events (Breitkreuz, Dougal, & Wright, 2016; Pelletier & Kneebone, 2016). For instance, a lower incidence of post-partum complications and a decrease in cesarean deliveries has been reported with the implementation of a simulation program across four hospital sites studied (Walker et al., 2016). Further research is needed to discern the impact on health outcomes and to understand the role that social modeling of behaviors may play in leading to positive health outcomes (Walker et al., 2016). As a nurse educator, I look to discover the ways that the experience in simulation aligns with a culture of patient safety for the new graduate nurse entering practice.

Transition into practice. The transition from university to the workforce is a difficult period for nurses (Boychuck Duchscher, 2009; Wolff et al., 2010). The new RN must acquire and refine technical skills, theoretical knowledge and practical know-how upon entry into nursing practice. In Canada, the entry-level requirement to baccalaureate nursing

education prepares nurses to respond to the complexities of healthcare (CNO, 2014; Wolff et al., 2010). The change from an apprenticeship model to a higher level of nursing education is aligned with healthcare trends and educational approach of other health-professional programs (Wolff et al., 2010). Practice education in nursing involves integration and application of theory in a real or simulation clinical practicum (CASN, 2015; RNAO, 2016). The preceptorship experience addresses the need for socialization to the clinical practice context while bridging the gap between theory and practice (Kaviani & Stillwell, 2000).

As Casey, Fink, Krugman, and Propst (2004) explore the new graduate experience and describe the stresses and challenges that influence retention of nurses, they note that their participants revealed that they did not feel skilled, comfortable, or confident during their first year in practice. In this study, the new graduate nurse experience depicts a lack of confidence in skill performance, a need for the development of critical thinking, and a deeper understanding of interpersonal skills. While new graduate nurses expect an extended orientation and look for the existence of support programs in order to make their entry-into-practice successful, the participants in this study expressed deep frustration with the work environment (Casey et al., 2004).

Again, to understand the transition into nursing and the learning needs of new graduate nurses, Dyess & Sherman (2009) conducted a study involving a focus group in which new graduate nurses were asked to describe themselves as new nurses. As participants shared their typical workday, they emphasized the transition into nursing as a period in which they lacked confidence and a moment in their life that was characterized by fear, horizontal violence, perception of professional isolation, less-than-ideal communication, and contradictory information. Dyess and Sherman (2009) recommend support for new graduate

nurses throughout their first year of practice through continuing education opportunities that meet their needs during the transition into practice. A formal link to leadership is emerging as millennials look for visibility and transparency from their leaders combined with peer mentorship, and consistent preceptors to provide them with strategies to respond to the complexity of healthcare and the inherent risk of horizontal violence (Dyess & Sherman, 2009). Because the complexity of specialty units calls for refined critical decision-making skills, the new graduate nurses in this study advocate for extended transition support for nurses choosing this career path (Dyess & Sherman, 2009). To support the nurse in transition, the Ministry of Health and Long-Term Care in Ontario offers a temporary six-month nursing graduate guarantee (NGG) residency program in which nursing graduates are paired with a nurse mentor for an extensive training period (Health Force Ontario, 2017). Simulation-based experiences are also appearing in the literature as a strategy to support continuing education through the transition in nursing (Nevin, Neill, & Mulkerrins, 2015; Meyer et al., 2014; Thomas & Mraz, 2017). Understanding the lived experience of novice nurses in transition may clarify the role of simulation in the development of entry-into-practice requirements.

Professional identity. Self-identity is formed as individuals grow and as they are socialized into various groups from the family through to the school and the work environment (Zimmerman & Schunk, 2009). Many researchers have taken the concept of identity and extended it into professional fields (Weideman, Twale, & Stein 2001; Wenger, McDermott, & Snyder, 2002). Professional identity in general can be seen as the socialization of new entrants into a profession through a range of interactions which began during their studies in a professional education program (Ralph et al., 2010; Wolff et al.,

2010). Initially, professional students identify as student nurses, student teachers, student therapist, medical students, business students; then gradually, as they gain experiences and greater interactions with members of the profession, they begin to identify as members of a community of practice (Benner et al., 1996; Benner et al., 2010).

In nursing, shaping of a nurse's professional identity occurs through a process of formation, re-formation, and socialization in which the nurse acquires professional values and recognizes the need to increase knowledge and the skilled know-how of how to be and how to act in nursing practice (Benner et al., 2010). Formation requires patience and occurs over time through experiential learning, situated coaching, and ethical comportment (Benner et al., 2010). Unfortunately, a disconnect is reported between skill acquisition, building professional knowledge, and the development of a professional self-image for nursing students and, for this reason, Benner et al., 2010 prefer the term 'nursing formation' over 'nursing training' in their recommendation for radical transformation of nursing curriculum. As Schön (1984) outlines a crisis of confidence in professional knowledge and a decline of professional self-image, he also describes the need for practitioners to question and uncover their value, worth, and contributions to society's wellbeing. As nursing students learn the fundamentals of nursing, their educators need to foster creativity, build citizenship, and help them explore their values against the central values of the profession (Schön, 1984). Nursing students need to engage in dialogue and self-reflection, to consider the "challenges, stressors, emotions, and successes during clinical practice experiences" (RNAO, 2016, p. 22). In nursing education, strategies for reflection are found in initiatives such as learning circles, peer sharing, journaling, and an increase in connectivity and exchange of healthcare stories via podcasts, online forums, mobile devices, and tablets (RNAO, 2016). The simulation-

based experience may incorporate many of these strategies as the simulation lab fosters an environment that gathers learners in a space designed to practice, to share perspective, and to engage in conversation about their challenges, stressors, emotions, and successes in providing nursing care.

The nursing profession is strongly based on the ethics of care, which may bring nurses to incorporate caring attributes as central to their professional identity (ten Hoeve, Jansen, & Roodbol, 2014). McLean, Johnson, Sargeant, and Green (2015) describe the use of simulation and the perceived effects of working with the simulated patient on the development of professional identity in medical education. As in nursing, simulation in medical education is used to develop technical skills and to develop a safe learning environment. McLean et al. (2015) suggest that simulation also effectively fosters socialization into the culture of a chosen profession and that professional identity is complex and requires role modeling and social construction of the knowledge, skills, and ethical behaviors that shape professional identities. Simulation represents a learning strategy and safe environment for honing technical skills and since ethical practice represents a broad competency in entry-to-practice in nursing, further studies are needed to understand the role of simulation in relation to formation and the development of professional identity.

Relational practice. In relational practice, the nurse's inquiry is based on consciousness in provision of care to foster attentiveness, consultation, empathy, mutuality, reciprocity, self-observation, sensitivity, and reflection (CNO, 2014). The nurse practices compassionate, therapeutic relationships with clients and the interprofessional team (CNO, 2014). Simulation presents an opportunity for learners to engage in relational practice, but the literature suggests that simulation is predominantly utilized to learn the technical skills

(Thomas & Mraz, 2017; Ventre et al., 2014; Walker et al., 2016; Weekes & Phillips, 2015). While the focus on biomedical aspects of care is important in the nurse's scope of practice, the simulation lab may present as an environment for new nurses to learn how to become reflective, attentive, empathetic, and compassionate (Weekes & Phillips, 2015). In a systematic review, Bearman, Palermo, Allan, and William (2015) describe a narrative synthesis presenting simulation as an effective method to teach empathy in health professions and highlight the value of the learner playing the role of the patient. In simulation, the activities designed may foster empathy for patients and help nurses guide their future communication toward the nurse-client therapeutic relationship (Weekes & Phillips, 2015). Further research is needed to discover the embodiment of relational practice in simulation-based experiences.

Simulation-Based Experiences

Few studies present the lived experience of students and new graduates in simulation. The literature is inundated with studies exploring student-perceived self-confidence and self-efficacy in simulation. It is not the intent of the present study to explore those concepts since the literature indicates that simulation is effectively used to foster clinical judgment and self-confidence and as a result, simulation has become a common component of clinical practicum (Jeffries, 2005; Lasater, 2007; Victor-Chmil & Larew, 2013). However, increased self-confidence scores show that learners identify simulation as a positive way to integrate theory and practice (Cardoza & Hood, 2012; Franklin, Burns, & Lee, 2014; Hallmark, Fentress, Thomas, & Grant, 2014). The ways in which simulation leads new graduate nurses to integrate theory with practice during the transition into nursing requires more research.

Student perception of simulation. Diaz, Maruca, Kuhnly, Jeffries, and Grabon (2015) have used phenomenology and Colaizzi methods to gather written reflections on the use of simulation and to uncover themes relating to body image, empathy, consciousness, humility, and respect. In Canada, Harder et al. (2013) describe the learning culture and factors influencing the use of HFS in which students recount their experiences in simulation as beneficial to learning the role of the nurse. Their participants have felt the need to perform as expected in the clinical setting while identifying relevance to the role of the primary nurse actively caring in the simulation. The lack of role clarity is perceived negatively in HFS experiences and while the study offers insight into the use of HFS in Canadian nursing curriculum, further research is required to discover the nursing student and the new graduate nurse experience in maternal-child simulation.

The emotional component of being in simulation is significant to the student experience. Nursing students perceive high levels of anxiety during simulation and relate their angst as a factor in their motivation to succeed and their desire to learn about the potential dangers in a clinical situation (Harder, Ross, & Paul, 2013; Neilsen & Harder, 2013; Parker, McNeill, & Howard, 2015). The use of simulation before and after a first clinical practicum experience provides an effective strategy to reduce anxiety while increasing self-confidence in caring ability (Khalaila, 2014). Nurse educators need to consider the level of anxiety among nursing students during simulation-based experiences in order to foster an environment that provides psychological safety, respect, and integrity (Khalaila, 2014; INACL Standards Committee, 2016b). The anxiety levels of learners in simulation increases in situations where they are closely observed, video recorded, and evaluated by instructors in the control room (Nielsen & Harder, 2013). Students experience less anxiety when

simulation is utilized as pre-clinical preparation for an upcoming practicum experience and to support their learning (Nielsen & Harder, 2013; Tyerman, Luctkar-Flude, Graham, Coffee, & Olsen-Lynch, 2016). The simulation environment represents an optimal place for learning and a safe academic space free from harm to patients and adverse events. Pre-simulation preparation combined with an orientation to the simulation environment reduces the anxiety and fears of participating in simulation (Nielsen & Harder, 2013; Tyerman et al., 2016). Easing learner anxiety and increasing their level of comfort with clinical practice through simulation-based experiences may also help them transition into practice. There is a gap in evidence on the transfer of skills and knowledge acquired in simulation as a student transitioning into practice as a novice nurse.

Maternal-child simulation experiences. In this study, maternal-child nursing encompasses perinatal, neonatal, and paediatric specialties with the student experience on maternal-child units often characterized by observation (Jeffries et al., 2009; Smith et al., 2013). Simulation effectively enhances communication, patient safety, and handling of obstetrical emergencies to actively prepare nursing students for clinical situations before they are required to safely respond to real-life medical events (Jeffries et al., 2009). As Kim and Shin (2016) identify the effects on knowledge, attitude, and skill acquisition of using simulation in maternal-child emergencies, their findings show an improvement in skill acquisition in the experimental simulation group over the traditional practicum group. Effective selection of maternal-child practicum for nursing students is an onerous responsibility and with increasing competition in the specialized setting, learners show high levels of satisfaction with a combination of traditional and simulation practicum (Kim & Shin, 2016). When comparing the performance in simulation and in a traditional maternal-

newborn unit, Veltri, Kaakinen, Shillam, Arwood, and Bell (2016) report similar results in assessment skills, response, and critical thinking and the authors support the combination of traditional and simulation practicum in specialties settings like maternal-child nursing.

While participants practice the ability to care for women and children, the satisfaction levels show positive response to a simulated maternal-child experience (Wagner, Bear, & Sander, 2009). As for transfer of skills, there is still much research to be done. Seeking learner feedback is an important research consideration. However, Sittner, Hertzog, and Ofe Fleck (2013) provide a study that shows the nursing student's ability to transfer maternal-child theory into a simulated scenario which was designed to bridge the didactic teaching with clinical practice. In their study, the simulation participants evaluate their ability to transfer information using a performance checklist and report a desire to be immersed in real situations and an appreciation of confidence building. The study suggests that the combination of low fidelity with HFS may be favorable for learners to incorporate their knowledge into practice. A blend of low fidelity and HFS requires in-depth planning and presents as an ideal strategy to prepare for obstetrical emergencies, intrapartum, postpartum, and neonatal care (Christian & Krumwiede, 2013; Raines, 2017; Utz, Kana, & van den Broek, 2014). Since there is limited evidence of the lived experience in a specialty, a need for further research in maternal-child simulation seems apparent.

Using simulation for role clarification. If learners perceive the simulation-based experiences as relevant in skill and knowledge acquisition in maternal-child nursing, another important inquiry into the lived experience is the role clarification that may occur when exposed to the interprofessional team. The Canadian Interprofessional Health Collaborative (CIHC) defines interprofessional education (IPE) as any instance in which healthcare

professionals learn together and from one another. The enactment of their scope in simulation creates greater clarity of roles and responsibilities (CIHC, 2010). The six competency domains delineate the required skills, knowledge, attitude, and values as incorporating abilities in interprofessional communication, patient/client/family/community-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution (CIHC, 2010).

The simulation environment is effectively suited to build IPE competencies and the maternal-child specialty often brings many learners together. Maternal-child simulation experiences provide simulation-enhanced interprofessional education (Sim-IPE) opportunities where roles are clarified (Jeffries et al., 2009). In a Sim-IPE pilot project, Baker, Pulling, Dagnone, Hopkins-Rosseel, and Medves (2008) describe the experience of nursing students, medical students, and medical residents and when asked to rate the activity's relevance to the understanding of their practitioner role, the research results indicated attitudinal scores being equal among the groups. However, the study shows the logistics of bringing learners together and coordinating a common session for learning as a main challenge for large professional programs (Baker et al., 2008). Hence, a blend of classroom activities combined with simulation may enrich the learner's experience. To explore the level of confidence in performing paediatric skills, Luctkar-Flude et al. (2013) studied the use of Sim-IPE paediatric modules. Although the communication and teamwork skills improved in the Sim-IPE group compared to the traditional group, the individual confidence performing paediatric skills scores, measured from a skills checklist, was reported by Luctkar-Flude et al. (2013) as being lower than team scores for both groups in the study.

Nonetheless, Sim-IPE is used widely in obstetrics for skills drills and acquisition of knowledge for emergencies with frequent updates of practical techniques, medications, communication, and delegation (Reynolds, Ayres-de-Campos, & Lobo, 2011; Scholes et al., 2012). Amatullah (2018) shows that adverse medical events in obstetrical care occur because of lack of staff training in obstetric emergencies and therefore pose a life-threatening risk requiring prompt response by skilled staff. In the systematic review, simulation-based experiences show improvements in response, staff skills, patient safety culture, and overall quality of care (Amatullah, 2018). Simulation is also useful to evaluate the entire unit's response to medical crisis. In a Sim-IPE model designed to assess the readiness of a new maternal-child unit, Ventre et al. (2014) explore and expose hazards, operational deficiencies involving equipment availability, staffing needs, ineffective interprofessional communication, and systems issues. The increasing integration of Sim-IPE fosters the rehearsal and repetition required for effective team communication, leading to improved response to real-life situations (O'Shea, Pagano, Campbell, & Caso, 2013). The student perception of simulation is missing from these studies.

Summary

In this chapter, I presented the theoretical framework of the study incorporating Dewey's theory of experiential education, Schön's reflective practice theory, Bandura's social cognitive theory, and Benner's stages of clinical competence. Adopting the philosophical underpinnings of social constructivism, I framed the study with the theoretical concepts of experiential learning, social learning, reflective practice, and skill acquisition. In the literature review, I synthesized the current evidence relating to practice education in

professional programs, nursing formation, practice readiness, and simulation-based experiences.

In the next chapter, I illuminate phenomenology and turn to phenomenology of practice to describe the methods used to explore the lived experience of new graduate nurses using maternal-child simulation in their practice.

Chapter 3: Methodology

We know not through our intellect but through our experience.

- Maurice Merleau-Ponty

In this study, I use van Manen's phenomenology of practice to observe the ways in which nursing graduates engage in practice and use imaginative thinking to embody the role of the nurse. In the first section of this chapter, I describe phenomenology as a philosophy and as a methodology to delve into lived experience. In the second section, I apply van Manen's articulation of phenomenology by illustrating the methods used: (a) turning to the nature of the lived experience; (b) recruiting participants; (c) conducting phenomenological interviews; (d) capturing the essence of the lived experience; (e) transforming experiential description into textual representation; and (f) adopting ethical considerations for this study.

Phenomenology

Phenomenology embodies methods from philosophical underpinnings and holds underlying assumptions familiar to human science as it searches for a general sense of experiential existence (Crotty, 1996; van Manen, 1990; van Manen, 1997). Phenomenology is interpreted by van Manen (1997) as systematically seeking to "uncover and describe the structures, the internal meaning structures, of lived experience. A universal or essence may only be intuited or grasped through a study of the particulars or instances as they are encountered in a lived experience" (p. 10). From the stance of an epistemology of practice, phenomenology adds to the body of knowledge in nursing by reflecting that reality in human practice is constructed through relational interactions between people, their world, and their social context (Crotty, 1989).

Husserl's transcendental phenomenology, the philosophical belief that knowledge is formed by understanding the essence of our existence as a phenomenon, serves as a starting

point. Pure phenomenology is a natural form of consciousness and a noemetic intentionality conceptualized while grappling with inter-subjectivity and the importance of reduction (Husserl, 1970). In the present study, I explore the ways that new nurses may use their experiences in maternal-child simulation to shape their existence in nursing practice. I turn to interpretive phenomenology to gain awareness of the sense of intentionality of one's practice.

Heidegger's interpretive phenomenology acknowledges the origination of intentionality and the concept of Dasein [being in the world] and the situated meaning of Being in the World (Heidegger, 1962; Heidegger & Krell, 1993; van Manen, 2014). Heidegger (1962) presents the phenomenon as "what shows itself, the self-showing, the manifest" and the essence of being is uncovered through three modes of persuasion: logos, which entails reason and logic, pathos, which provides an appeal to the emotions of the experience, and ethos, which represents moral sensitivities (p. 27). Letting the essence be seen occurs through Being (Heidegger, 1962). Professional programs incorporate simulation-based experiences to imitate and imagine the sense of being in the nursing world, and a consideration for this research is to understand the idea of gazing into relational practice as a lifeworld experience. Contemplating the phenomenon in a pure and reflective viewpoint requires setting aside the technological component of simulation because when technology is viewed as the ingenuity of the experience, the complexity of praxis is minimized (Gaba, 2007). The technical nursing skills routinely taught in simulation may go far beyond a systematic, logical sequence and I intend to engage in personal stories of emotional appeal, intentionality, and reflexivity to see the ways that simulation-learning may bring opportunity for professional formation.

van Manen's Articulation of Phenomenology

I take interest in the primal impressions and reflective state of consciousness in praxis through phenomenology of practice. In my phenomenological approach, I elicit experiential descriptions as they relate to time, body, and space. Specifically, our consciousness in professional education elicits a humanistic nature of caring for people. Indeed, intentionality digs into the human mind to reach a sense of awareness and consciousness (Crotty, 1996; Dowling, 2007, van Manen, 2014). My pursuit into human experiences takes account of the learner's perspective on the ways that their traditional nursing practicum, preceptorship, and transition into practice are connected to their maternal-child simulation experiences. For the new graduate nurse, the practicum may be a distant experience and through phenomenology of practice, the life story of the transition into practice is cultivated as it is lived in that moment in time. More to the point, as new graduate nurses tells the stories of entering practice, their accounts of applying simulation-based learning offer valuable insight for practice education. van Manen (2014) expresses the living human experience as

> …the main epistemological basis for qualitative research, but the concept lived experience (translated from German Erlebnis) possesses special methodological significance. The notion of lived experience, as used in the works of Dilthey, Husserl, Merleau-Ponty, and their contemporary exponents, announces the intent to explore directly the originary or prereflective dimensions of human existence: life as we live it. (p.39)

Hence, in adopting phenomenology of practice, I seek practical insights, ethical sensitivities, reflexivity, and the meaning of entering a caring profession following simulation-based experiences in the final practicum, preceptorship, and in the transition into practice (van Manen, 2014). Above all, as a methodology, phenomenology of practice

provides the methods to probe into human experiences of simulation through narrative reflections. With this in mind, I draw from hermeneutic phenomenology for in-depth, rich descriptions fitting with an epistemology of practice. Hermeneutic phenomenology grounds my interest in the complex phenomenon of entering practice after being exposed to traditional and maternal-child simulation practical experiences. It is not merely simulation that I consider in relation to lived experience since I gather stories of being a nurse that bring forth learners' perspectives beyond simulation.

Research Methods

As I enter into a deeper connection with the lived experience of new graduate nurses and their maternal-child simulation experience to turn to its essence, I incorporate phenomenology as a philosophy and as a methodology. Next, I present the specific methods used in my phenomenological research.

Turning to the Nature of the Lived Experience

In phenomenology of practice, turning my attention to the nature of the lived experience and orientating myself to the phenomenon first required a deep awareness of the physical characteristics of being present (van Manen, 1997). In short, in order to explore the essence of what it is to be in a simulation-based experience during a practicum experience and into practice as a new graduate, I needed to be sensitive to the details involved in the simulation, the traditional practicum, and the new nurse's transition.

The use of simulation has garnered much attention in Canadian nursing curriculum as an emerging pedagogy to scaffold theory and practice. As an educator and researcher with expertise in simulation, I selected phenomenological methods that would tease out the meaning behind the lived experience of learners in their final year of study and into their

experiences as new graduate nurses in practice. I placed the ethics of care at the center of nursing practice in the chosen methods of this study. The notion of how "I ought to be" in my caring role as described by Noddings (2012b) became central to understanding the ethics of care experienced in the last year of study in nursing and into nursing practice (p. 232). I searched for ethical caring behavior, described as a refined ability to incorporate acts of intelligent kindness, moral thinking, procedural ethics, and deontology from the nursing code of ethics (Canadian Nurses Association [CNA], 2017; Noddings, 2012a). I selected van Manen's articulation of phenomenology of practice to approach the concept of identifying assumptions and current understanding of the phenomenon through reflexivity. The identification of personal assumptions and pre-notions of a lived experience occurred through an ethical process of self-exploration rather than traditional bracketing (van Manen, 2014). In anticipation of not distancing my views and to insightfully complement my experience with the learner's lived experience, reflexivity served as a method in this study to delineate my suppositions and assumptions of maternal-child nursing. Without reflection on my existing presuppositions, my assumptions may have influenced my interpretation (van Manen, 1997). Thus, articulating my beliefs and biases explicitly was inherent to phenomenology and I began the research journey with a prologue as a phenomenological reflection. In the prologue, I reflected on my own practice and philosophy of teaching to contextualize my role in nursing. My personal journey served as a starting point to help me search for the learner's perspective while the identification of my own assumptions and existing understanding of the lived experience incited me to reconstruct my experience.

Recruitment of Participants

I recruited new graduates from a nursing program in northeastern Ontario within the past two years with experiences in maternal-child simulation during the fourth-year clinical practicum and preceptorship components of their curriculum. For all participants, the senior-level clinical practicum included an instructor-led twelve-week acute care placement at a regional hospital and four hundred and twenty hours of preceptorship prior to graduation. The maternal-child simulation experiences included scheduled formal on-campus simulation and unplanned hospital-based simulation while in preceptorship. The scheduled scenarios for the recruited group included a two-hour simulation scenario eliciting care for a child with bacterial meningitis and a three-hour simulation scenario focusing on the care of a woman with gestational hypertension. All scheduled simulation-based experiences represented replacement hours for their traditional practicum; that is, the participants attended simulation rather than going to the acute care placement on the planned simulation day. There was no scheduled simulation during preceptorship, which left the exposure to hospital-based activities as unplanned and undisclosed to faculty overseeing the preceptorship course. For the participants who had already entered the workforce, the use of the maternal-child simulation was a part of their orientation experience in their new workplace. Those participants detailed most recent simulation-based experiences.

I recruited participants by working with the nursing student association to email a recruitment letter which was sent out twice (Appendix A). I contacted prospective participants directly if they agreed to discuss the possibility of being interviewed. During the initial contact with those interested in the study, I outlined the time required to engage in a three-step interview. In addition, I presented the risks inherent to their involvement by noting

that the faculty and student relationship did not oblige them to participate and that they could refuse and withdraw from the study at any point during the study. I also indicated that their names would be replaced with pseudonyms and that I would have sole access to the log that matches their names with their pseudonyms (Ferguson, Myrick, & Younge, 2006). I used a purposive sampling technique to accommodate the gathering of subjective experiences in the use of maternal-child simulation in a traditional and simulation practicum, in a preceptorship, and into the transition into practice.

Description of participants. Of the one hundred and forty-four new graduate nurses invited to participate, ten were recruited for the study. Since the sample size in phenomenology seeks to find enough experiential descriptions from participants, I aimed to recruit three to ten participants to meet the goal of gathering descriptions until the data no longer revealed anything new about the lived experience (Dukes, 1984; van Manen, 2014). None of the prospective participants were turned away, but a few opted not to participate.

The ten participants in the study, presented in table 3.1, included eight women and two men. Although all participants held a Bachelor of Science in Nursing (BScN), they presented differing entry points into nursing. While five participants indicated direct entry into nursing from secondary school, the other five participants reported entry into nursing with prior post-secondary education. In this study, three participants held an undergraduate degree prior to their nursing education and three had a dual-role status in nursing as they held a CNO designation of registered practical nurses (RPN). These three participants were completing a bridging program to study at the BScN level. Of the three participants with RPN designation, two reported a direct entry into the BScN post-diploma while one had an

additional undergraduate degree prior to studying in a RPN to BScN bridging program, making her nursing studies the third post-secondary academic pursuit.

Table 3.1 Entry Points into the Nursing Program

Direct entry from secondary school into BScN	5
Prior undergraduate degree prior to BScN	2
Prior undergraduate degree and RPN diploma bridging into BScN	1
RPN diploma bridging into BScN	2

Summary of placement and employment status of participants. Study participants described a range of preceptorship placement settings. Areas of nursing practice for the final practicum included emergency nursing, perinatal nursing, neonatal nursing, mental health nursing, surgical nursing, and gerontological nursing. At the time of the present study, all participants had written the National Council Licensure Exam for Registered Nurses (NCLEX-RN) with one participant needing to re-write beyond the initial attempt to pass the examination. As for timing after graduation for the data collection phase, the first interview occurred a few weeks after graduation of one cohort and a full year after the other recruited cohort of graduates. One participant had less than six months of nursing experience, five participants had six to twelve months of nursing experience and four participants indicated more than twelve months in nursing practice. The workplaces of study participants included the following: paediatrics (PEDS), neonatal intensive care unit (NICU), perinatal unit, emergency department (ED), and adult mental health unit. Additionally, one participant indicated being unemployed while searching for her first nursing job while one participant claimed to work as an unregulated care provider (UCP) while studying for the NCLEX-RN.

Table 3.2 Summary of Placement and Employment Status

Setting	Preceptorship	Employment
Emergency	1	2
Paediatrics		1
Paediatric Emergency	1	

Perinatology	4	2
Neonatology	1	2
Psychiatry	1	1
Surgery	1	
Gerontology	1	
UCP		1
Unemployed		1

Table 3.3 Time Since Graduation

Time since graduation	
<6 months	1
6-12 months	5
>12 months	4

Conducting Phenomenological Interviews

Phenomenology of practice served to investigate a phenomenon as lived by participants and to understand their primal impressions, their state of pre-consciousness, and their evoked awareness of the experience (van Manen, 2014). Intentionality, which shaped consciousness, was uncovered through the process of data-gathering methods and involved using narrative methods through two phenomenological interviews plus one member-checking contact with the participants (van Manen, 2014). The conversation, language, words, and descriptions served as ways to examine the lived experience of maternal-child simulation in nursing education and nursing practice. I incorporated two phenomenological interviews to capture experiential descriptions in a semi-structured hermeneutical approach. Using interviewing techniques acquired as a nurse, I focused my attention on uncovering the lived experience and the process felt natural. During the interviews, I searched beyond limited descriptions, repetitive themes leading to unveiling sentences and statements rather than looking for a frequency of words used (van Manen, 2014). Although I composed guiding interview questions for the two interviews (Appendix B), I focused on letting the conversation flow to gain experientially rich accounts of the lived experience (van Manen,

1997). Open-ended questions were used because of their effectiveness in building upon and exploring an experiential statement (Seidman, 2006). The study included two interviews per participant, with options for face-to-face, teleconference or a virtual interview through Skype™. Most interviews were face-to-face meetings held in a private, public, and quiet comfortable space for the conversation. The approximate length of each interview was forty-five to fifty minutes. One participant was contacted through Skype™ interviews and one participant preferred two audioconference calls without the video option. I accorded approximately a week between the first and second interview to allow time for reflection while ensuring that the connection to the lived experience was maintained (Seidman, 2006).

The initial interview. In the first interview, I followed an interview guide protocol (Appendix C) to contextualize the lived experience and initiate experiential conversation. The first interview related back to their practicum and preceptorship experiences in which maternal-child simulation activities were integrated into their learning. Broad questions were included in the interview guide to facilitate substantive experiential descriptions (Moustakas, 1994). I also captured the premise of the described experience through note taking in a reflective journal in which I recorded my triggered emotions when listening to the participants' stories and I took the opportunity to recite my own thoughts of the dialogue. In the journal, I wrote about some of the participants' current experiences from their transition into nursing because their conversation about simulation in their nursing program incited them to share examples of how they were applying their learning from simulation-based experiences in their lives at that particular moment in time. I used the reflective journal to help me process their lived experience, since I was surprised that the conversations that originated from their perception of using maternal-child simulation in practicum and in

preceptorship as nursing students turned into in-depth conversations about entering practice and how simulation may have played a part in their transition. Hence, I found the reflective journal useful to guide subsequent interviews and to provide information on each person's unique story.

The subsequent interview. The goal of the second interview was a reconstruction of the abundance of detailed experiential accounts of the participants (Seidman, 2006). In this interview, I used three broad semi-structured questions to verify and elaborate their experiential descriptions. All participants engaged in conversations about their transition into practice and the interview focused on their current experiences in learning to become a nurse. In the second interview, I journaled to reflect on the ways to best capture their story and to prepare their vignettes as new nurses.

The member-checking contact. The purpose of the third contact with study participants was to conduct member-checking as a means of authentication of information (Seidman, 2006). Member-checking consisted of inviting participants to review their transcribed, verbatim interviews combined with a written vignette of their story. Two participants preferred a face-to-face interview for member-checking, while all other participants opted for electronic exchange of information to review the data gathered in their transcripts and the written piece depicting their story. A follow-up email (Appendix D) was sent to all participants to acknowledge my gratitude for sharing their lived experience as new graduate nurses using simulation in this study.

Capturing the Essence of the Lived Experience

I listened to twenty confidential, digitally audio-recorded interviews, transcribed them into words, and then listened to the recordings again to trace the etymological sources, and

search for idiomatic phrases (van Manen, 1997). As described by Denzin & Lincoln (2011), the human interviewer demonstrates intelligence as an instrument for collecting data. Given this, I carefully transcribed the interviews verbatim in order to approach transcription as an important opportunity to modify and improve my interviewing techniques, employ adaptability, and rely on my intuitive response to human situations in a skillful, caring, and thoughtful manner (Denzin & Lincoln, 2011). I read over one hundred and twenty pages of transcripts to trace the etymological meaning of the experiential statements gathered to identify idiomatic phrases and expressions in the stories shared (van Manen, 1997). To find the phenomenological meaning of being in simulation and the essence of being in the novice stage of nursing practice, I read the verbatim transcripts twice and was attentive to the structure, speech style, affective characteristics, motives, attitudes, and beliefs. Then I used writing as a way to discover the lived experience. As van Manen (2014) describes a need to write and re-write a rich deep text to interpret the voice, I searched for the emotions and the meaning of using maternal-child simulation in the final nursing practicum, preceptorship, and into the transition into practice. I coded the data set by writing sixteen groupings of significant statements and phrases presented in table 3.4 onto a separate document and clustered the statements into emerging themes. Allowing the emergence of themes consistent with each participant resulted in an integrated and in-depth description of the phenomenon.

Table 3.4 Groupings of Significant Statements

1. Acting like a nurse and being exposed to simulation helps later in my practice.
2. Do I have the imposter syndrome?
3. I do not know everything but I have nurse's intuition!
4. Simulation triggers emotions that I am experiencing in practice.
5. The ability to step in and step out of imagination is required in simulation.
6. A higher level of realism matters in simulation.
7. Learning to become a nurse requires good teamwork.
8. It is possible to integrate classroom, lab, and clinical.

9. As a nursing student, I can handle more in the debriefing stage.
10. Simulation is a safe learning environment for all nurses.
11. I acquired knowledge and skill in preceptorship.
12. I need to work on problem solving skills through repetition.
13. The NCLEX-RN licensure exam is on my mind!
14. I am learning about family centered maternal-child nursing in my practice.
15. Reflective practice is useful in my first year of practice.
16. I wanted to be ready for practice after preceptorship to hit the ground running in my first year.

Transforming Experiential Descriptions into Textual Representation

In the present study, I used writing as a method to attend to the meaning in the dialogue, the silence, and the anecdotal narrative of experiential descriptions (van Manen, 1995). Writing as a fundamental part of the hermeneutic circle served to expose a grounded and insightful textual representation (van Manen, 1997). The phenomenological approach of moving forward and backward in writing was useful to reflect, to recognize, and to rewrite textual interpretation (van Manen, 1997). Through the data interpretation phase, I read and reread textual descriptions to identify constitutive patterns that hinted at what it is like to be a new graduate nurse with experiences in maternal-child simulation combined with traditional practicum and preceptorship.

Transforming experiential descriptions into textual representation created an opportunity to reflect on the learners' perspectives. The purpose of creatively writing in capturing a phenomenon of life was to provide linguistic description in which the participants' voices surfaced in a written story of the essential nature of a lived experience (van Manen, 2014). After listening carefully to the transcribed interviews and incorporating observations from my reflexive journal, I wrote and re-wrote each participant's story and composed the participants' vignettes while also gathering themes that captured the hermeneutics of a lived experience that evoked a recollection of real-life phenomena.

Ethical Considerations

The study received approval from the university's research ethics board (Appendix E). To mindfully consider my role as faculty when entering a research relationship with new graduate nurses, I reflected on the fact that past students had a distinct social relationship with faculty that may present vulnerabilities in their ability to consent voluntarily. With each of the participants, I acknowledged that when entering a research relationship with faculty, participants could potentially be exposed to potential risks and burdens in discussing their experiences as learners and new graduates (Wendler & Grady, 2008). I verbally explained that the reflective approach on their current learning experiences as new graduates might recall past events from practicum and preceptorship. All participants were new graduate nurses and therefore there was no association between participants' academic standings and their participation in the study (Bradbury-Jones & Alcock, 2010).

Informed consent. Obtaining informed consent from the participants required their understanding of the nature of the options presented and, incidentally, that as participants, they acknowledged their right to refuse and to withdraw their participation at any time (Wendler & Grady, 2008). Techniques used to obtain informed written consent included a verbal and written explanation in a letter of information to participants (Appendix F).

Confidentiality and privacy. Confidentiality and protection of privacy of information of the participants in this research were inherent ethical considerations. The interviews took place in a publicly-accessible private room on campus outside of the School of Nursing. To preserve privacy and confidentiality, the data was attributable to specific participants using only their pseudonyms and consequently, pseudonyms were used to protect the identity of participants throughout the study (Clark & McCann, 2005; Ferguson et al.,

2006). I kept only one hard copy of the log tracking participant names with their pseudonym and stored the document in a locked cabinet.

Risks of participating in the study. In this study, there was no identified potential for physical harm. Although the psychological effects of disclosing experiential accounts of learning may have presented a risk, this did not arise as an issue during the study. Participants may have considered personal aspects of their entry into practice as private and intimate, which could include aspects of their learning, their feelings, their thoughts, their reactions, and their response to clinical situations. Additionally, they may have feared the experience of the faculty listening to their personal account (Ferguson et al., 2006). Since the listening ear of the nurse as a researcher can foster disclosure of intimate details, it was important that I respect this possibility of gathering sensitive information without exploiting personal stories of entering nursing practice (Bradbury-Jones & Alcock, 2010). I provided the participants with contact information for counselling should the information shared cause any distress.

Benefits of participating in the study. There were no identified or explicit benefits of participating in the study and no financial incentives were offered to participate. Participants may have been drawn to the opportunity to advance the knowledge of their simulation-based experiences as new graduate nurses to the wider nursing discipline (Ferguson et al., 2006). Participation could also have resulted in learning more about simulation and in exploring their transition into practice in greater depth (Bradbury-Jones & Alcock, 2010).

Trustworthiness and rigor. Phenomenology of practice requires discovering meaning beyond describing words, actions, and behaviors and more appropriately through

the notion of thick descriptions (Geertz, 1973; van Manen, 2014). Hence, an understanding of the simulation-based experience in its broader sense required incorporating the use of interpretive, thick descriptions connecting the phenomenological interviews, the transcripts, and the thematic analysis to uncover the essence of the new graduate nurse's experience. Extending beyond a report of actions, my writing of the lived experience was intended to reach into the integrative thinking of a nurse to understand intentionality in clinical practice. To establish rigor in phenomenological research, I applied Lincoln and Guba's (1987) criteria of trustworthiness and authenticity. Through a naturalistic approach of ensuring credibility, transferability, dependability, and confirmability, my textual descriptions were carefully orientated to the research question in the appraisal of findings (Lincoln & Guba, 1985; van Manen, 2014). I turned to the methodological aspects of phenomenology of practice, which consisted of reading and re-reading textual descriptions in the interpretation of data to ensure dependability and confirmability in the data quality (Lincoln & Guba, 1985; van Manen, 2014). I read the transcripts, reviewed my notes in my reflective journal, and thought about the connections between the significant statements and the overall lived experience. The member-checking consultation represented an important act to establish trustworthiness and credibility (Denzin & Lincoln, 2011). By incorporating a three-step approach of two interviews and a member-checking phase for reliability and credibility, I established a process of verification of the data for the quality and clarity of each participant's story.

Summary

In this chapter, I described phenomenology and applied van Manen's articulation of phenomenology of practice to discover the lived experience of new graduates as they

transition into nursing practice following a final practicum and preceptorship using maternal-child simulation. The methods of phenomenology of practice were used to turn to the nature of the lived experience, recruit participants, carry out phenomenological interviews, capture the essence of the lived experience, transform experiential descriptions into textual representation, and apply ethical considerations.

In the next chapter, I share the participants' stories to interpret the meaning of being a new graduate nurse using maternal-child simulation in practice.

Chapter 4: Uncovering the Lived Experience

We are what we repeatedly do.
Excellence, then, is not an act, but a habit.- Aristotle

In this chapter, I share the findings of the study and present the emerging themes that captured the essence of being a new graduate nurse following a traditional practicum combined with simulation-based experiences. Within these themes, I narrate the participants' stories to illustrate their lived experience of their transition into nursing. I offer a vignette for each participant and then I uncover four emerging themes in the analysis: (a) performing like a nurse; (b) forming a clinical imagination; (c) embodying the role of the novice nurse; and (d) embracing life-long learning in simulation.

Participant Vignettes

I begin by introducing the research participants and their pseudonyms (Table 4.1) then go on to present a brief profile of each one.

Table 4.1 Nursing Profile of Participants with Pseudonyms and Months into Position

Name	Post-graduate Employment	Months into Position
David	Emergency Nurse	1 month
Megan	Neonatal Nurse	10 months
Lilly	Perinatal Nurse	11 months
Meredith	Neonatal Nurse	1 month
Hazel	Emergency Nurse	3 months
Lexie	Perinatal Nurse	10 months
Lisa	Mental Health Forensic Nurse	1 month
Derek	Unregulated Care Provider	8 months
Lys	Unemployed	Not applicable
Jenny	Paediatric Nurse	12 months

David's entry into emergency nursing. David acknowledges a long-time interest in emergency nursing and critical care and he is currently working in the ER after completing his preceptorship there. When he reflects on the realities faced by new nurses after preceptorship, he talks about the long journey he has taken to become a nurse. The pursuit of

a career in nursing represented his third post-secondary academic achievement and he brings a multitude of life experience into his nursing practice. Although proud to provide care in situations of critical illness and life-altering trauma, the responsibilities and the preparation required to practice in a nursing specialty often leave David feeling like an imposter. He even goes so far as to call himself a fraud, associating this feeling with a strong sense of duty to provide quality care. For David, simulation provides an opportunity to act like a nurse in moments where he does not feel that his identity has shifted from student nurse to practicing RN. He admits feeling pressure to perform as a specialized ER nurse.

David goes on to highlight situations where simulation is used in the workplace. He recognizes that the exposure in nursing school helps him to execute the complex skills in emergency nursing simulation. He participates in emergency simulation at the hospital where he is asked to rush to a designated location to assess the situation and think critically about the next steps. When he gets to the code, health professionals playing various roles evaluate the responding team's performance. He stays calm and uses the strategy as a rehearsal for real-life situations.

Megan's search for neonatal certification. As an educator, I am fascinated by Megan's undertaking of the specialized role of neonatal nurse immediately after her graduation. She suggests that her preceptorship provided the opportunity to validate her interest in neonatal nursing. Megan outlines a rapid pace of learning on entry into neonatology as she tries to gain experience in managing various neonatal cases while also preparing for the additional certification required to work in this setting. She discusses certification courses in neonatology, which include both coursework and a practical component. I learn that neonatal programs are offered by a limited number of colleges in the

province and have a yearlong wait-list for admission. As Megan waits for acceptance into the certification program, her goal is to gain experience at the hospital. She describes the use of simulation in her current employment and sees the value of incorporating the strategies adopted from simulation labs in nursing school into the Sim-IPE activities as a staff nurse. At the hospital, simulation is used for practice within the team and is also an evaluative strategy to help achieve certification in practical skills and resuscitative response. As a neonatal nurse, Megan sees similarities with the simulation experiences as a nursing student and this gives her comfort to actively participate in her workplace.

Lilly's life-long learning plan. Like David and Megan, Lilly outlines the major accomplishments of new graduates in a short timeline. As I listen, I sense her pride in her achievements in perinatal nursing. Having a prior degree before entering into a bridging RPN to BScN program, Lilly identifies as a life-long learner and describes a desire to pursue more education once she gains confidence and clinical expertise. Since Lilly works on a perinatal unit, she details the perinatal certifications required for the RN in this setting. For instance, she is currently completing an obstetrical perioperative education module at the hospital in which simulation is used to learn a new perinatal skill prior to providing patient care. The learning strategy is part of the perioperative nursing education for the caesarean section birth, a role in which the nurse is accountable for the strict aseptic field, communication within the team, and the identification of surgical instruments. She describes how she practices to perform the scrub nurse role in the hospital's simulation lab where she engages in a rehearsal and breakdown of the surgical role she is expected to perform in a high-pressure, high-stake perioperative environment. During our conversation, she presents simulation-based experiences as helpful in preparing a skilled response in obstetrical emergencies. Lilly

accords importance to the teamwork in a specialty setting which improves with simulation, and she values a blend of perinatal theory with practice in refining the team's response.

Meredith's move into neonatal nursing. Meredith outlines discovering a passion for maternal-child nursing during her second year in nursing. Entering nursing with a prior degree, she explains pursuing every opportunity in nursing school as a way to explore maternal-child nursing through the exploration of maternal-child topics in essay submissions, case-study presentations, and practicum choices. To gain an understanding of maternal child-nursing, she believes that a learner needs exposure to the specialties of perinatology, paediatrics, and neonatology and that simulation-based experience provides this exposure for learners. In her stories, Meredith indicates a desire for more maternal-child simulation in her practicum, in her preceptorship, and in her transition into neonatal nursing. Simulation is the place for her to apply her learning as she claims to want to "put her hands on as many clinical situations as possible" before entering practice. Meredith is completing hospital certifications required in neonatology and exploring postgraduate certification courses in neonatal nursing. After her preceptorship in NICU, Meredith describes engaging in a lengthy, careful approach to the RN licensure process. Because the exam preparation requires setting time to study and practice taking computer adaptive-style exam questions, she attributes her success to the purchase of content review, online products, and test banks. Meredith's story clearly indicates that she perceives herself as a reflective nurse.

Hazel's adventurous beginnings. Hazel's story is one of first-year adventures highlighting her aspiration to move through various experiences, something that she calls "playing the field." After passing the NCLEX-RN, Hazel gained employment in a rural ER and finished the workplace orientation in which she was mentored by an expert nurse as they

worked together on an assigned patient workload. She details taking her first shifts without her nurse mentor and views herself as a novice with interest in emergency nursing. Ambivalent about her selection of ER nursing in a rural hospital, Hazel points out the various options in nursing and anticipates having many experiences in her first years as a nurse. At the moment, emergency nursing fulfills a desire to feel her way through the next steps. For Hazel, a start in emergency nursing helps her participate in a multitude of experiences while using her transition to try different aspects of nursing. Hazel describes her transition into practice as time to reflect on the possibilities of various career choices and presents this time as an exciting aspect of entering the nursing profession. Hazel speaks about simulation sparking her interest in trying various nursing roles and claims to enjoy trying out various roles in her simulation-based experiences on campus and at the hospital. For instance, she gains familiarity with the role of primary nurse, secondary nurse, team leader in simulation but most important for her is the exposure to various areas of nursing from maternal-child nursing, emergency nursing, community health nursing, and mental health nursing.

Lexie's passion for the perinatal unit. Lexie entered nursing through a bridging RPN to BScN program and conveys a clear desire for the role of perinatal nurse, something she identified as her calling after preceptorship on a perinatal unit. Although she details her trajectory into nursing as challenging, she suggests that the transition feels right for her and imagines herself as successful in this role. Although she characterizes herself as shy and reflective, her compassion for nursing practice is evident as she imparts her maternal-child experiences. She recalls wanting to work as early as possible after graduation attributing her success to a low-cost, paper-based strategy to review the content and prepare for the NCLEX-RN. In her perinatal education, she values the use of maternal-child simulation, but

for Lexie, simulation feels awkward and contrived. She prefers learning through human interaction to the use of HFS. While she describes her approach to licensure and subsequent entry into a specialized setting as unceremonious, I attribute the reflective, mindful nature of her personality combined with a passion for nursing as elements in the success of her entry-to-practice.

Lisa's insight on dual registration. Lisa's story offers insight into the role confusion that can arise when a nurse enters practice with dual registration as both RPN and RN. As Lisa discusses her transition as imagining herself in the role of the RN required to handle various complex situations early in her career, she outlines cutbacks in healthcare and a low nurse-to-patient ratio on her unit. Lisa shares her experience of overcoming the challenges of returning to nursing school and then the joy of celebrating accomplishments with her family. Familiar with the scope of practice of the RPN, she is gaining experience in the RN role and speaks about confusion about the scope of practice of each role. During simulation, her understanding of the RN role increased, but she is frustrated that the simulation-based experiences are not always taken seriously by learners and that the lack of pre-simulation preparation affects the level of engagement during the scenario. Human interactions from role playing and using standardized patients are perceived as more valuable for her needs than the use of mannequins. A few weeks into her new role, Lisa works in forensic mental health nursing and reports feeling uncertain about her role, mainly because of the constraints placed on nurses, something which she claims is not evident to nursing students. For instance, entering forensic nursing in a time of high turn-over of nurses as a result of healthcare restructuring, she finds that there are not enough expert nurses to mentor the new RN. In returning to the experiences where the delineation of the dual role is unclear, Lisa

adds that working with a less-than-ideal complement of professionals contributes to her fear and frustration of stepping into the role of the RN. Only a few weeks after graduation, she has already been placed in leadership roles that required her to manage complex nursing issues.

Derek's unexpected transition. Derek's account of the past several months is one of determination. He begins with an explanation of the time that has elapsed between the completion of his nursing degree and his entry into the profession. Several months have passed since graduation and, according to him, the skills and knowledge from placement in practice education are increasingly difficult to transfer without immersion in practice. Derek perseveres through the challenges of obtaining licensure to entry-to-practice and feels testing anxiety has led to needing to re-write the NCLEX-RN. Disappointed, he acknowledges that other new graduates across the country are experiencing similar challenges. He is part of the second cohort of candidates for the newly implemented licensure examination and feels that he and his classmates were unprepared for the newly implemented computer-adaptive test. Derek is focused on preparation for another attempt at the examination while working in the role of UCP to cover his living expenses, preparatory costs, and exam fees. For Derek, simulation is potentially ideal for new graduates facing similar challenges because it could incorporate a type of remedial plan and could bridge the gap between theory and practice when an unexpected transition occurs. He refers to his transition as a setback, a delay to his entry into nursing but he is confident that he has chosen the right profession for his future.

Lys' longing for more learning. While David, Megan, Lilly, Meredith, Hazel, Lexie, Lisa, and Derek creatively imagine embodying the role of a nurse in practice, Lys, a new graduate with aspirations for continued study, is overwhelmed by the choices available to a

nursing graduate and likes the possibility of graduate studies. She is torn between assuming the role of a nurse in direct practice or pursuing additional education to become a nurse practitioner, a nurse researcher, or a medical doctor. Ambivalent about nursing practice, she describes herself as most comfortable in the academic setting and articulates how she feels comfortable and confident in simulation-based experiences. In other words, she is in agreement with her role as a learner than as a novice practitioner, but she indicates that her current goal is to increase her level of confidence in nursing practice. While she has recently passed her licensure examination and the CNO jurisprudence examination, both requirements for RN entry-to-practice, she is seeking employment in nursing and expressing difficulty making career decisions. Although uncertain about entering the workforce, Lys claims to feel pressured by her family and friends to begin working as a nurse. She is considering three offers of employment, finding that each one differs slightly from the other and deliberated on these choices during the interviews. Drawn by her maternal-child experience in preceptorship, she prefers the employment offer in perinatal nursing but is also applying for post-graduate certificates, graduate studies, and medical education.

Jenny's practical experience in paediatric nursing. Jenny says that her comfort level as a nurse has improved after being in practice for a year. She came into the nursing program with a prior degree, and now experienced on the paediatric unit, she describes herself as proficient in her role, a self-perception that she says occurred through learning by doing. Jenny details a year-long transition into nursing practice and an immediate affinity to work in an interprofessional team. Her prior studies in health sciences helped her reflect about the functions of a healthcare team. She recalls her preceptorship in the perinatal unit as being overwhelming for a nursing student as she tried to grasp the role of a nurse in entry-to-

practice. She remembers having difficulty understanding the distinction between the novice nurse and the mentoring nurses. Would she be expected to feel as comfortable with decision-making as the expert nurses? Jenny expresses difficulty grasping the expectations of a new graduate in entry-to-practice, especially when taking on a workload in a specialty setting. She details a slow and gradual acquisition of skills and an understanding of strategies in providing care to children and their families while respecting the vulnerability and unique needs of children. Simulation is used in her workplace to practice clinical situations and she welcomes more maternal-child simulation in her nursing practice and in her role of staff nurse.

Emerging Themes from Examining the Participants as a Group

Although the participants in this study shared a common experience in maternal-child simulation during their final year of nursing school, these ten new graduates each experienced their own transition into practice. Their experiences were shaped by prior knowledge and past experiences. For some, this knowledge came from others in health-care fields, while for others, the prior experiences of being students, daughters, sons, parents, brothers, sisters, or friends derived from the various activities that constitute life. Yet all of these participants shared some common experiences during their transition to practice. For many, that experience was partly mitigated by the shared common prior experience with maternal-child simulation and in many cases, continued use of simulation in the workplace.

First Emerging Theme: Performing Like a Nurse

I now present four themes that distill the essence of the transition to practice of newly graduated nurses who have undergone a maternal child-simulation experience as part of a final practicum. I begin by outlining the theme of performing like a nurse and present three

components within this theme: performing the role of the nurse, feeling like an imposter, and nurturing the nurse's intuition.

Performing the role of the nurse. New graduate nurses describe a multitude of opportunities to observe role models and study how they act in healthcare situations while in practicum, in preceptorship, and in their new employment. As learners, participants observe faculty, instructors, mentors, and colleagues. In the field, the participants look to shape their own image of the role of the nurse as they watch, listen, and emulate others around them in their new careers. One of the ways in which all participants describe their role rehearsal is through engagement during in-situ simulation, which occurs in a clinical environment rather than in a nursing simulation lab. Participants refer to these simulations as mock codes and the terms are used interchangeably in this study. Having been exposed to simulation experiences in the nursing education program, participants indicate that immersing themselves in workplace simulation felt natural in their transition into nursing practice. David shares his thoughts on performing like a nurse during simulation activities:

I would act…even though it was in a simulated event in a lab or at work, there were certain things I would do to make it as real as possible…It was about doing it properly and getting in there as quickly as possible to do my assessment. I was aware that it was really a fake, created environment, I wanted to act as real as I could to get the most learning. [David]

Participants disclose moments where they continue to feel like nursing students although they want to feel like a nurses, like the RN in the workplace. In several instances, simulation requires them to enact the role of a novice nurse while they imagine the characteristics of a more proficient, competent, expert nurse. In his role in emergency nursing, David reflects on the need to practice in an environment such as simulation where no harm occurs from performing a skill for the first time. For David, practicing the role helps

clarify all roles within the team while gaining an understanding of the conduct required to practice effectively in emergency nursing. He claims:

Being exposed to a simulated environment and taking a serious approach to the simulated environment prepped me to manage simulation at the hospital. Taking a step further, the simulated events helped me give better care when those situations arise. [David]

Megan guides me through her experiences as a new graduate nurse entering the hospital setting and suggests that simulation during entry-to-practice enabled her to learn the theoretical and practical components of the neonatal specialty. She identifies exposure to simulation in her final practicum as helping her to become more confident with the complexities of neonatal distress identified in the hospital as a 'code pink':

We had a 'code pink' a few weeks ago. The clinical educator tried to get the residents and the newer staff on the unit to take part. I participated and I was actually the most experienced of the newer staff. I was supposed to be the leader. It was a good learning experience; I think we were all terrified. That was much scarier than when I was a student. Suddenly I was no longer a student and I was the RN. I thought now…what if this was real because now I really was at my workplace. [Megan]

Lilly claims to have refined her practical skills through her involvement in simulation and proposes that the opportunity to practice techniques is important to her as a nurse. Since her unit has a simulation lab in which she is able to practice obstetrical skills, she enters the lab to connect complex intravenous lines, perform neonatal resuscitation, or handle the surgical instruments used during childbirth. She recalls the challenges of performing a skill, such as taking infant vital signs for the first time as a nursing student, and reminisces about having to auscultate carefully to the rapid heartbeat while considering the growth and development of infants. Now those nursing actions come with ease because they are part of her daily work in caring for a neonate. Recognizing from nursing school that a simulation lab is an open area for practice helps her to appreciate the simulation space at the hospital. For Lilly, the opportunity to act like a perinatal nurse during simulation activities fosters

competency in developing the specific skills needed in order to provide safe care. She talks about the rapid pace in emergency obstetrical situations, in which such skills are often required. Lilly claims to need more practice with nursing skills to increase her level of proficiency in perinatal nursing:

As the situations happen, you become more familiar with how you respond. The perinatal program includes readings, skills-drills...for obstetrical emergencies such as forceps and vacuum delivery…shoulder dystocia, postpartum hemorrhage, and seizures. Those mocks are helpful for preparing how to respond to the actual situation when it happens. [Lilly]

Specialty training occurs over several months. Now, having completed the theoretical aspect of emergency obstetrical training, Lilly is gaining comfort with the practical component of her profession and emphasizes the use of simulation as a strategy she uses to achieve her goals. As in the simulation-based experiences in her undergraduate studies, she uses a checklist, then performs the actions listed in front of a peer to receive feedback. She suggests that this prepares her to provide care in a real-life crisis. For Lilly, practicing skills is valuable when entering RN practice, especially in a nursing specialty. As a result, she devotes much of her own time to increasing her comfort level with practical nursing skills in the obstetrical nursing simulation lab:

It makes for an easier transition for sure. Simulation helped me prepare me for the mock OB simulations. [Lilly]

Meredith feels pressure to prepare for a specialty practice and although she enjoyed the broad array of nursing placements, Meredith wants to see more maternal-child experiences for nursing students. She explains that simulation provided exposure to maternal-child nursing, a passion she describes having since nursing school:

My passion lies with paediatric and NICU but we get minimal experience. But at the same time, I have found it invaluable, I use the information that I learned in simulation. I use it every single day…It is eye-opening that my role as a nurse is a position of power. Your

expertise and the knowledge that you carry even as a novice nurse is still incredibly valuable and so certainly simulation helped shape that. [Meredith]

Participants' stories of handling mock codes reveal an appreciation of their early exposure to simulation as nursing students and capture their intention to run through various clinical possibilities in a safe and non-threatening environment. Since they are familiar with simulation from their school experience, participants perceive mock codes as less intimidating as they adjust to the role of a nurse and as an opportunity to enact the RN role.

Feeling like an imposter. As participants describe their personal experiences, varied educational backgrounds, and work-related knowledge, they speak about a desire to find a deep connection with the role of the nurse and to place the ethics of care at the center of their practice. Despite the fact that most participants meet regulatory expectations for entry-to-practice and bring a rich array of past experiences, for many, some semblance of an imposter syndrome is present in their transition into practice. Participants outline instances in which academic preparation for providing ethical care is achieved; however, on a practical level, a sense of inadequacy produces feelings of inferiority and causes them to question how a nurse is supposed to act, feel, and think. New graduates feel the need to rise to the image of the proficient, expert nurse rather than allowing themselves to assume the role of a novice.

David recalls feeling like an imposter during his clinical placement and notes that this feeling continued in the ER after graduation. As he discusses mock codes, he worries that other health professionals will discover he still has a lot to learn. Since he has not embodied the identity of the novice nurse yet, he wonders whether others can see his knowledge gap with respect to various ER situations. For example, when consulted about a cardiac rhythm, he interprets the reading correctly but attributes the answer to a lucky guess. The simulation

context helps him move towards feeling like a nurse while acting like a nurse as he describes his motivation to perform effectively in simulation:

Simulation makes me feel like I have an imposter syndrome but it pushes me. It is my motivator. [David]

Lilly also speaks about the overwhelming anxiety of assuming the role of the nurse during perinatal mock codes at work despite prior experiences with simulation. She suggests being intimidated by the pressure to perform in front of other health professionals who have greater expertise in perinatology. For Lilly, being observed in simulation highlights feelings of pretending to be a nurse rather than seeing it as a way to become introspective regarding her assumption of the role of the RN. She describes entering a simulation scene at the hospital as follows:

I was part of a 'code pink' recently. It was also terrifying, all the doctors were there, everybody was there…[Lilly]

I note that feeling like an imposter rather than feeling like a novice nurse is a recurring feeling. When Meredith indicates that she puts on the image of being a nurse, her reflective nature causes her self-doubt and over-thinking about her abilities to face clinical situations. Although Meredith easily acquired the theoretical aspects of nursing care, her skill acquisition continues to improve with practical experience; her goal after only a few weeks into practice is to gain exposure to clinical situations in which she can develop hands-on experience. Every time she handles a clinical situation, her course readings come to life and she then feels more like a real nurse. Likewise, Hazel tries to discover as many new experiences as possible during her first year in practice in order to learn how to approach clinical situations. She describes herself as a nurse in the making, an imposter searching for her own professional identity.

As I expected to gather experiences about maternal-child simulation, I make more entries in my reflective journal about the participants' uneasy feelings of being a novice nurse. I listen to Lys as she expresses being ambivalent about nursing as a profession and accepting employment in nursing to push aside the uncertainty about her future. As Lisa works to reconcile her RN role with her scope of practice as RPN, she suggests that she displays a false sense of confidence when stepping into team leader roles. To compare and contrast, though both are in maternal-child programs, Lexie indicates that perinatal nursing has felt right for her from the first moments she entered practice and Jenny speaks of a yearlong discovery of her professional identity of RN in paediatrics.

Although participants discuss feeling like imposters, they each works to provide safe care in spite of the anxiety they describe. Certainly, the imposter syndrome is a recurring storyline in conversations with participants, especially in moments of reflection about their transition into practice. As participants work through the feelings of being imposters, they move towards nurturing their nurse's intuition to embrace the role of the novice nurse.

Nurturing the nurse's intuition. Many participants admit that although they may not know everything in their day-to-day role as novice nurses, they are developing intuition. Jenny, who has been working for a year, recognizes the impossibility of knowing everything about paediatric nursing, especially on entry-to-practice, but feels that she has always been able to assume the human interactions. For example, when a mother is worried about her baby, Jenny knows to listen, comfort, and collaborate with her team. Jenny suggests that this is a gut reaction, a sense gained from their human interaction. Similarly, in NICU, Meredith uses reflective practice and creative thinking to ask herself what the situation may mean, while Lexie believes she has an innate ability to interact with women and children. She

clarifies that she needs more experience but that the role of nurse feels like a calling. For Megan, the reality of practice sets in as she participates in mock codes and realizes that a potentially life-altering moment is possible at any time when working with infants. The belief that such a situation could occur triggers her skill acquisition and a desire to think like a nurse who makes sound judgments. Megan reports:

This could actually happen to me during the course of my shift. It was a good learning experience because I was able to identify my learning needs and I was able to address them with the clinical educator later in the week. It was good. [Megan]

Meredith suggests that she breaks down the complexity of a situation by first determining what she knows in order to identify what she refers to as her basic tools. She thinks about what is required to control this situation and what is expected of her as a new nurse. She answers those questions by identifying resources and timely accessing of life-saving medical equipment. As she outlines the pressure of responding to obstetrical and neonatal situations, she suggests the innate need to know one's own role within the team in order to collaborate effectively, quickly access resuscitative equipment, and respond quickly:

Every birth is very much like walking into simulation lab except that it is higher stake…If I am walking into an elective caesarean section, it's going to be a lot different than a stat caesarean section for a baby with meconium aspiration with late decelerations or a placenta abruption. I start to think of my role. Do I need a bolus? Am I going to need endotracheal suctioning…what do I need to have available when the physician gets there? And when they [the rest of the team] get there, what will I be doing? [Meredith]

For Meredith, familiarity and comfort with every clinical situation, combined with the high expectation of the need to be aware of every possibility, results in anxiety that she manages every day as a nurse. Hazel highlights that preparation for the multitude of clinical possibilities is warranted and that a novice nurse needs to be aware of intuition as an important consideration in entry-to-practice. She claims that as long as she attends to the

danger signals of potentially harmful situations, she will learn from other skilled healthcare providers as situations arise:

I think it gave me the ability to prepare how to respond to the pressure that you face in those tough situations. It puts the pressure on you and you have to critically think it through and maybe go to somebody else for help. [Hazel]

Megan, a new NICU nurse, also values every experience as an opportunity to learn more about both her role and her patient population. Through observation of expert nurses on her team and participation in mock codes, she becomes increasingly comfortable with caring for vulnerable infants born in a large metropolitan hospital. Megan indicates a need to step into neonatal situations safely and feel comfortable in the novice role.

Derek expresses concerns that his entry-into-practice has been altered by having to re-write the licensure exam and that not being immersed in clinical situations in the role of the RN is affecting his self-confidence and his intuition. He states that without applying his nursing knowledge, he may lose the instinct to grasp the response to clinical situations. Similarly, Lys enters practice before moving on to graduate studies because she fears losing the instincts she acquired in preceptorship. The multitude of experiences during the preceptorship and early in practice helps participants form the imaginative thinking required to act, feel, and think like a nurse. As participants enter practice, they use their intuitive thinking to help them problem-solve in clinical situations. Intensely concerned that they "get it right", they place significant importance on a biomedical approach. Simulation provides opportunities to practice skills and techniques required in the understanding of an illness, and, ultimately, life-saving actions. An understanding of relational care surfaces in brief instances when they are able to imagine what it is like to be successful and think about the impact of their actions on those for whom they care.

In sum, the theme of performing like a nurse in simulation presented three components of becoming a nurse as a new graduate nurse: performing the role of the nurse, feeling like an imposter, and nurturing the nurse's intuition.

Second Emerging Theme: Forming a Clinical Imagination

New graduates use creativity and imaginative thinking to make simulation relevant to real world problems faced in practicum, in preceptorship, and in the transition into nursing. For new graduates, simulation may require clinical imagination. I map out the theme of forming a clinical imagination and present three components within this theme: clinical imagination in simulation, realism in simulation, and working with simulated patients.

Clinical imagination in simulation. Most participants speak about needing to move in and out of reality during simulation. For instance, David imagines the simulation scene as a real-world moment in which the mannequin is a real person and he performs an assessment as if the moment were occurring in real life. Although David immerses himself in the clinical scenario, occasionally, he also breaks from the role to reflect upon his next actions. In simulation, unlike in a real-world scenario, he is able to pause, consult with others and even lighten the mood by stepping out of role to share a few laughs and find humor in the moment. He explains:

During the scenario, I allowed myself to step in and step out of reality… Maybe it was a little bit of the safety piece but it was maybe a way to deal with some of the anxiety…I stepped out as an opportunity to say where are we going next? [David]

Megan warns that entering a maternal-child specialty requires a refinement of nursing skills to care for infants and children and during simulation, she can rehearse her technical skill in caring for children. Megan describes a simulation experience where she assessed the respiratory rate and administered oxygen when caring for an infant with respiratory distress:

You have to use your imagination to apply your learning…We did not deal with preterm infants or my patient population, but there are elements that have transferred over like dealing with parents and communicating with other members of the team…This could be a real baby; this could really be someone's child. What needs to be done next for this human being that could be right here? This could be a real 'code pink', there could be a father behind me or a grandparent watching on and what would I as the nurse do if that were a baby right there. Always thinking about airway, breathing, and circulation. What's next? Do we need to give antibiotics next? Do we need to give medication next? [Megan]

For Lilly, Lexie, Meredith, Megan, Hazel, and David, it is important to imagine each simulation scenario as potentially happening to real people in their work in the perinatal unit, NICU, and ER respectively. They claim to take this approach as students in placement, in simulation, and now in practice. Every time they observe a situation, they visualize a real event requiring their response. Simulation helps them to conceptualize patient care, family interaction, and teamwork and helps participants rehearse what to do, what to say, and how to handle each situation. Lexie indicates that observing and reflecting before a real-life experience makes it worthwhile:

It is nice to see something before you see it with a real person. It was hard to attach the emotions to the mannequin that you would with a person where that comes naturally. It is just using your imagination, trying to put yourself as if this were a real situation…the simulations at work are very similar to the simulation in lab. Getting to know your skills in a safe environment before it is applied where error can really hurt somebody in a real scenario. The way that we run through various drills is the same way we would in school. [Lexie]

Lexie's quote represents the desire to master the technical skills and concentrate on the therapeutic nurse-client relationships in her practice. For a new graduate, critical emergencies unfold rapidly and represent a terrifying possibility during every shift. Lexie describes the pressure in her new role where she is assigned care in a context in which obstetrical emergencies need to be identified early and considered carefully. During mock codes, she rehearses and imagines that the person is real and that the context is authentic. In her final practicum as a student, Lexie recalls envisioning herself as the nurse providing care

and now that she works on a perinatal unit, she is immersed in clinical experiences that require her to know what to do, what to say, and how to react. Lexie credits simulation for helping her imagine what could happen:

Because of simulation, I am now imagining the possibilities before they happen or before they even have the chance to happen. [Lexie]

Lisa worries about her role on the forensic mental health unit, indicating that she is the nurse in charge of the unit being the only RN on her scheduled night shifts. She reports having difficulty with this transition of role, but notes that professional growth as a nurse occurs predominantly in the last practicum and into preceptorship as a nursing student:

It is definitely a big leap to go from student in fourth year to now…you are constantly thinking that this is real now, this is not simulation. It is very different when you understand that the responsibility will pretty soon be yours. The simulations offer that time to think about what to do in a given scenario. [Lisa]

In preceptorship, and into recent employment, Meredith comments that the shift from student to nurse is a profound one. At this juncture, her ability to imagine what the RN on the unit is handling is developing. Although Meredith places importance on early exposure to simulation-based experiences, it is only toward the end of her studies that she indicates growth in her professional identity:

Fourth year was really a big deal for me because I knew my studies were coming to an end and in a matter of months, I was going to be having a lot of responsibility. It was something that I tried to take very seriously. [Meredith]

As Hazel and David navigated various experiences in emergency nursing, their simulation-based experiences and final placements helped them discover the role of the nurse and imagine the situations faced by nurses in emergency practice. For example, Hazel states:

The fourth-year practicum was extremely helpful because it allowed you to see what nursing is about and discover the field that you are interested in…to just get a taste of it. [Hazel]

As Lys and Derek prepare to enter the workforce, they identify simulation as a way to build their nursing knowledge. Lys claims to be making decisions about her future while having to visualize what each RN role will offer. Using positive imagery, Derek feels hopeful about meeting the requirements for entry-to-practice but describes the exam center as intimidating compared to the testing environment a student experiences in the academic setting. He considers the importance of psychological preparation for a high-stakes exam as something for which his educational experience did not prepare him. For Derek, simulation is a place to pretend and visualize positive outcomes to clinical situations and he wishes simulation was available to him at this time. He claims that simulation-based experiences are ideal moments to include exam-taking strategies for learners:

The aspect of pretending that there is a real person or pretending that you are actually in that situation pressures us to really need to know what could happen and how to bring positive results. [Derek]

Simulation-based experiences enable participants to have various experiences in order to find the role that suits them best. For participants, simulation is an imitation, an artificial scene which enables them to creatively visualize the reality represented as they make their experiences meaningful. In simulation, participants build their clinical imagination to prepare their response to clinical situations.

According to participants' responses in general, the use of simulation activities not only brings refinement of technical skill but also an opportunity to imagine themselves in caring relationships. For many, the notion of relational care is something that must be imagined until they have the opportunity to work with patients in the real-world environment, yet most speak about simulation as providing a terrain to at least think about what it could be like in reality. I note that for most, the degree of realism in the simulation experience may

either add to or detract from the ability to develop a clinical imagination with its accompanying notion of relational care.

Realism matters in simulation. Although the use of mannequins in HFS is common in the participants' stories, none mention any use of artistic moulage to mimic bodily fluids, blood, wounds, and injured body parts. In their experience with simulation, participants describe mostly the use of medical equipment such as blood pressure cuffs, stethoscopes, thermometers, and personal protective equipment such as gowns, goggles, and gloves to stage the patient's bedside. Interestingly, participants attribute a greater level of realism to their unplanned, off-campus simulation experiences. For instance, David describes a simulation of the effects of drinking and driving aimed at local high school students where actors and professional makeup artists participated. For him, the collaboration of various disciplines produced a realistic scenario:

We did a simulation scenario for the PARTY [Prevent Alcohol Risk-Related Trauma in Youth] program where we intentionally tried to bring out emotions in students to make an impact. As nurses and doctors participated in the program, there was an element of emotion for the mom, a nurse pretending to be the mom of this child, who passes away. In order to cry, she has to go somewhere in her head to bring out those emotions. Simulation is an emotional game. [David]

Meredith indicates that she has learned to pretend that the mannequin is a real person in order to find a way to engage in conversation while providing nursing care. In her work in neonatology, her interactions with infants are predominantly non-verbal but as with mannequins, Meredith provides comfort by speaking softly and explaining her next steps. She explains:

If I can let myself jump into that role of pretend, I tend to have conversations with the mannequin whether they answer me or not… I am still very focused on the infant even though it is just the mannequin in front of me. I find that in real life and in those scenarios, I often still talk to the infant too. Like 'come on little guy or wake up, start breathing'. [Meredith]

Lexie and Jenny express difficulty with developing relational practice through the use of a mannequin, but admit imagining the clinical scenario and its possibilities for their own benefit. Although Jenny feels a real-life encounter is required to practice the nurse-client therapeutic relationship, she takes a systematic approach to handling emergencies through simulation. Lys pictures the mannequin as real because the doll represents a child in need of similar care and the experience brings her readings to life. To imagine the mannequin as a human interaction, she explains:

I try to imagine and I try my best to talk to the mannequin like a child…I tried to portray myself as really taking it seriously because I wanted to know that if I could do this, I could take it and apply the interaction in a situation where it is going to really count. [Lys]

Lisa disengages when a mannequin is used in HFS and finds it difficult to display empathy during patient interaction. The disconnect has an impact on her level of urgency to assess, plan, implement, and evaluate nursing care. Lisa describes the impact on her level of empathy as follows:

I always prefer the simulations where it is not the mannequin because find it difficult to interact with a mannequin. I know it is a mannequin and I am not able to get myself to the level of empathy maybe that I would achieve with a person…a mannequin does not put the same level of urgency into the situation that a person does for me. [Lisa]

Similarly, in her work as a perinatal nurse, Lexie describes herself as having a natural inclination towards relational care and feels differently in simulation. She suggests that in simulation, she must try to imagine and outwardly display empathy with the mannequin. Although she feels detached, she accepts working with mannequins in order to play out a scenario that could happen in real-life:

It is hard to attach emotions to the mannequins, you have to use your imagination. [Lexie]

Many suggest concerns with the lack of realism and the commitment they make to contextualize the use of simulation. Lisa mentions that if she is removed from the clinical

practicum setting to spend time in simulation, she expects a meaningful experience. As for pre-simulation preparation, she voices concerns about the inconsistent level of engagement in the student groups that also affects realism. David, Meredith, Lilly, Jenny, and Lisa each tell stories of situations that required caring for a mannequin and suggest that the activity felt like a stage performance rather than a formative assessment of their learning. For instance, Lilly describes Noelle, the birthing mannequin, as mechanical in nature:

Sometimes with Noelle, the birthing mannequin, it is funny….as opposed to an actual person who is screaming. I am not really convinced. [Lilly]

The participants question the mannequin's ability to reproduce responses, reactions, and vocal sounds in clinical situations. Without the use of artistic moulage, Lilly is left to imagine the blood loss and the amniotic fluid present at birth. If a mannequin does not have a temperature, Lys indicates that they have to ask the instructor or pretend for a reading. The technical aspects alter her ability to critically think through the situation:

Some things are really technical such as cyanosis in the mouth; it is a blue light. I am looking at the light and think: Is that supposed to be something? When an infant would seize, you hardly feel it and I am not sure if it would be the same as it would be on a mannequin than on a child. Feeling the skin, you would never be able to tell if they are sweaty. [Lys]

The technology used in simulation is distracting to participants. Lys spends a portion of her time in simulation examining the various ways technology mimics clinical signs and symptoms. She is careful not to trip on the cords, looks at the lights, and hears the mechanical sounds of the machines running the equipment. With each breath being simulated, the participants hear the sounds of a loud compressor. By her senior year, Lys describes being accustomed to the technical aspect of simulation and begins to feel the pressure of the situations planned as potentially real events in her nursing practice.

Another distraction for participants is the use of previously used and often damaged equipment. In simulation, Meredith also respects the need to recycle items. Although she values the need for reusing items such as syringes, intravenous lines, dressing trays, she finds it difficult to draw the line between real and imitation when requiring to pretend to use an item or when using an item with broken or missing parts. Although a reuse and recycle approach to simulation is cost effective, Meredith's experience suggests the strategy may interfere with a learner's ability to imagine a real-life scenario.

As I listen to participants share their desire for realism in the simulation-based experience, I capture their approach to caring for a mannequin and their ability to overlook the unrealistic components in simulation to dig into their imaginative thinking of what could happen in their clinical setting.

Working with the simulated patient. In nursing school, mannequins are often used for the role of the patient while family members are often portrayed by fellow nursing students. In hospital simulation-based experiences, the patient is said to be portrayed by a person scripted in the role of the patient. Lexie, Jenny, Meredith, and Lisa suggest that their best experiences in simulation occurred when a person played the role of an adult caregiver with a child. Meredith feels empathy with a simulated patient that is not evident during role-playing with a mannequin and another nursing student. Over her last year in practice, Jenny learned about the importance of including the child's parents in the provision of care. She also favors an actor with a script of a family's reaction to hospitalization because of the realistic questions that are posed to the nurse in simulation. The participants reflect on the importance of the therapeutic nurse-client relationship when the role is played by a standardized patient rather than portrayed by a nursing student or a mannequin. Lexie says:

You feel an attachment for a child more than for a mannequin, even though you know that they are pretending…you become more attached to people in a simulated role. [Lexie]

For Lilly, being immersed in a scenario with a simulated patient brings a level of realism that adds to her anxiety in simulation. She attributes her fears to the complexity of understanding developmental stages and the pressure of finding effective communication strategies in the provision of care. On the other hand, Meredith finds the exchange highlights the emotions of a patient and triggers a need to act and think like a nurse. She welcomes the challenge of an unpredictable situation where a human reacts to her actions:

It gives my brain another place to go when I am having a conversation and when I am talking to someone playing a role. [Meredith]

Although scripting is used by simulated patients to ensure standardization, the participants identify a greater human connection and empathy in the simulation with human interactions.

In summary, the theme of forming a clinical imagination outlined moments in which the participants shape their clinical imagination, seek realism, and prefer working with simulated patients. The themes presented thus far of performing like a nurse and forming a clinical imagination highlight the imaginative thinking of new graduate nurses as they face the unpredictable and complex nature of practice.

Third Emerging Theme: Embodying the Role of the Novice Nurse

In this theme, the new graduate nurses embody the role of the novice nurse as they seek practice readiness, meet entry-to-practice requirements, and gain practical knowledge. To outline the theme of embodying the role of the novice nurse, I present five components within this theme: integrating theory with practice; repetition through experiential learning; greater depth in simulation debrief; patient safety culture; and interprofessional collaboration.

Integrating theory with practice. Experiential accounts from participants show significant professional growth between the final practicum facilitated by a clinical instructor, the preceptorship, and the first year of practice. For participants, simulation provides an opportunity to bring the theory of classroom learning and clinical practice closer together. For example, Lexie emphasizes the need for repetition and claims that simulation-based experiences prepare her to face similar situations:

Simulation helps because you repeat things and you prepare yourself for what to expect. Then in preceptorship, you get to actually see it in the safety and guidance of a nurse. I had to approach situations that I only simulated before and those experiences have prepared me for being on my own. It is hard to imagine not having that preparation going in. [Lexie]

In NICU, Meredith easily grasps neonatal concepts from the textbooks, but in order to apply the information, she needs support and guidance. She wants to be a good nurse from an ethical perspective and understands the biomedical aspect of caring for people during illness. Meredith looks to gain more confidence with relational practice through real-life events:

I had a good understanding because I always read and studied…It was the hands-on stuff that I was really anxious about…there is a certain safety because I know no one is going to get hurt, it is a mannequin but at the same time, it is definitely a higher level of anxiety than just sitting and watching a power point or taking a test. It stays longer with those experiences. [Meredith]

David and Meredith, both mature students, find that meaningful experiences integrate theory and practice and blend their own life experience with education received prior to nursing school. David suggests that his personal values influence his ethical approach in the emergency department and his pride of working within a team of healthcare professionals to save lives. He looks to tie all aspects of nursing together in his care:

Nursing care incorporates the practice in simulation, the experience in clinical and a lot about your own real life too. [David]

In paediatric nursing, Jenny uses nursing skills and knowledge and applies classroom theory in real life. For Jenny, working with children requires early recognition of symptoms and ability to intervene appropriately. When performing in a paediatric simulation scenario, she learns from the simulation prompts to handle situations with children. Jenny also affirms that new graduates feel isolated in figuring out their roles and acknowledges her first year of employment as stressful.

It is a very specialized area, and it is difficult to touch on everything in simulation. I learned a lot as I went along. It is hard to read then try to remember and then apply it, you have to do it…Having experience with real people really helped. With limited experience in paediatric*s, it is hard to cover everything in labs. The work experience made me a better nurse. [Jenny]*

Similarly, Lilly enjoys the visual aspect of seeing the cardinal movements of the fetus through childbirth to help her understand the concepts of maternal positioning and comfort during the intrapartum period. Lilly points out:

Or just even learning the process of delivery when we saw how the baby rotates and is delivered. Even seeing how to deliver because it is different than in the textbook. [Lilly]

Lisa describes the need to integrate theoretical classrooms discussions in a safe space where students have the opportunity to ask questions and discuss clinical situations. For Lisa, dialogue occurs most frequently in simulation and in the post-clinical conference in placement. Lisa feels the important part of learning about the profession occurs in practice education because the work of the nurse happens outside the classroom.

For participants, learning to embody the role of the nurse begins after graduation as they focus on the RN role and assume the novice competencies in nursing. In perinatal nursing, Lexie speaks about a high learning curve in a specialized unit and denotes that being on her own since preceptorship presents as challenging. She explains:

The perinatal unit is very specific and highly specialized. Having those few months there with the preceptor helped me to learn everything before being on my own. We only touch a little

bit on it in school really for mat-child but the area itself needs such a wider area of knowledge. [Lexie]

Similarly, Meredith reports that integrating classroom and practical learning experiences fosters the sorting of the salient information required for decision-making in neonatal nursing. In simulation, she finds the information on the patient's profile, reviews the documentation on the chart, and prepares a care plan in a way that brings in-class learning into practice. Imitating the review of a patient's medical history, presentation of a problem, and development of a plan of care in simulation enables her to synthesize the relevant information more rapidly in real-life events. Meredith describes a refinement in her thinking that needs to occur as a novice nurse in neonatology:

Being able to weed out some of the extraneous and focus on the care required for an infant in this state, this is what I need to know. [Meredith]

For David and Hazel in emergency nursing, the rapid pace demands a quick grasp of theory and practice. Their comfort level is building and they point out that being comfortable as a nurse is a primary goal in the nursing transition. For participants, the multitude of experiences will lead to more confidence in their new role. Each time David and Hazel are exposed to a clinical situation, the response becomes increasingly familiar, helping them bridge the theory-to-practice gap.

Simulation in their last placement, in preceptorship, and into their transition into nursing enables participants to integrate theory with practice and build their professional identity as a novice nurse.

Repetition through experiential learning. The use of simulation in the transition into nursing brings repetition through experiential learning for novice nurses to assume the scope of practice of the RN. The quest for confidence as a nurse is a common element in

conversation as participants indicate a need to continue to work on problem-solving skills through experiential learning strategies. David, Meredith, Lilly, Lexie, Megan, Hazel, and Lisa clearly say that in their first year of nursing practice, their main professional objective is to build confidence and acquire practical know-how. Jenny reflects on a year marked with practical experiences that increased her confidence and helped her to develop a professional identity as a nurse. Lexie speaks about her desire for repetition and exposure to situations while acquiring problem-solving abilities in perinatal nursing:

The more you see things, the more you do things, the skills become second nature and then you are able to focus on your communication and just knowing what to do… If you know your skills, you can focus on looking ahead and on problem solving for future events. [Lexie]

Lilly finds that exposure to simulation fosters confidence when approaching a similar clinical situation in the first year of practice. She describes situations where the skills practiced in simulation serve as an asset because they allow her to complete practical tasks such as starting an IV infusion while working through complex obstetrical situations like placenta previa, gestational diabetes, and pre-eclampsia. Lilly shares her appreciation for repetition:

It is very helpful to know how to do a blood transfusion and having the experience of practicing before having to actually do it. My first experience was following a postpartum hemorrhage; it was nice to know how to set up the lines, I could then focus on the care of the woman experiencing the bleeding…It helped having the experience to practice different types of simulations and applying the situations after already practicing for them. [Lilly]

For participants, the repetition is positively received. To learn more about specialty settings, David enjoys the possibility of mastering the skills required in problem-solving while in simulation. For instance, he appreciates exposure to simulated medication calculation, IV infusion calculations, and safe handling of technology used in emergency nursing. David claims to learn to break things down into practical application in simulation:

The experience has taught me to slow down a little bit. Then things like drip factors and the IV bolus doses were easy to calculate. [David]

Simulation enables Hazel to relate to the role of the team leader in the emergency unit. Working in a rural hospital, she is preparing to take the leadership role early in her transition into nursing. Thus, she needs to distinguish between normal and abnormal findings and focus on the salient information to share within the team. An intelligent skilled response in emergency situations refines itself in the workplace and as a new graduate nurse, Hazel needs support to build self-confidence. She explains:

As a new nurse caring for a patient that has an abnormal finding, I will think of what I can do but I am always going to run it by somebody else like the team leader. Working as a team in clinical and in simulation really helps to start the foundation later on. The hard part as a team in clinical is that everyone has a different perspective but…our actions feel like a bit of a guessing game. [Hazel]

Derek is working in the role of UCP in a healthcare setting. He looks forward to moving into the scope of RN practice. He also uses repetition in his preparation for the exam. He feels that the interruption in gaining nursing experience has affected his self-confidence and that he needs to work through professional identity issues as a result of not passing the licensure exam. He claims that an immediate entry-into-practice would have led to repetition of clinical events and a shaping of his professional identity in nursing. Likewise, Lys is looking to enter the workforce while exploring various post-graduate options and her entry-into-practice is prompted by the desire to increase her self-confidence as a practitioner through exposure to a variety of clinical situations.

Greater depth in simulation debrief. In simulation, reflection on the salient information in a clinical scenario occurs in the debrief, a step viewed by participants as necessary to the acquisition of knowledge, skill, and confidence to handle a similar situation in real life. Participants express a desire for more depth in the simulation debrief and feel

equipped to handle more immediate feedback in simulation which may offer insight on their performance and guide their reflections on the ways to handle situations in reality. The debrief too often focuses on the technical aspects of care, leaving them wanting more reflection into what could have been done to benefit the patient and improve their practice.

The debrief is a place for reflective practice to begin and the debrief itself could become an excellent vehicle for working on entry-to-practice. Derek speaks about debriefing as the significant part of his learning because it pulls everything together. He leaves with a good feeling when the team has performed well and received praise during simulation debrief. Meredith, in her reflective nature, prefers a situated coaching type conversation in a simulation debrief. She enjoys breaking down the actions, reflecting on how it could be done differently, and comparing styles between learners. Meredith conveys:

In the debriefing, I wish it had included more…like going step by step, everything that we may have missed, and the positive things as well. I like to dig deep and I appreciate the low anxiety level that are created but at the same time, I really want the information. [Meredith]

In emergency nursing, David and Hazel feel that going through a clinical situation after simulation highlights the potential risks and dangers. Debriefing creates a reflective environment where the learner thinks about a different course of action to improve health outcomes and prevent adverse events. Hazel remembers her errors and once she sees a pitfall, she has an opportunity to reflect on actions in simulation debrief and is likely to identify the risks in a real-life setting. She outlines the step-by-step playback she remembers from the simulation debrief:

Running through the process of what happened and what we did and the steps that you took. Especially if you did something wrong during the simulation and when you debriefed about it you are highly unlikely to do those mistakes again. [Hazel]

In practicum, Lys notes that the critique afterwards tends to be cautious and kept to a lower level of understanding than she expects given that simulation and clinical placement have been combined in their last year in nursing school. She hopes that the simulation debrief in her workplace goes over the related clinical practice guidelines, the thought process required to make those clinical decisions, and the opportunity to reflect on action. Lys describes how she is made to feel in her simulation debrief experiences as a senior nursing student:

I never felt embarrassed. When they were critiquing something afterwards, I never felt embarrassed…I wish we were challenged a little bit more during the simulation. [Lys]

For Meredith, there is a need to incorporate debriefing in traditional placement and in simulation because the debriefing period represents an opportunity to reflect on the ethics of caring and on being a good nurse. Looking at each situation in a way that depicts the best course of action for the patient and avoids harm draws in both the ethical values of the profession and the patient's rights to compassionate and safe care. Meredith, describing the use of debriefing as fitting in simulation and in placement, explains:

Simulation teaches you to look at a situation and examine it from a different lens, a lens of creating this care environment and doing no harm, your basic tenets of nursing. [Meredith]

Jenny continues to enjoy debriefing after mock codes on PEDS and describes the facilitated debrief as an opportunity to collaborate with members of the PEDS team and reflect on her practice. She values the conversation it creates within the team because she learns to respond to emergencies affecting children and their family. Participants provide rich stories that explore their simulation debrief and share a desire for increased depth in the conversations identifying an ability to handle more as they approached entry-to-practice. The simulation-based experiences appear to focus on providing safe and compassionate care.

Patient safety culture. Simulation represents an important movement towards patient safety by allowing participants to practice important concepts without putting anyone at risk for harm. As Meredith speaks about the ethical and moral obligation in healthcare of doing no harm, she speaks about simulation as a safe learning environment. Jenny concurs that simulation is perceived as a safe place to learn; they can come in and out of situations to take action, to reflect, and to engage in dialogue with other health professionals on the team. She explains:

Simulation is where I really learned. I was allowed to make mistakes and we would go over everything. I also determined a vocabulary that paediatric patients and their families were going to understand. [Jenny]

For new perinatal nurses, simulation fosters teamwork in identifying obstetrical risks and preventing errors in the medical treatment of the vulnerable population of women and children. For Lexie and Lilly, simulation-based experiences create an optimal situation for the woman giving birth because the nurses rehearse scenarios in order to provide better labor support. Incidentally, in Lexie's desire to embody the role of a perinatal nurse, she relies on the combination of simulation to promote safe, competent practice while also having people around to guide her actions when faced with obstetrical emergencies. For instance, she says:

It promotes teamwork and helps to prevent error. It is getting your critical thinking going in a safe environment. And in practice, it eliminates harm while you are in the real world of real patient care. [Lexie]

Megan appreciates the ability to practice events that feel scary in practice. Megan explains that the emotions triggered for the first time in emergency situations and the communication skills required to handle critical moments are fortunately covered in simulation. For Megan and Meredith in NICU, being in simulation represents a place where a nurse deals with the raw emotions and the response that comes with life-threatening neonatal

emergencies. Megan concludes that in NICU, a sense of calamity and composure is required, especially in neonatal resuscitative emergencies. She recalls:

Being able to do so in a safe learning environment is so valuable. We really realize that when we get into the real world. We realize that this is a real person and it is a good thing I practiced. I am so glad that we were able to have a safe learning environment to be able to learn to handle my emotion and improve my responses. [Megan]

Lys identifies struggles when trying to apply theoretical concepts learned from textbook readings. Although the concepts of nursing ethics are important to her, she easily forgets the sequence in practice that leads to safe outcomes for the patient. In her search for employment, she wants to belong to a team actively using safe learning environments to improve teamwork, communication, and patient safety. Lys analyzes her simulation-based experience:

It is so much different than reading it from your textbook which is so easy to forget. When you are doing it, hands on and you are making mistakes. Doing the skills in a safe environment helps to remember and to take the skills learned in simulation and apply them in a high-pressure situation. [Lys]

For David and Hazel, the scope of practice in the ER is inevitably fast-paced and requires them to handle life-threatening clinical situations. Mock codes are routine in their work day in order to build a patient safety culture. They both appreciate that simulation has been a part of their undergraduate experience as they continue to rehearse their emergency response in a safe environment. Lisa questions whether her current employment is long-term as she claims that the ratio between nurses and patients affects her ability to provide the level of care she imagined as optimal to foster positive health outcomes. She speaks about the possibility of taking a position on another unit and credits her experiences in practicum and simulation with helping her shape a sense of patient safety.

For participants, simulation embodies the elements required in a patient safety culture, allowing them to practice important skills, concepts, and emergency response without the risk for harm to patients.

Collaboration with the interprofessional team. Hazel and David articulate the importance of collaborative teamwork in acute and critical situations. Hazel identifies simulation as an opportunity to learn about teamwork because learners practice communicating with other healthcare providers. In addition, David speaks about family-centered care and the value of providing care to a child and their family in simulation. He incorporates the child's parents into his care and suggests that interaction with the family members lightens the mood and eases the tension for the nurse. For Hazel and David, simulation provides a time for role clarification to develop the characteristics leading to leadership within a team. Hazel describes being supported by the rest of the team:

Having the confidence in my assessments and my skills means that if I do not know something, I can go to a team leader. The team around me will support me. [Hazel]

Jenny adds that as she entered practice, she realized the importance of including the family members in the provision of care in maternal-child nursing. She adds that simulation-based experiences should incorporate family-centred care to enable learners to practice their approach with family members:

I find that the parents play a big role in it too because it is not just the child you are looking after. A paediatric patient has really concerned parents and you have to involve them in the plan of care. The child's parents might be asking why are you doing such a procedure and you really have to explain everything. Paediatrics is really a family centered area. [Jenny]

In forensic mental health, Lisa relies on the effectiveness of her team to assure her own personal safety and provide continuity of care for the patient. As she is learning aspects of teamwork in her workplace, she feels that in simulation and on placement, students are

still learning to work effectively in teams. She recalls working in isolation as nursing students and not feeling a sense of belonging to a team:

We were often isolated from the nursing staff. We did not feel like it was an environment where you could ask questions or make mistakes because you did not have a connection with the staff. That was very difficult and it required a huge amount of self-direction to get a good clinical experience. [Lisa]

For Meredith, working in simulation with other nursing students represents a team-building activity allowing her to work with other nursing students that she may not have met or worked with in the classroom or placement setting. She reminisces:

Simulation is good for team building. When I came out of simulation experiences, I felt closer to the people that I went in with, people that I had not necessarily worked closely with in the past. This was an opportunity to become a team and get to really know people. [Meredith]

For Derek, simulation means learning together. If a learner hesitates or freezes, another learner is there to trigger a response. When a learner collaborates with others in simulation and in placement, the relationship changes within the team. Derek shares his thoughts on being with other learners in simulation:

It also helps to work in a team. Others in simulation can calm me down because if I do not know something, there is chance that someone else will know. We all succeed together. [Derek]

Lys and Meredith warn that some learners come unprepared and prefer to take the role of bystander. For this reason, Meredith sees the need for a classroom lecture prior to simulation in order to cover the theoretical aspects of nursing. She recommends more opportunities for students to master their role in the clinical setting combined with simulation. For instance, Meredith describes that as students, they work separately on their own patient care assignments and then come together at the nursing station at the end of the shift. She emphasizes a disconnect with reality where in NICU, collaboration is essential to provide quality care.

Megan also admits that the concept of teamwork is poorly understood by students in simulation. In her role in NICU, she now sees teamwork as necessary to deliver safe, effective care. In the first year of practice, Megan wants to understand prioritization, delegation, and collaboration. Participants state that these are missed opportunities in their simulation-based experiences. They appreciate the calming presence of having other nurses, their classmates, while in simulation; however, the simulation experiences could include other learners from other disciplines. In perinatal nursing, Lexie and Lilly look forward to Sim-IPE to decrease their anxiety with labor support and manage obstetrical emergencies. Lilly reveals her views of being in Sim-IPE experiences as follows:

It is very team oriented. I guess if you think of yourself as part of a team, you can stay calm. You have your peers to help you and you are never really alone. [Lilly]

The participants' stories expose a common thread of wanting to gain expertise, especially in specialty settings. As Hazel and David pursue experiences in the ER, Meredith and Megan are learning about the role of the nurse in NICU. Jenny works on PEDS and Lexie and Lilly have entered practice in the perinatal unit. Lys continues to explore a job opportunity in the perinatal unit and although Lisa and Derek work outside of the specialties that provide participants with maternal-child experiences, they both indicate interest in specialty nursing settings. The new graduate nurse's perspective highlights a shared desire to achieve practice readiness while also being exposed to specialty nursing. For participants, simulation is a considerable part of learning various roles in nursing during the transition into nursing.

In summary, the theme of embodying the role of the novice nurse allowed me to examine more deeply the participants' desire for practical wisdom in their new role as a nurse. Participants expressed a need for integration of theory with practice, repetition through

experiential learning, greater depth in simulation debrief, adoption of a patient safety culture, and collaboration with the interprofessional team. The themes previously presented from performing like a nurse, to forming a clinical imagination, and embodying the role of the novice nurse uncover the essence of being a new graduate nurse using simulation to prepare for clinical practice.

Fourth Emerging Theme: Embracing Life-Long Learning in Simulation

In the fourth theme, I seek an understanding of in-situ simulation, the simulation occurring in patient care areas while nurses are in the workplace; the emotions triggered during in-situ simulation represent an important element as neophytes assume the responsibilities of the RN. I describe the emerging theme of embracing life-long learning in simulation and present three components within this theme: anxiety as a new normal, some days are just harder, and admiration for expert nurses.

Anxiety as a new normal. Some of the participants' anecdotes highlight joy as they speak about overcoming the challenge of a mock code while other accounts present bewilderment with realities in nursing. As participants outline the use of in-situ simulation as a way to learn their new role, they describe the level of anxiety evoked in simulation. For some of the participants, entry-into-practice produces fear and anxiety when having to respond to emergency situations. The use of in-situ simulation triggers anxiety and pressure in having to know how to react as a nurse. Megan identifies that one of the best parts of in-situ simulation is the ability to address the initial state of fear and recounts getting over that initial reaction of panic and conquering the situation. Neonatal simulations are intimidating but Megan tells herself that mock codes are similar to the simulation-based experience in

nursing school. She finds comfort in being able to handle the situation in a safe environment and optimistic that she will do the same in a real situation. Megan explains:

Sometimes it is a state of panic. Am I doing the right thing right now? Is this what I am supposed to be doing? It triggers feelings of uncertainty and not knowing if your actions in the scenario are supposed to play out. I find the uncertainty the most challenging. [Megan]

For Megan, the best part of a simulation-based experience is the exposure to the real feelings because they are part of her transition in practice: fear, panic, and being overwhelmed by the responsibilities of a new neonatal nurse. She is able to address the emotions and explore her reactions in a safe way. For example, being able to talk to the HFS mannequins and to approach other healthcare professionals builds her interpersonal skills in real situations. Megan reports fear when a patient's condition deteriorates and although this emotion is part of caring for people during illness, she claims that simulation prepares her reaction to critical and life-altering situations. Although she describes deterioration in a condition as terrifying, she is confident in her management of similar feelings in simulation and has accepted that nurses experience many clinical situations that are going to feel terrible in real life. David and Hazel's desire for new adventures in emergency nursing comes with a high level of satisfaction with new experiences, but at the same time, the unpredictability of life-altering situations produces anxiety. Hazel outlines the uncertainty of immersing herself in work-related simulation:

I get anxiety during simulation at work because it is stressful. Things happen and you are not always sure what to do. This is the biggest part of learning. We learn from mistakes while also being judged by our peers because we work as a team…A couple of times, when the situation started to escalate, I felt the stress level go up and then my stress level went through the roof. Then I would do a task and think that I do not even know what I am doing. [Hazel]

Hazel and Megan's observations represent the challenges faced in early career. She admits that many clinical situations are difficult to handle, especially when presented for the

first time. Meredith discloses anxiety relating to caring for the neonate in the NICU, especially without the close observation of her workplace RN mentor. Meredith understands theoretical concepts in neonatology, but her need for more exposure to real-life critical illness in neonates leaves her feeling unprepared and frightened in her first months of employment. She describes her anxiety levels:

I was talking to my mentor about my anxiety level being so high when I go into a delivery. She said that anxiety is normal. We all feel this. The anxiety going into simulation…while it touched on what I feel now, it prepared me for the pressure of having to work your way through a situation. I need to be functional and thinking in the moment still. [Meredith]

Jenny reports feeling more at ease at work now that she has been working for over a year. She is able to respond to most paediatric clinical situations and knows to reach out for help if she needs the advice of a nurse with expertise. Lys and Derek have been exposed to mock codes in their preceptorship and look forward to the anxiety-provoking aspect of in-situ simulation as they prepare to enter practice. Derek describes attributes simulation as beneficial with the responsibility of sorting out priorities in nursing:

In preceptorship, you are incorporating everything from simulation…Having multiple patients on a usual dayshift, they all have many co-morbidities and multiple medication and simulation was definitely helpful to sort out the nursing process… [Derek]

In perinatal nursing, Lexie and Lilly find that working through a simulation scenario within a team makes the response to childbirth and associated obstetrical emergencies less anxiety provoking. As Lisa points out, the goal of in-situ simulation is to provide learning opportunities that reflect nursing skills such as approaching the patient, interacting with their family, and explaining your plan of action. She explains:

Well, I think sometimes people enter simulation assuming the situation is going to be a life or death television 'ER' moment. The child will crash and we all need to panic and stuff. It is not like that…Donning the PPE and performing health teaching for the child's family makes the situation realistic. [Lisa]

In simulation, participants connect with members of the interprofessional team to reflect on their role in nursing. Although the use of in-situ simulation produces anxiety, the participants find the experience helps their understanding of real clinical situations.

Some days are just harder. In their quest to move through various nursing experiences, Hazel, David, and Lisa admit that some days are harder than others and require them to use reflective practice to get through the challenge. As they present the experiences in their transition into nursing, participants refer to simulation as a strategy to help get through the hard days they inevitably experience as novice nurses. Hazel describes a difficult shift as a nurse while having to respond to a complex health situation in which a patient unexpectedly passed away. She shares feelings of blame as though she could have done more for the patient and their family and speaks about being disappointed with the team's response during a critical situation. Her facial expression shows fatigue and disappointment as I listen to the sadness in her tone. Hazel looks for the opportunity to debrief the clinical situation with her peers and feels that the team's support is the reason she is able to learn from this experience. In her workplace, a critical incident debriefing fostered conversation and reflection, and she links the importance of debriefing in simulation to this real situation in her practice.

One of the biggest things in debriefing was learning to interact with the families. That caught me off guard the first couple of times. But I got to see it in placement so that helped to prepare me. When I had to deal with family members, I was overwhelmed at first. [Hazel]

David speaks of hard days in emergency nursing. During his recent shifts, he recalls providing care to a young man with children undergoing complications following chemotherapy. He also speaks about the kindness within the team in his emergency

department and suggests that it is like belonging to a new family. The opportunity to reflect and to debrief difficult situations is invaluable to him in this setting as he describes:

There is a huge connection to the team and while you feel connected at school too, there is the title of the student in simulation. Whereas at work, you can acknowledge the need for help and identify your limitations. When you are caring for a child, you are always a bit scared. [David]

Through reflection, participants bring a desire to handle a situation better with each exposure. Megan, Jenny, and Meredith adopt a one-day-at-a-time approach and a need to look back to analyze their interactions in healthcare. When Meredith critiques her communication skills, she finds herself filling space with non-therapeutic communication such as saying to the parents that she will keep an eye on the child. In their practice in NICU, Megan and Meredith incorporate reflective practice as ways to think about experiences as they arise and hope to continue to improve every day. Megan describes her use of simulation:

I use simulation as a way to reflect as much as possible. What did I not understand in this scenario? What are the steps of NRP [neonatal resuscitation program] that I forgot? Reflection was the best part of this experience because it was pretty alarming to realize how many learning barriers I have in a mock 'code pink'. Reflection is the best part to be able to look back at what went wrong even if looking at the things you do wrong is difficult. [Megan]

For Lys in her search for the ideal employment, she feels attracted to the specialty nursing settings. She is about to accept employment and predicts having to use reflective practice because she constantly questions herself in practice. Lilly and Lexie reflect on their actions to try to improve their care for women and their families as they feel this is an important part of their entry-into-practice. Prior to being exposed to neonatology, Meredith admits that she rarely considered interactions with parents and focused her studies more intensely on the pathology, the nursing interventions, and the ways to evaluate care provision. Then, she recalls a parent in a simulation-based experience asking multiple

questions about lab tests and diagnostics and while their presence was challenging, exposure facilitated imagining the caregiver's perspective. Meredith claims:

I would like more simulation experience because I felt anxious, pressured, and challenged. [Meredith]

Jenny now communicates effectively with parents and children in the paediatric unit and recommends refining communication skills more intensively in simulation because she has learned about therapeutic communication from real-life situations. For Meredith and Jenny, it is important to reflect on actions and learn from a situation of relational practice. Jenny finds that there is a different approach to simulation than in nursing school where they seemed most interested in the tactile skills of nursing. Jenny explains being challenged by where to begin in her assessments:

It is difficult to know what to assess with all of these things that we have never seen before but with the simulation, you get your basics. From your assessment, you decide what you are going to do in your interventions. After the interventions, you evaluate…When you go into a patient's room, you have a plan figured out. [Jenny]

In the ER, David uses reflective practice to ensure that he is providing care to the patient without being distracted by the technology. For instance, the use of cardiopulmonary monitors offers valuable information on the patient's status. He admits the need to be technologically adept in emergency nursing, but suggests that with children experiencing emergencies, the interactions should be focused in a developmentally appropriate manner. He values the mindfulness of thinking-in-action and thinking-on-action brings him to review the situation after the fact to learn from each moment. Although David and Hazel admit difficulty keeping up with the quick pace in the ER, proficient acquisition of skill is required to rapidly move on to the next clinical case. Mock codes help David understand the response to emergency situations:

I use my time in the ER to reflect and improve. When we care for kids, it is important to look at the whole patient and not just look at monitors. Part of our actions in emergency nursing incudes interacting with the family and asking the child's parents about their needs. [David]

Jenny reflects on her past year as a nurse on a PEDS unit to acknowledge that comfort with the RN role comes with time through an everyday recognition of the complexity of situations. After a hard day, she reflects on her actions by engaging in debriefing conversations with other nurses on her team. For Jenny, learning in simulation helps define the nursing process of assessing, planning, implementing, and evaluating provision of care but her interactions on the unit within the team shape her practice. She says that one of the hardest part of being a new nurse is realizing that there is so much to know:

The simulation labs really help with the nursing process. And of course, you cannot expect to know everything right away as it takes time to reflect and to recognize certain things. [Jenny]

Derek continues to work towards passing the licensure exam and provides examples of the hard days that come with facing the need to re-write a high-stakes exam and a delay in entering practice. He views remedial opportunities in using in-situ simulation as a way to help new graduates navigate the licensure examination. He brings up the hardship of losing his new graduate nurse funding opportunity and describes the limitations of the NGG being revoked with a failure to pass the exam on the first attempt. However, Derek is optimistic that the upcoming changes in the Nursing Act may better reflect the needs of nursing graduates and keep them in practice while they are studying to re-take the exam. This way, in-situ simulation could continue to be used in the preparation for the licensure exam.

Admiration for expert nurses. While participants search to embody the novice role, they respect and admire the proficient, competent nurses in their workplace. According to participants, being a new graduate nurse requires them to immerse themselves in a nursing environment that exposes them to the realities of the nursing workload, the complexities of

patient acuity levels, and the need for teamwork. Working their way from novice to expert in their acquisition of nursing skills, participants highlight the desire to take part in simulation with nurses in practice with a varying degree of proficiency and expertise. Meredith and Megan describe the PEDS rotation as observational for nursing students, and claim that the use of in-situ simulation may enhance the nursing student experience to prepare them for the transition into nursing. Meredith explains:

It became a struggle for us to learn a lot of the paediatric concepts and I give props to all of clinical instructors that go out of their way to find opportunities for students to learn… It is just really difficult sometimes when you do not have the patients and the bodies. Again, it is another place where I feel that simulation can also really fill in the gaps in practice. [Meredith]

The use of simulation in the workplace enables Meredith to actively engage in mock codes in her workplace which requires her to learn with other health professionals. She relies on her reflective and thoughtful approach to guide her through the transition into practice. She also describes in-situ simulation in NICU in which she provides neonatal resuscitative care using HFS with the help of expert nurses. Since she enters the profession academically prepared but in need of practical experience, she seeks to acquire practical skills when participating in interprofessional simulation activities at work. Meredith adds:

My comfort comes with studying but I need more experience to feel competent. I am struggling with my inexperience…Getting my bearings with very simple things that experienced nurses just do not need to think about. In training, it feels awkward…from handling equipment to always having to think am I forgetting something? [Meredith]

When referring to in-situ simulation, David enjoys the opportunity to run through a clinical scenario with the interprofessional team, but also feels that simulation offers a place to loosen up and enjoy the transition as a new graduate. He perceives in-situ simulation as a time to respond to serious situations while also feeling closer to the team members in a less intense setting. David admits that when he has never done a technique, or handled a piece of

equipment in simulation, the use of humor helps him loosen up and enjoy the transition into nursing practice. Being able to share laughs and lighten the mood with expert nurses makes him feel a sense of belonging. For Lys, completing her preceptorship experience left her wanting more time with experienced nurses and she fears that employment will mean being on her own in practice. The final placement and preceptorship made her realize that there is so much to learn from working closely with nurses that have achieved proficient, competent, and expert practice. She shares:

There is a lot to learn. I discovered in preceptorship that there is a lot to know, a lot of protocols, a lot of clinical guidelines, it is just so much…and I feel that I only touched the surface while in preceptorship. [Lys]

As Lisa reminisces on the comfort of having an instructor as a nursing student, she sometimes feels isolated in situations where she must use her decision-making skills in an autonomous environment. Workplace in-situ simulation allows her to think about practice situations and reflect on setting goals towards building her clinical decision-making skills. Hazel describes initial exposure to in-situ simulation while in preceptorship and how, from that moment, she realized that simulation would be used in her transition into practice to observe how expert nurses handle clinical situations. She recalls her time in simulation as a time to observe, reflect, and learn:

I would engage in simulation as learning experiences. Sometimes I would participate in the care and other times, I would observe, step back, watch and learn. It depended on the situation but I definitely took advantage of everything I could. [Hazel]

Derek's preceptorship has not led to immediate entry into nursing and he continues to draw from his time with expert nurses. However, he wishes he could have additional time on a nursing unit to learn from their expertise and he expresses admiration for the nurses in his

preceptorship placement. He is enrolled in a review course facilitated by a nurse with expertise and feels that this experience is helping him achieve his goal:

From my preceptorship, a lot of knowledge and skills can be applied to any part of my studying for the NCLEX-RN across all different types of topics. [Derek]

Lexie and Lilly report that in a mid-sized hospital, maternal-child programs require nurses to cross-train and respond to emergencies from PEDS, perinatal, and NICU. Lilly reports experiences from in-situ simulation that build on her exposure as a nursing student. For instance, despite not completing a PEDS placement, she is required to respond to pediatric mock codes as a staff nurse. She values the opportunity to observe and work closely with expert nurses in simulation-based experiences. She recalls:

I participated in a scenario with a child acting out the role and it was terrifying… I remember the experience being really helpful because I did not do a pediatric rotation. Conversing with a child is obviously different than with an adult. [Lilly]

For Lexie and Lilly, the mock codes represent an opportunity to observe the skilled response of expert nurses in action. In a low-stakes environment, conversations take place to allow reflection and dialogue. Lexie and Lilly use the in-situ simulation experiences in their practice. For participants, simulation brings them to build relational practice by observing how skilled nurses approach therapeutic relationships as nurses.

To summarize the fourth emerging theme, participants identified as novice nurses in their need for exposure to clinical situations through various experiences and looking to integrate their knowledge from the classroom, placement, and simulation into their practice as a way to possibly acquire practical wisdom. I detailed the emerging theme of embracing life-long learning in simulation and presented three components within this theme: anxiety as a new normal, some days are just harder, and admiration for expert nurses.

With this in mind, I return to the literature to discover the meaning of being a novice nurse and to understand the ways the experiences shaped professional identity and practical wisdom. The participants reveal experiencing anxiety, frustration, and an imposter syndrome when asked to perform like a nurse and embody the identity of the novice nurse. In spite of uncertainty in their employment situation, the new graduates look to "hit the ground running", but also realize that clinical imagination and practical wisdom tend to emerge over time. After overcoming the initial anxiety of writing the entry-to-practice examination, they reflect on final experiences in the nursing program and in the transition into practice. The participants value life-long learning and welcome ways to practice in safe spaces with experienced mentors.

Summary

In this chapter, I used phenomenology of practice to find the meaning of being a nurse entering practice in a blend of maternal-child placement and simulation experiences. I described the lived experience of participants to carefully construct the story of their transition into nursing through a participant vignette. I presented four emerging themes: performing like a nurse, forming a clinical imagination, embodying the role of the novice nurse, and embracing life-long learning in simulation.

In the next chapter, I describe the findings, reconnect with the literature, and convey the significance of my research on nursing education and nursing practice.

Chapter 5: Discussion and Implications of the Study

The true sign of intelligence is not knowledge but imagination. – Albert Einstein

In this chapter, I return to the research questions and the emerging themes of performing like a nurse, forming a clinical imagination, embodying the role of the novice nurse, and embracing life-long learning in simulation to understand the essence of what it is like to be a new graduate nurse who has experienced maternal-child simulation combined with a traditional practicum. To present the implications of the study, I list three recommendations based on the lived experience and I reflect on being in simulation to reveal its meaning for nurses in entering practice. Finally, I draw conclusions to identify research limitations and future research recommendations.

Research Questions

I used phenomenology of practice to discover the phenomenon of transitioning into nursing practice (van Manen, 2014). Hence, the research questions were designed to find the essence of entering nursing practice when maternal-child simulation has been used as a learning strategy in the final placement, preceptorship, and transition to nursing.

The overarching research question in this study was: What was the lived experience of new graduate nurses entering practice after a practicum in maternal-child simulation? Three sub questions that emerged were: In what ways did the practicum that involved maternal-child simulation experiences contribute to the development of: a) reflective practice, b) ethics of care, and c) the development of a clinical imagination during the transition to practice of new graduate nurses. Answers to each question were not entirely distinct, but emerged from within and across the themes. First, I addressed the research questions by describing the themes uncovered in the previous chapter.

Getting to the Essence of Performing Like a Nurse

With the overarching research question in mind, I assembled the textual data to examine the question of what it is like to be a new graduate nurse in transition to practice following a practicum experience with maternal-child simulation. In the first theme, I gathered experiential descriptions from the participants in which they conveyed performing the role of the nurse, feeling like an imposter, and developing the nurse's intuition.

Performing the role to develop a professional identity. While the participants view the maternal-child simulation experience during their initial training as a learning strategy, they embrace simulation in their initial employment situations as a way to develop continuing competence and undertake professional growth. In the participants' stories, simulation is commonly utilized during the transition into nursing and research is showing an increased use in hospitals to ease new staff into their responsibility of handling high-stakes clinical situations (Murphy & Janisse, 2017; Rutherford-Hemming & Alfes, 2017). In practice education in nursing, simulation is adopted as an educational strategy and as a quality improvement strategy directed toward patient safety (CASN, 2015; RNAO, 2016). Participants report that their nursing curriculum prepared them as nursing students to engage in simulation in their practicum, preceptorship and into their transition into nursing. Since the frequency with which simulation-based experiences are used in the final clinical placements including preceptorship is poorly reported, the stories of study participants may provide valuable information for nursing education (CASN, 2015).

As the participants in this study detail their use of maternal-child simulation during their final semesters and into their new roles, they describe the pressure to perform like a nurse during simulation activities. Although they enjoy the role-playing aspect of simulation,

their desire is to be immersed in the real world. That is, although they could imagine feeling competent during simulation, they want to bring that feeling into their new roles as novice nurses. The make believe aspect of simulation that involves responding to the roles and responsibilities of nursing is relevant to the goal of entering the professional role in reality (Benner & Tanner, 1987). Performing in the role of the nurse during simulation is important to the formation of professional identity in the transition into practice (Benner et al., 2010). Thus, being in the nurse's role in simulation may produce varying degrees of readiness for the new graduate nurse during transition. For many participants, being in simulation also provides an opportunity to engage in conversation about professional growth.

Imposter phenomenon. Being engaged in simulation elicits an emotional response, and some participants feel uneasy about fulfilling the role of a nurse. The imposter phenomenon, described as an internal feeling of intellectual deceit, produces postsuccess anxiety for the reflective practitioner (Clance & Imes, 1978; Kamarzarrin, Khaledian, Shooshtari, Yousefi, & Ahrami, 2013). As an emerging theme, performing like a nurse highlights a self-perception of being an imposter when immersed in real-life situations. Although the new graduate nurses may receive praise for day-to-day accomplishments such as correctly reading a cardiac rhythm, successfully interpreting electronic fetal monitoring strips, and competently performing a cervical examination, they often feel unworthy of recognition for their performance, and internalize feelings of inadequacy. Many suggest that they have been mistakenly acknowledged for their nursing actions and that their application of nursing knowledge occurred by chance. In this study, the participants identifying with the imposter phenomenon are those with prior degrees, significant past experiences, and dual roles in nursing. High-achieving new graduate nurses entering a specialized setting seem to

minimize their judgment during their transition. Although study participants indicate feeling comfortable and competent with theory, when it comes to independent practice, they feel tension and discomfort. In short, reading about a situation is different from the lived experience (Parker, Giles, Lantry, & McMillan, 2014). Thus, in new situations, the participants describe feeling as if they are merely acting in the role of the nurse rather than acknowledging that they have been prepared to respond throughout their educational journey. The simulation environment may help them grow out of the imposter feeling and into their professional identity as a nurse.

Nursing intuition. Participants in this study show enthusiasm for gaining practical wisdom in their practice and their transition story may have an impact on their practical wisdom as many researchers have understood that acquisition of skill and knowledge occurs through a multitude of clinical experiences and over an extended period (Benner, 1984; Benner et al., 2010; Tanner, 2006). Using thinking-in-action, the novice nurses learn to apply their skilled know-how and the notions of good practice to develop practical wisdom (Benner et al., 2010; Schön, 1987). Here, the nurses move from relying on set rules, guidelines, and parameters to develop patterning and a sense of salience to recognize what stands out in a clinical situation (Benner, 1987; Benner & Tanner, 1987; Schön, 1987). The participants in this study look for situated learning in their simulation-based experiences to work through clinical problems and in this study, situated learning is integral to their practical experiences because it helps the nursing student and novice nurse learn how to use their knowledge. An imaginative student requires an imaginative teacher and this is why situated coaching is important in nursing education (Benner & Tanner, 1987). Nursing educators need to find real-life problems in the clinical setting, in the classroom, and in the simulation lab to help

nursing students to learn how to apply tacit knowledge in nursing care (Benner & Tanner, 1987). Schön's notion of artistry in practice is relevant to nursing practice as the nurse begins to use tacit knowledge to diverge from the rules, which will require stepping back and using reflection (Argyris & Schön, 1974; Benner & Tanner, 1987; Schön, 1987). New graduate nurses look to build practical wisdom for real-life encounters by working through the technical skills of nursing, the integration of healthcare technology, and the relational practice skills of communication, teamwork, and delegation (MacKinnon et al., 2015). The simulation environment is recognized in the literature as a safe place to practice technical skills while incorporating comparable experiences into the maternal-child placement (MacKinnon et al., 2015). Simulation may also represent a way for the participants to develop intuitive thinking and practical wisdom in their practice as novice nurses.

Shaping Clinical Imagination in Simulation

Participants step in and out of imagination to see themselves in a role in order to effectively perform the nursing responsibilities and, most importantly, execute the thinking that has been shaped by their experiences in nursing to this point. In the second theme, I describe the essence of shaping clinical imagination in simulation, the importance of realism in simulation, and working with simulated patients.

Clinical imagination in simulation. Participants imagine themselves in clinical practice during their simulation-based experiences and report a need to come in and out of the imagined role in order to execute the thought process required to perform as a nurse. According to researchers, clinical imagination is tied to clinical judgment, which is inherently essential in the provision of safe, ethical care (Benner & Tanner, 1987; Benner et al., 1996; Tanner, 2006). In nursing, clinical judgment is required to adeptly identify

abnormal, critical, and life threatening clinical findings (Tanner, 2006). In the present study, the new graduate nurses suggest that clinical imagination is required in both the traditional placement and in simulation to provide safe care and visualize the clinical outcomes for the client. To develop their clinical imagination and clinical forethought, participants in this study break from their simulated role at times to pause, sort out their thoughts, generally recompose, and execute what they imagine a nurse in practice would do next. For participants, learning occurs in simulation when they are challenged to demonstrate their knowledge of the next steps in the nursing process. Their ability to detect symptoms, perform assessment, and intervene appropriately is on stage for others to view and potentially critique in simulation (Zulkosky, White, Price, & Pretz, 2016). The tension of being observed may also require them to move in and out of their imaginative thinking.

When being observed by other health providers in simulation, one study participant admittedly reported concerns with the ability to act like a nurse while not yet thinking like a nurse. The participants welcome a shaping of clinical imagination and forethought in their practice but what they really desire is to move from imagery into the goal setting of becoming a skillful nurse. In their transition stories, participants share moments where they are using concepts of self-regulated learning to imagine, reflect, set goals, find motivation, perform, and shape their practice (Zimmerman & Schunk, 2009). Clinical imagination in simulation may be also shaped by vicarious learning as the learner observes, imitates, and forms an interaction between behavior and personal motivation factors (Bandura, 1995). Thus, participants indicate that the use of simulation in the last year of study and into the workplace may bring them to observe and imitate the actions of practitioners in their field more carefully. As a result, study participants welcomed simulation-based experience as an

opportunity to build their cues to modelled behaviors, and establish new patterns of thinking in their clinical practice.

Realism and appropriate use of simulation. The participants in this study also expressed a need for rich clinical placements in their baccalaureate education. When learners come to simulation, the appropriate level of fidelity needs to fit the learning objectives to influence the realism of the simulation (CASN, 2015; INACSL Standards Committee, 2016b; Raemer et al., 2011). If the learner is expected to embody the role portrayed in simulation, realism needs careful consideration. Yet, study participants report a lack of connection with mannequins used in simulation and a need to dig deeply into their imaginations to clinically relate to the experience as one that could happen in practice. The possibility that a similar critical event can occur in real life motivates them to respond during simulation and then helps them imagine clinical scenarios. Simulation incites learners to imagine themselves immersed in a similar clinical situation in real-life and also represents an opportunity to imagine the possible solutions to real health-care issues (Gaba, 2007; Kneebone, 2009). Participants reflect on the need to explore multiple nursing experiences to develop their imagination as they creatively engage in forethought in caring for people in similar critical health situations.

In terms of appropriate use of simulation, the replacement of clinical placement hours remains controversial in nursing education (Breymier et al., 2015; CASN, 2015; Jeffries et al., 2015). In the present study, participants are apprehensive about replacement of required clinical placement hours with mandatory simulation-based experiences during their final clinical course. Their simulation-based experience on campus, which included low and high-fidelity simulation, included obstetrical and PEDS emergencies. In addition, study

participants also described unplanned, unscheduled in-situ simulation during their preceptorship, and in the transition to the role of the RN. As mentioned, participants expressed concerns with whether their clinical hours were used appropriately toward building a rich learning environment to prepare them for placement and subsequently for their transition to practice. In the guidelines for clinical placement and simulation by CASN (2015), broad recommendations for baccalaureate education in nursing include the consideration for appropriate choice of placement according to the level of fidelity aligned with the expected learning. In their choice of most effective placement, nursing faculty are urged to select between the use of traditional placements in the hospital and community settings, or the innovative use of simulation as a replacement or enhancement of clinical placement hours (CASN, 2015; RNAO, 2016). While some educators replace practice time with simulation, others opt to add simulation in addition to practical hours as a course enhancement. In other words, some nursing programs in Ontario use simulation as a strategy within a course, while in other nursing programs the use of simulation represents an extra-curricular experience in the simulation lab. Inconsistent practice reflects a need to explore an inventory of current simulation in practice education in nursing. In this study, participants view simulation within a course as replacement of traditional clinical time and although they regarded their simulation experiences positively, as senior students, they look for real-world experience that would aid their transition to practice.

Although CASN (2015) formulates principles for practice learning and recommends the use of a theoretical framework to guide simulation practice, the effectiveness of simulation strategies for entry-to-practice competencies in nursing education needs to be further studied. Simulation is used to provide learners with opportunities that would

otherwise be inconsistent due to limited availability of placement, competition from other programs, and high enrolment for smaller-sized specialized units (RNAO, 2016). Participants suggest that in simulation they could provide care that would otherwise become the responsibility of those students with a higher level of academic preparation. For them, simulation facilitates exposure to clinical scenarios that may not be experienced in their communities, a factor that may be particularly significant for northern and rural health education. CASN (2015) clearly outlines educational guidelines for the use of simulation in placement by emphasizing the appropriate use for the targeted learning goals. While there is limited availability of clinical placements in nursing, the participants indicate a wish to engage in simulation only when clinical scenarios carefully mimic a real-life setting. Hence, simulation that facilitates transition to practice requires a mutual understanding of the learning objectives set by the learner and the faculty (Jeffries et al., 2015; Parker, McNeill, & Howard, 2015). In the present study, participants articulate a desire to embody the role of the nurse in entry-to-practice.

Simulated patients. Simulated patients, often played by professional actors or volunteers who may have had a clinical encounter, are used to help the learners in simulation focus on their interpersonal skills and history-taking skills (Kneebone, 2009). Study participants felt that their interactions with simulated patients provided a meaningful connection because they authentically portrayed patients. Collaboration with simulated patients helps the learner develop professional identity in a supportive environment where role-playing leads to honing skills, knowledge, and ethical behavior (McLean et al., 2015). The use of simulated patients requires a standardized, scripted enactment of the nurse-patient encounter in which nursing students receive immediate feedback on their performance

(INACSL Standards Committee, 2016b; McLean et al., 2015). Participants point out interactions in simulation where the roles of the patient and family members were enacted by peers during nursing school in the hospital setting and identify a greater connection with the scripted, trained actor than with their classmates in the role. Through their interaction with the simulation patient, the participants are able to reflect on their words, their intentions, and their actions and, generally, participants allude to a mechanical, technical, and awkward approach with the HFS mannequin. Dieckmann, Gaba, and Rall (2007) describes the "as if concept" as a key to effective simulation where participants successfully suspend disbelief, reject the artificial aspects of the phenomenon, and willingly accept the experience as real patient care (p.189). By treating the mannequin as a person, the participants in this study arrive at an ability to accept the likelihood of the simulation-based experience as representing clinical reality. The use of simulation for the transition into practice may present a need to blend the use of HFS mannequins and simulated patients.

Uncovering the Meaning of Embodying the Role of the Novice Nurse

In general, nursing graduates who are striving to meet entry-to-practice requirements experience arduous work and study participants showcased an intense preparation for preceptorship, licensure, and employment as RNs as they simultaneously described their anticipatory emotions as new nurses. The new graduate nurses expected to hit the ground running yet seemed uncertain of how to step into the novice role. In this section, I gather the instances where the participants begin to integrate theory with practice, use experiential learning for repetition, incorporate reflective practice through debriefing, build a patient safety culture, and explore their role within the interprofessional team.

Integrating theory with practice. Participants displayed pride for their recent accomplishments and yet often felt overwhelmed by their responsibilities as nurses. They shared an intrinsic desire to apply theory to practice and looked for opportunities to integrate the classroom, clinical practicum, and simulation to foster the acquisition of imaginative thinking in nursing (Benner et al., 2010). Their desire to integrate theory to practice may be assisted by their experiences in simulation activities. Research suggests that facilitation of learning in simulation-based experiences integrates theoretical knowledge with practical, hand-on application (INACSL Standards Committee, 2016b). In simulation, learners perform the role of the nurse, but also aim to acquire the decision-making skills required in nursing. As previously highlighted, participants enjoy situated learning as moments to focus on the application of knowledge in a clinical situation. Here, situated coaching is reviewed as a learning strategy for learners to blend theory with practice.

In situated learning, the connection between knowing and the learning environment cannot be separated (Lave & Wenger, 1991). In situated coaching, the nursing student depends on multiple interactions in the practice environment to model social behaviors and begin to craft their professional identity (Benner et al., 2010; Lave & Wenger, 1991). As participants make meaning in simulation-based experiences, they engage in practice and gain knowledge through making connections between the context, the lessons learned in their formal education, and the informal learning that occurs in the clinical setting. Participants indicated that the exploration of a rationale for behaviors occurs during the simulation debrief. Simulation may be well positioned in the transition into practice to provide situated coaching.

Learning by doing. In nursing education, the clinical practicum course is perceived as the most beneficial for acquisition of skills (Benner et al., 2010; RNAO, 2016; Veltri, 2015). The practical approach in the clinical setting, often combined with the use of simulation, is important to the nursing student wanting to learn through experience (CASN, 2015; Veltri, 2015). Few programs offer simulation during the final practicum as this is often a time of varying schedules, course work with full-time placement hours, and out-of-town placements (RNAO, 2016). However, participants in this study clearly indicated that simulation often occurred in an unplanned manner during preceptorship and that their familiarity with the simulation environments may have made them feel confident in participating in the workplace. In the present study, participants reported early exposure to simulation in their first semesters as nursing students and felt that the use of simulation throughout their undergraduate nursing studies may have provided them with a desire for practical learning opportunities as they entered practice. Many have had experience with in situ-simulation in their workplace and have also entered the hospital simulation lab on their own time to practice their technical skills. Simulation represents an optimal learning environment for new graduates to learn by doing and increase their confidence with the practical aspect of entering practice.

Simulation debrief. Participants described simulation as providing a reflective learning environment which promotes the development of the ethics of caring and the imaginative thinking to assume the role of the RN. The simulation debrief seemed to be the participants' top choice of a vehicle that enabled them to reflect on what to do and what not to do as nurses as they prepare to care safely for their patients. The INACSL Standards Committee (2016a) outlines that simulation-based experiences must incorporate a debriefing

activity with the purpose of reflecting on the participants' performance and creating new interpretation as well as future improvements in the provision of care. A simulation debrief is an opportunity to reflect on the relevance of the clinical situation, promote learner self-assessment, explore the rationale for behaviors, and close the performance gaps (Cheng et al., 2016). For the participants, debriefing was a time to engage in discussion, to learn strategies, to identify various responses, and to reflect on their future educational needs. Participants suggest that debriefing in simulation is most valuable, and claim that their debriefing session was often tailored to suit the learners with less pre-clinical preparation which typically involves a review of concepts and strategies applicable to the planned, live simulation scenario (Tyerman et al., 2016). Participants indicated a concern that the debriefing session was not as rich when learners overlooked the preparatory work. Because the assigned homework involves reading textbook chapters and best practice guidelines, many participants reported that the learners in simulation minimized the pre-clinical preparation. Regardless of the level of pre-simulation preparation of the group, the participants in this study suggested that pre-briefing and debriefing represented useful strategies in transition into practice. In looking back at their experiences in maternal-child simulation, participants felt that linking simulation to their licensure exam as well as to their transition into practice would enrich the debriefing moments in the final year of study. In their hospital-based simulation experiences, participants felt an increased motivation to prepare and utilize the debriefing session as reflection for future practice; however, as nursing students in the simulation lab, they perceived the homework as optional and something eventually captured in the debriefing dialogue. Simulation is viewed as useful to learn about clinical situations and build confidence in approaching a strategy for the licensure examination. One study participant

suggested that simulation-based learning could be used to remediate a failed attempt at the NCLEX-RN and that the debriefing would provide insightful reflections in their subsequent attempts to the exam.

As the new graduate nurse develops a professional identity, the simulation debrief provides an opportunity to reflect on the assimilation of knowledge, skills, and attitudes required to function as a nurse in practice. Ensuring that a learner-centered approach occurs in the debriefing period requires a skilled educator (Cheng et al., 2016; Jones & Hegge, 2008; Levett-Jones & Lapkin, 2014). The debriefing session should be effectively conducted by a competent facilitator in an environment conducive to reflective, purposeful learning (Gardner, 2013; Husebø, O'Regan, & Nestel, 2015; INACSL Standards Committee, 2016a). The debriefing activity assists the learner in translating the simulated experience into their practice and into the real clinical world (Fanning & Gaba, 2007; Raemer et al., 2011). The learners make sense of the simulation experience through an opportunity to reflect on their actions as nurses. In terms of considering the impact of reflective practice in simulation, further research is necessary to understand the transfer of learning into situations encountered by new graduate nurses (Raemer et al., 2011).

Building a patient safety culture through simulation. During the transition to practice, new graduates are faced with embracing a new culture and are expected to exhibit sound judgement as they learn to build an environment focused on patient safety. In the hospital, simulation is widely accepted as a way to create a culture of patient safety and to focus the team's function toward optimal outcomes for the patient. In simulation, learners take action as nurses and introspectively relate to the professional role they are embodying while finding ways to improve patient outcomes (Pelletier & Kneebone, 2016). Participants

complete the clinical scenario imagining their role, the patient's response, and the team's collaboration. However, that embodiment of a role in a mimicked environment produces varying degrees of comfort (Nielsen & Harder, 2013). When participants genuinely step into the simulated role, they are embodying the ethics of caring and improving their level of preparation in the real setting to translate their knowledge into practice (Raemer et al., 2011). Even within a safe, non-threatening environment, participants in the present study expressed concerns about assuming the role of the novice nurse and indicated impatience as they strove to think like proficient nurses. Graduates may benefit from greater preparation for their first year of practice by exploring concepts that relate to transition into practice while in simulation (Meyer et al., 2014; Murphy & Janisse, 2017). The stories of these participants suggest that simulation plays a part in the beginning of the nurse's journey in helping to shape a culture of patient safety and the development of the ethics of caring.

Engaging in collaboration. IPE brings healthcare professionals to learn together and from one another (CIHC, 2010). The experiential learning activities in simulation encourage learners to engage in collaboration (CIHC, 2010; RNAO, 2013; Rogers et al., 2017). Learning and collaborating with other health professionals leads to clarification of roles, interprofessional communication, collaborative values, coordination of decision-making, reflective practice, and teamwork (CIHC, 2010; Rogers et al., 2017; RNAO, 2013). While new graduate nurses work to shape their own professional identity and their nursing judgment, new RNs encounter a model of interprofessional collaboration (IPC) in their practice. IPC is a process of forming effective interprofessional relationships between learners, practitioners, consumers, and communities to achieve optimal health outcomes (CIHC, 2010).

While participants showed enthusiasm for simulation with other health professionals, they reported no occurrence of Sim-IPE events while studying on campus. For the participants in this study, the Sim-IPE experiences took place at the hospital while in preceptorship and into their new employment. While new graduates work within a model of IPE and IPC to provide care, the Sim-IPE exposure is minimal in nursing education and mostly limited to preceptorship where a nurse mentor in the hospital setting oversees the learning activities during the shift.

In nursing curriculum, the articulation of clear, leveled learning objectives for IPE competencies is essential to integrate assessment strategies and documentation tools in clinical practice (RNAO, 2013). In most nursing programs, there is a programmatic approach of combining formative and summative assessments of IPE competencies as learning outcomes in clinical courses (Rogers et al., 2017). The participants described formative assessments in simulation that made up one single component of their summative evaluation at the end of a clinical course over a semester. Similarly, in the workplace, new nurse graduates described mostly formative evaluations while high-stake, summative assessments are reserved for nursing certification required for employment in specialized settings such as the neonatal resuscitation, pediatric advanced life support, and advanced cardiovascular life support courses. In these courses, the learner participates in Sim-IPE for a high-stakes, summative evaluation and until then, the new graduate nurse has few experiences in high-stakes examinations using simulation. An important research gap exists around the use of Sim-IPE in the nursing transition.

Finding the Meaning of Embracing Life-Long Learning in Simulation

As the participants recounted their experiences in simulation, they took comfort in knowing that their previous exposure had led them to embrace simulation as a life-long learning opportunity. In the fourth theme, I provide evidence that simulation is adopted in the workplace for new graduate nurses to transition and denote the ways in which simulation is suited as a life-long learning strategy to ease anxiety in new nursing roles, to foster practice readiness, and to cultivate social imitation of expert nurses.

Simulation as a way to overcome anxiety as a novice nurse. New graduate nurses in the study consistently reported the use of simulation in their workplace and described simulation as integrated in their hospital orientation and widely used in specialty training. Hence, there is an increased use of simulation in hospital educational programs in perinatal, neonatal, and paediatric nursing and it has long been utilized in other areas such as emergency and critical care nursing (Rutherford-Hemming, & Alfes, 2017). Participants described the use of in-situ simulation that takes place in their real-life clinical setting to help them identify organizational and systemic challenges while learning about the technical and non-technical aspects of provision of care (Lutgendorf et al., 2017). The participants also expressed a sense of gratitude for the designated hospital simulation lab which seems to be available to drop-in and practice a skill. Patterson, Blike, and Nadkarni (2008) support the combination of in-situ simulation with scenarios facilitated in a simulation lab and participants agree that both lab-based simulation and in-situ simulation are beneficial to them as new hospital employees. Incidentally, in-situ simulation has only been accessible to the study participants as preceptorship students in their last weeks of placement. Based on this finding, nursing education programs may benefit from incorporating off-campus simulation earlier in the nursing curriculum since the participants in the study perceived benefits to

having an on-campus simulation lab combined with simulation activities in the hospital setting.

Hard days call for simulation. Participants speak about the adversity they faced preparing for entry-to-practice and mention meeting the following requirements for licensure: a jurisprudence examination, the NCLEX-RN, a criminal record verification, and payment of registration fees with their provincial legislative body. The early months of transition into nursing are often recalled as a stressful, challenging time in a nurse's career (Boychuck Duchscher, 2009; Dyess, & Sherman, 2009; Kramer, 1974; Parker et al., 2014). Participants spoke of moments where the transition into a new role was difficult as they feared that the academic preparation was insufficient to help them perform competently in critical situations. Boychuck Duchscher (2009) characterizes the new graduate experience as a time of frustration and disappointment and the adversity faced by the new nurse may have an impact on the ways they imagine the care provided to patients. What is seen in reality may not align with what they had imagined to be optimal work conditions. In these situations, the participants mentioned worrying about their ability to positively affect patient care and clinical outcomes. The new routine and workload may cause anxiety for the graduate who also puts high expectations on themselves to perform as they did as students (Casey et al., 2004; Parker et al., 2014).

The study participants used simulation as a way to achieve readiness for practice as they describe simulation lab activities in their last year of studies that combined simulation scenarios with NCLEX-RN competencies. However, they were also clear about their desire for increased specialty training, exposure to advanced roles and responsibilities in simulation. Several researchers note that the new graduate nurse experience is known to come with high

personal expectations, a high demand for mentors, a need for a solid residency period, and an adjustment period of approximately six to twelve months after their hiring (Boychuck Duchscher, 2009; Casey et al., 2004; HealthForce Ontario, 2017). According to participants, the transition into nursing is a time with no specific direction or guidance and simulation may provide a great opportunity to create conversation about what to expect in the transition into practice. Further research may help to further understand the impact of simulation in the preparation for the transition to practice.

Emulating expert nurses. A few participants are experiencing full-time employment under a provincial grant involving a temporary six-month nursing graduate guarantee residency program; as new nurses, they are working closely with a nurse mentor in a supernumerary position on the unit for an extensive transitioning period of six months (Health Force Ontario, 2017). Other participants set their own transition strategy through part-time staff RN positions on their unit and in a more informal way, establish their own mentorship with expert nurses. While full-time employment is limited in nursing, participants maintain a full-time complement of hours through temporary, contractual, and part-time employment. Their schedules tend to vary and shifts become available to them on a call-in basis, meaning they are not scheduled in an organized rotation of days, evenings, and nights. Under such precarious work conditions, the mentorship established by new graduate nurses and their mentors is difficult to nurture. However, as described in the literature, the new graduates in the study described a deep connection with expert nurses and a desire to emulate the expert nurse in order to improve their skill proficiency (Benner, 1984; Tanner, 2006).

When probed, participants related their admiration of the expert nurse to the ability to make clinical judgments and to seamlessly decide on the best course of action for the patient.

Clinical judgment is complex, ambiguous, contextual, undetermined, and often exposes conflicting values within a team (Tanner, 2006). The intricacy of clinical judgment is an abstract concept for nursing students, since as learners, they observe expert nurses make clinical decisions, critically think through complex situations, and offer clinical judgments with varying degrees of comfort (Benner & Tanner, 1987; Tanner, 2006). As participants expressed profound admiration for the nurses who demonstrate proficiency, they appeared eager to achieve expert nursing practice, which adds to their confusion of being a novice nurse. Simulation may be the optimal place for them to work with expert nurses and to vicariously learn through observing and imitating their actions (Zulkosky et al., 2016). The new graduate nurse values theoretical aspects of clinical judgment in nursing and wants to apply the knowledge acquired in nursing education in their nursing practice. Although participants agree that practical wisdom is acquired through experience, they look to enter practice with proficiency rather than viewing their first months in practice as post-graduate training, residency, and transition. Their rush to compare their abilities with the proficient, expert nurses produces feelings of anxiety with situations where clinical judgment is necessary in their new roles as RNs. As a result, there is an opportunity to examine the use of simulation-based experiences in the formation of professional identity and in the establishment of mentorship in the transition into practice.

Recommendations Based on the Lived Experience

In this section, I offer recommendations from the findings of the study as outlined in Table 5.1. and highlight a need to reflect on practice and policy issues relating to the new graduate nurse transition experience. In so doing, I reflect on the role that simulation might play both before and during the transition into practice.

The first recommendation arises from new nurse graduates wanting to experience immersive and realistic simulation during their education programs and in their entry to practice. The second recommendation stems from considering the intentionality of simulation and the strategies that integrate the transition experience. The third recommendation espouses the need to incorporate Sim-IPE to assist new graduates with practice readiness.

Table 5.1 Recommendations for the Use of Simulation in Nursing Education

Recommendations for Nursing Education
1. Design simulation-based experiences that are immersive, realistic, and accord careful attention to detail of the clinical environment being simulated. 2. Combine the unique needs of the nursing students approaching graduation with simulation-based experiences that integrate interactive strategies relating to the transition into practice. 3. Incorporate Sim-IPE into health education curriculum to assist new graduates with practice readiness.

Designing Simulation-Based Experiences with Careful Attention to Detail

Proper staging of the scene with moulage and role preparation creates an environment to excite the imagination (Dieckmann et al., 2007). Study participants describe an emphasis on mannequins and technological components of the experience rather than on attending to the potential relational elements of practice. Simulation-based experiences need to be immersive, realistic and carefully detailed. To live by Gaba's definition of simulation as a learning strategy not solely defined by its technology, simulation scenarios should provide learners with a close comparison to the real experience in nursing practice (Gaba, 2007; Stokes-Parish, Duvivier, & Jolly, 2017). The attention to detail is described as a priority to make learners feel like they have been set up for successful immersion into the clinical experience. Having everything in the right place for the simulation assists them to embody the role they are playing in the simulation without having to break from performance to ask

the facilitator a question or seek clarification. There are several moments of pretending in simulation that graduate nurses find disruptive in their thinking: pretending that there is fluid when the syringe is empty, hemorrhaging with no visible blood, a telephone call for help is required without access to a telephone or a call bell. The list of examples by study participants is plentiful and new graduate nurses are quick to point to them as unnecessary distractions. A lack of attention to detail often results in the learner implying that they would act differently in a real situation but empathy requires them to be mindful and curious about the clinical possibilities. The attention to detail in staging the simulation scene is important to shift the conversation to more profound topics of empathy, inquiry, and clinical imagination in the simulation debrief.

Realistic simulation fosters thinking about of what a nurse will really need to do in clinical situations (Stokes-Parish et al., 2017). The nurse graduate wants to uncover the moments where they are learning what they have to do in a particular situation, and what they ought to be doing as a good nurse. A messy set up creates unnecessary distractions from achieving learning goals and from shaping the clinical imagination required to transfer the playing-out of being the RN in practice. To truly delve into the ethics of caring, participants indicated that moulage of bodily fluids, injured body parts, and age-appropriate props are an essential part of the simulation-based experience.

Combining Strategies Relevant to the Transition into Practice

The second recommendation in this study is to combine the unique needs of the nursing students approaching graduation with simulation-based experiences that integrate interactive strategies relating to the transition into practice. To consider the intentionality of being in simulation, learners use simulation-based experiences to practice a skill while also

emulating a role and gaining an understanding of the relational practice that leads to achieving positive health outcomes for the patient and their family (Schoenherr & Hamstra, 2017). Encounters within the interprofessional team may bring nurses to understand and reflect on caring intentions and the embodiment of the ethics of caring in nursing. Interactions with the patient and their family also need to be realistically depicted in simulation to prepare the nurse to reflect on the real-world variations that exist in practice.

Intentionality is also relevant to unravel the moments in which a learner performs unsuccessfully in a practical situation (Schoenherr & Hamstra, 2017). In these instances, patient safety becomes a priority and the risks need to be carefully considered. In order to understand a near-miss occurrence that can pose a danger to patients, nursing educators may need to attend to the design and the level of pre-simulation preparation completed through the recommended readings, assignments, and homework (Tyerman et al., 2016). It is essential to address the emotional responses triggered in simulation, especially when the learner is preparing to enter practice. As new graduate nurses experience in-situ simulation which requires them to run through a procedure in the clinical site, they report those moments as ideal to learn how to handle a situation, and reflect on their emotional reaction to clinical scenarios. Although the new graduates in the study described the anxiety and the fears in their first human encounters that required them to use their skills, knowledge, and judgment, they also tell their stories with joy. The senior-level student needs preparation for hospital in-situ simulation bringing learners from various disciplines together to learn a procedure in a practical approach (Lutgendorf et al., 2017; Patterson et al., 2008).

CASN (2015) recommends appropriate use of clinical placement and simulation in nursing education and the new graduates in the present study concurred. The participants

were concerned that clinical hours are being ineffectively used when the simulation environment is not being taken seriously; they further advocated for the use of simulation to achieve practice readiness.

Most nursing programs in Canada take the approach of early exposure for simulation as a pedagogy and learners may adopt simulation as a strategy throughout their career if introduced early in the nursing curriculum (CASN, 2015; RNAO, 2016). Since the use of simulation in the workplace may offer continuing education opportunities, there is a need to explore educational practices in the transition into nursing (Murphy & Janisse, 2017).

Incorporating Sim-IPE to Enhance Practice Readiness

The third recommendation is for the incorporation of Sim-IPE into the health education curriculum in order to assist new graduates with practice readiness. This recommendation calls for the inclusion of the CIHC competencies in the simulation design and delivery. The use of Sim-IPE enhances collaborative relationships leading to improved quality of care and patient safety (Krueger, Ernstmeyer, & Kirking, 2017). Therefore, there is a need for ongoing commitment by nursing educators to incorporate Sim-IPE in their curriculum. Likewise, further studies are needed to understand the transferability of interprofessional learning outcomes into nursing practice. While in their undergraduate nursing program, the participants shared experiences of learning mainly with other nursing students, noticeably leaving out Sim-IPE experiences until their entry into practice where Sim-IPE is used widely. The infrequent use of Sim-IPE represents an important gap in the study. Future research may explore the use of Sim-IPE in the transition into nursing and explore the ways that nursing graduates may be better prepared for this experience.

Limitations

There are several limitations to this study. As I gained an understanding of being a new nurse graduate entering practice in a world where simulation is used as pedagogy, undoubtedly, my own simulation experiences represented an important bias that I needed to consider throughout the study. I brought my values, my teaching philosophy, and my guiding assumptions in practice to this research. Through reflexivity, I carefully situated my role in this inquiry by identifying my approach to the theoretical stance, the methodology, the design, and the methods. I brought in my past experience when putting together interview questions for participants and in the conversations about simulation, practice education, and transition into practice. In my data analysis, I used phenomenology of practice to read and write, forward and backwards, the narrative accounts of the new graduate nurses' perspectives on using maternal-child simulation in the transition in nursing. To validate my findings, I incorporated member-checking as a third interview in the data collection phase where the participants reviewed the transcripts and the emerging themes from the research findings.

Although the study originated from an interest in maternal-child simulation, the use of phenomenology provided a lens for discovering stories about the nursing transition of new graduate nurses. Keeping the stories within the specialty of maternal-child nursing created a limitation in this research. While the research tried to capture the experience of nurses in transition who have used maternal-child simulation as part of their learning, the participants described real-life encounters, and emotions relating to their entry into nursing, making it difficult to connect those experiences to the use of simulation. To accurately capture the essence of being new graduate nurses using maternal-child simulation learning, the

participants' experiential descriptions of entering practice informed the study on their lived experience.

The lived experience of the new graduate nurse in this study is not viewed as representative of the entire nursing population. However, the authenticity of their experiential account offers the perspective of new graduate nurses using maternal-child simulation in their transition into nursing. Although the findings are not generalizable to a larger context, the recommendations in the study may offer insight into maternal-child simulation experience and general use of simulation in the transition into practice. The stories represent the participants' own exposure to simulation during the final clinical placement in an undergraduate program in nursing and into their new professional life as RNs.

Future Research Recommendations

Given the contributions of these results, I will situate my research as an opportunity to identify areas for more research in clinical nursing simulation. Firstly, the next research step is to create an inventory for the current utilization of simulation-based experiences in Canadian nursing education to describe the current blend between traditional placement and simulation in practice education. Since the new graduate nurse experience appears to lack Sim-IPE exposure, additional studies on the use of Sim-IPE in health education may inform current practice in nursing education. Future research could also examine the transferability of maternal-child simulation into nursing practice and could offer valuable information on the formation of nurses in their transition into practice.

Careful attention to details of the simulation scene appears to be a significant consideration in being able to immerse learners in simulation. Having heard participants express their desire for a simulation-based experience that comes as close to reality as

possible, there is an obvious need for further studies of the intricate details that affect fidelity to discover the reasons for the art of moulage being overlooked in the implementation of simulation scenarios.

In addition, the participants are left looking for more depth in the simulation debriefing. They described the debriefing phase as an opportunity to connect their simulation experience to the real clinical world. They outline the simulation debriefing as the richest part of simulation; however, they looked for more profound conversations about their transition into practice. The literature is plentiful on the role and benefits of debriefing in simulation; yet the debriefing session is often focused only on the task being accomplished, the errors that occur, and the remediation to provide better care. Participants in the study saw the debriefing also as an opportunity to reflect on their actions in an existential manner; in a way that explores their identity, their intentions, and their emotions triggered in the situation. Simulation offers an opportunity for the nursing student in their final placement to explore the following questions: What would the new nurse graduate do in this situation? What preparation would the new nurse graduate need to be successful in this situation?

Lastly, the participants in the study embraced simulation as a life-long learning strategy for clinical practice and called for simulation-based experiences in a simulation lab combined with in-situ simulation in the clinical setting. Further studies may need to investigate the combination of simulation lab and in-situ simulation in order to prepare the graduate for the workplace.

Final Reflections

Although the study findings are not generalizable or reproducible to the new graduate nurse population, the lived experiences of participants do provide a sense of what it is like to

be a nurse entering practice with simulation exposure in maternal-child nursing. My take-home message is two-fold: the lived experience in the study reveals that clinical imagination immerses learners in simulation-based experiences in entry-into-practice; secondly, new graduate nurses take an interest in maternal-child simulation when approaching readiness for practice. The novice nurse requires a multitude of experiences, and simulation represents a strategy for learning how to become a nurse and how to perform the scope of RN practice.

Shaping clinical imagination in simulation. I conclude this study by highlighting the significance of shaping clinical imagination in simulation-based experience to effectively integrate the use of traditional placement with simulation. I am also marked by the level of trust instilled by learners engaging in simulation scenarios, especially under circumstances where mandatory hours were replaced with simulation-based experiences. The participants took their simulation-based experiences to build on the forethought of what could happen in real-life. In the ethical duty to care for others safely, nurses must imagine the multiple clinical scenarios that may present themselves in practice and there are multiple ways to shape the self-perception of being a nurse. The use of imagery is important in simulation and in the transition into practice as it leads to the embodiment of the role of the nurse. The essence of being nurses requires fully immersing ourselves into our imagination of what it means to dedicate ourselves to the ethics of caring, to do what is right in complex clinical situations, and to respond skillfully to life altering situations. The stories in the study showcase the use of simulation and how it may potentially develop professional identity, self-perception, knowledge, attitude, and values required to safely and competently provide care.

Ongoing exposure to simulation to develop a professional identity. It is important to note that all study participants had experienced maternal-child simulation during their professional education program and were recruited using this experience as a criterion. As a result, many of their comments regarding simulation reflected at least a part of that experience; yet our conversations extended beyond that experience into their transition to practice. Perhaps because of their initial experience, several nurse graduates sought specialization in maternal-child fields such as perinatology, neonatology, and paediatrics (Wolff et al., 2010). However, those who were specializing in emergency nursing also expressed a need to maintain competency in maternal-child emergencies and indicated a similar need for ongoing exposure to maternal-child simulation and to simulation in general in their clinical practice. They described lab simulation experiences and mock codes in the clinical site as ways to facilitate their learning in the workplace and ease the anxiety and trepidation during their transition to practice.

Summary

In this chapter, I returned to the research questions to explore the implications of this study. This inquiry began with the use of maternal-child simulation in nursing education and extended into the transition to practice. Analysis revealed the four emerging themes of performing like a nurse, forming a clinical imagination, embodying the role of the novice nurse, and embracing life-long learning in simulation. I summarized three recommendations based on the lived experiences as I reflected on the meaning of being in simulation for novice nurses in entry-to-practice. Finally, I drew conclusions to identify research limitations and future research recommendations which are doable, actionable, and applicable to nursing practice.

Future research needs to investigate another dimension of using simulation in the new nurse graduate experience. Following this study, there is a need to explore the professional identity of becoming a nurse and uncover the role simulation plays in this formation.

Conclusion

When I began my research journey, I was fascinated by the role of maternal-child simulation in the education of new nurses. As a nursing educator, I wondered whether my own experiences as a new nurse, a nurse in practice, and a nurse educator might be reflected in the experiences of new graduate nurses. Thus, I began the study with the intent to recruit nurses with experience in maternal-child simulation during their program and in the early years of practice. My initial conversations with them focused on maternal-child simulation experiences but soon moved to what was for them more immediate; true to phenomenological research, the lived experience became about the participants' transition into practice and the stories that emerged were honest, passionate, and reflective of the hard work and dedication that goes into becoming a nurse.

Their stories were messy and uncertain as they described their journeys toward understanding the meaning of being a nurse. They offered beautiful moments of learning within the first days, weeks, and months of entering practice and their stories inform the reader about what it is like to be a new nurse who experienced integrated, innovative maternal-child simulation. As the participants narrate the intimate ways that have helped them bring theory and practice closer together, they highlight a desire to develop a clinical imagination and be immersed in simulation in their entry into practice. Yet their lived experiences raised more questions about the connection between nursing education, simulation, and practice readiness.

I was left wondering about their continued paths and about my own research journey as the study ended. As a researcher, I have learned to attend to the voices of the participants, and that the phenomenological research methods must honor the lived experience. I have

learned much from the participants of this study; I appreciate their willingness to share their most intimate details of their entry to practice and the ways in which it could be facilitated by careful, thoughtful use of simulation. I will take with me what I have learned from them in my work with other nurses entering the profession.

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Appendix A- Participant Recruitment Letter

Dear Nursing Alumni,

I am a student in the PhD in Educational Sustainability at Nipissing University and I am seeking interested participants for my doctoral research. I am inviting nursing graduates to participate in a research study entitled: *The Lived Experience of Learners in a Practicum Using Maternal-Child Simulation*. The research supervisor for this study is Dr Sharon Rich, Nipissing University. This study (REB #101000) has been reviewed by the Research and Ethics Board at Nipissing University.

The purpose of the study is to understand the practicum learning experience using maternal-child simulation. You are being invited to participate in this study because you are a graduate nurse within the past 2 years from a program offering maternal-child simulation during your clinical practicum. If you decide you want to participate, my name and contact information are provided at the end of the information letter. For this study, you will be invited to participate in a series of 3 face-to-face or Skype™ interviews to describe your experience in maternal-child simulation as a new graduate of the nursing program. The first interview will take approximately 30 minutes and will involve guided questions around maternal-child simulation and some of your clinical experiences. These questions will be made available in advance for participants to review. Two weeks following the first interview, you will then be invited to participate in a second 30-minute interview guided by a review of the descriptions and to add what you think is important in maternal-child simulation. Once the information has been carefully reviewed, a third interview of approximately 30 minutes will serve to review and verify the descriptions of your experience. All interviews will take place in a quiet, private, safe space to be designated by the participant and out of ear-shot of others (ie. library, coffee shop, restaurant, office on campus). The first two interviews will be digitally audio-recorded.

Participation in this study is voluntary and there are no consequences of choosing not to participate in the study. There are no right answers and you may choose to respond to only the questions you are comfortable sharing with the researcher. You have the right to withdraw at any time without penalty or consequence.

Some people may find being asked about their experiences and or reflecting on their experiences intrinsically beneficial and this would be personal to each participant. Some people may find it beneficial to offer information providing an overall picture of their simulation use in an undergraduate nursing program in Ontario. The goal is not to assess specific trends or approaches.

In this study, there is no identified potential for physical harm. Emotional distress such as embarrassment or worry is an inherent risk for a participant disclosing intimate details of a learning environment.

Participants can connect with counselling services such as the XXXXX by phone XXX-XXX-XXXX should the need to reach out for help arise from participating in the study.

Your participation in the study is private and confidential. Raw data containing individual identifiers will be collected at the beginning of the interview and will be available only to the PhD student and thesis supervisor in the study. Pseudonyms will be used throughout this research to protect the confidentiality of the participants.

A summary of findings in the study will be provided by email to participants of the study. The results of the study could be published and/or presented at conferences. All reference to individual participants will be removed when reports, presentations, and discussions are prepared, thereby protecting the confidentiality of the participant.

[redacted]

Sincerely,

Laurie Peachey, RN, BScN, MN, PhD (c)

This study has been reviewed and received ethics clearance through Nipissing University's Research Ethics Board. If you have questions regarding your rights as a research participant, contact: Ethics Administrator, [redacted]

Appendix B- Interview Guide

The phenomenon studied is the lived experience of learners in a practicum that offered simulation.
The research questions in the proposed phenomenological study are:

1. What is the lived experience of new graduate nurses entering practice after a practicum with maternal-child simulation?
    a. In what ways does the lived experience in maternal-child simulation prepare for reflective practice?
    b. In what ways does the lived experience in maternal-child simulation develop the ethics of caring?
    c. In what ways does the lived experience in maternal-child simulation support clinical imagination?

Interview #1
The proposed guiding questions will begin to examine the nature of your lived experience with the research questions in mind:

a) Describe your maternal-child simulation scenario.
b) What dimensions, incidents and people intimately connected with the maternal-child simulation experience stand out for you when thinking about the time spent in a simulation practicum?
c) How did the maternal-child simulation experience affect you?
d) What changes in your nursing skills, knowledge and attitude can be associated with the simulation experience?
e) What feelings were generated by the maternal-child simulation experience?
f) What thoughts stand out for you when remembering the maternal-child simulation experience?
g) What bodily changes or emotional states were you aware of at the time?
h) What do you imagine your clinical response to the maternal-child simulation clinical scenario will be if it presents itself in clinical practicum in the near future?
i) How does the maternal-child simulation experience affect your future learning goals?
j) Describe other significant thoughts relating to the maternal-child simulation experience.

Interview #2
These 3 broad questions will be tailored to add to the descriptions given in the first interview.

a) Since our last meeting, what changes in your nursing skills, knowledge and attitude can be associated with your practicum and the simulation experience it offered?
b) Have you encountered situations in your practice and/or in your studies toward the licensure examination (NCLEX-RN ©) that reminded you of your experience in maternal-child simulation?
c) Do you have anything to add to your description of your maternal-child simulation experience?

Appendix C- Interview Guide Protocol

This guide will be used prior to initiating the first interview. This part of the interview will not be audio-recorded and will be kept separate from the transcribed data of the interview.

Introduction
Thank you for participating in the study. What you share in this /interview will be kept confidential. You may be identified in the study report through the use of a pseudonym and in a way that will not reveal your individual identity such as, "Graduate nurse _____ said," so please tell me what you really think and feel; this will be the most helpful in examining the lived experience in maternal-child simulation in nursing education.

Digital audio-recording
I will be tape recording the interview to try to make sure that we have an accurate record of your views and I also will be taking a few notes for the same purpose.

Do you agree to allow me to tape-record this interview?

If NO: I will be available to meet with you for an individual interview where the audio recorder will be turned off.
If YES: Thank you, I will proceed with the interview.

Follow-up
This permission also confirms your agreement to be contacted at a later date to review your interview as data analysis begins to identify themes.
If NO: I will not be able to provide follow-up information on the findings of this study.
If YES: Thank you, I will use your contact information for follow-up when the data is transcribed and interpreted.

Demographical information collected
I will collect a few demographics relating to your nursing education. This information is private and confidential and will not be connected to your descriptions of simulation.

LOG OF INITIAL INTERVIEW INFORMATION
Date of interview: _____Time: from _____ to _____
First Name: _____Participant Pseudonym_____
Contact information to use for subsequent interviews _____

Title or topics of the maternal-child scenarios used	Year of graduation	Highest level of education prior to enrolment in the program	Area of practice for final practicum preceptorship experience

Appendix D- Follow-up Letter for Participants

Date:

Dear [Name of Participant]

Please accept my sincere thank you for taking time in your schedule to be a participant in my study entitled "The Lived Experience of Learners in a Practicum Using Maternal-Child Simulation". Your contribution to the body of knowledge being developed in the field of maternal-child simulation in nursing education is greatly valued. Your willingness to provide your lived experience with this learning strategy will help examine the meaning of maternal-child simulation during clinical practicum.

Sincerely,

Laurie Peachey, RN, BScN, MN, PhD (c)

This study has been reviewed and received ethics clearance through Nipissing University's Research Ethics Board. If you have questions regarding your rights as a research participant, contact: Ethics Administrator, Nipissing University, 100 College Drive, North Bay, Ontario, P1B 8L7 or [redacted]

Appendix E- Research Ethics Board Approval Letter

Ms. Laurie Peachey
Schulich School of Education
Nipissing University

File No: 101000
Expiry Date: ***May 05, 2017***

Dear Laurie,

It is our pleasure to advise you that the Research Ethics Board (REB) has reviewed your protocol titled 'The lived experience of learners in a practicum using maternal-child simulation' and has granted ethical approval. Your protocol has been approved for a period of one year.

Modifications: Any changes to the approved protocol or corresponding materials must be reviewed and approved through the amendment process prior to its implementation.

Adverse/Unanticipated Event: Any adverse or unanticipated events must be reported immediately via the Research Portal.

Renewal/Final Report: Please ensure you submit an Annual Renewal or Final Report 30 days prior to the expiry date of your ethics approval. You will receive an email prompt 30 days prior to the expiry date.

Wishing you great success on the completion of your research.

Sincerely,

Dana R. Murphy, PhD
Chair, Research Ethics Board

Appendix F- Participant Information Letter and Consent Form

You are invited to participate in a research study entitled: *The lived experience of maternal-child simulation in nursing education*. This study (REB # 101000) has been reviewed by the Research and Ethics Board at Nipissing University. Please read the following carefully, and do not hesitate to ask any questions that you might have of the researchers.

Researchers
This study is being conducted by *Laurie Peachey* as a partial fulfillment of the PhD in Educational Sustainability at Nipissing University. The research supervisor for this study is Dr. Sharon Rich, Nipissing University.

Purpose and Procedure
The purpose of the study is to understand the practicum learning experience using maternal-child simulation. You are being invited to participate in this study because you are a graduate nurse within the past 2 years from a program offering maternal-child simulation during your clinical practicum. If you decide you want to participate, my name and contact information are provided at the end of the information letter. For this study, you will be invited to participate in a series of 3 face-to-face or Skype™ interviews to describe your experience in maternal-child simulation as a new graduate of the nursing program. The first interview will take approximately 30 minutes and will involve guided questions around maternal-child simulation and some of your clinical experiences. These questions have been made available in advance for your review. Two weeks following the first interview, you will then be invited to participate in a second 30-minute interview guided by a review the descriptions and to add what you think is important in maternal-child simulation. Once the information has been carefully reviewed, a third interview of approximately 30 minutes will serve to review and verify the descriptions of your experience. All interviews will take place in a quiet, private, safe space to be designated by the participant and out of ear-shot of others (ie. library, coffee shop, restaurant, office on campus). The first two interviews will be digitally audio-recorded.

Right to Withdraw
Participation in this study is voluntary and there are no consequences to choosing not to participate in the study. There are no right answers and you may choose to respond to only the questions you are comfortable sharing with the researcher. You have the right to withdraw at any time without penalty or consequence. Participants can withdraw from the study by contacting Laurie Peachey by email at [redacted]

Potential Benefits
Some people may find being asked about their experiences and or reflecting on their experiences intrinsically beneficial and this would be personal to each participant. Some people may find it beneficial to offer information providing an overall picture of their simulation use in an undergraduate nursing program in Ontario. The goal is not to assess specific trends or approaches.

Potential Risk or Discomfort
In this study, there is no identified potential for physical harm. Emotional distress such as embarrassment, worry is an inherent risk for participant disclosing intimate details of a learning environment. Participants can connect with counselling services such the [redacted] should the need to reach out for help arise from participating in the study.

Confidentiality
Your participation in the study is private and confidential. Raw data containing individual identifiers will be collected at the beginning of the interview and will be available only to the PhD student and thesis supervisor in the study. Pseudonyms will be used throughout this research to protect the confidentiality of the participants.

Storage of Data
All data will be stored in a password-protected encrypted USB key in a locked drawer in a research team member's office, and available only to the PhD student researcher and the thesis supervisor. Raw data containing individual identifiers collected at the beginning of the interview will be coded and stored on a password-protected encrypted USB key under double lock and stored separately from other data. The code sheet connecting the identifiers with the data will be permanently deleted at the conclusion of the study.

Incentives for Participation
There are no monetary incentives to participate in this study.

Dissemination of Results
A summary of findings in the study will be provided by email to participants of the study. The results of the study could be published and/or presented at conferences. All reference to individual participants will be removed when reports, presentations, and discussions are prepared, thereby protecting the confidentiality of the participant.

Contact information
If you have any questions or concerns about the research, please feel free to contact: PhD student, Laurie Peachey, [redacted]

Consent to Participate
As a participant in this research project, I clearly understand what I am agreeing to do, and that I am free to decline involvement or withdraw from this project at any time, and that steps are being taken to protect me. I have read the Participant Information Letter and Consent Form and my questions were answered to my satisfaction. I have been provided a copy of this letter. I consent to participate in the study. I give permission for digital audio taping during interviews.

_____	_____	_____
Print Name	Signature of the Participant	Date
_____	_____	_____
Print Name	Signature of the Researcher	Date

This study has been reviewed and received ethics clearance through Nipissing University's Research Ethics Board. If you have questions regarding your rights as a research participant, contact: Ethics Administrator, Nipissing University, 100 College Drive, North Bay, Ontario, P1B 8L7 or [redacted]