Discussion paper

Role transition in primary care settings

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ABSTRACT

Background This paper reports on research that explored how nurses who are engaged in advanced practice adapt and adjust to their roles in primary and community health settings. Successive government policy has highlighted how the changing roles of nurses, who are engaged in advanced practice, are crucial to delivering high-quality patient care. The paper offers a framework for role transition which is potentially generalisable to doctors, physiotherapists and other healthcare professionals. The aim of the study was to enable an understanding of role transition, from a study of nurses going through changes to their roles or moving to new roles. The intended purpose of the study was to explore what was going on within role transition, and considers by what process(es) role transition evolves or is experienced.

Method Eleven nurses' actions, expectations, and experiences of role transition were explored, within three district nurse centres and two community NHS trusts. Data were collected from participant and non-participant observation, content analysis of job descriptions and from individual and group interviews, including semi-structured schedules and focus group techniques. Data were comparatively analysed to conceptualise and saturate core themes, which were discussed and developed with participants and healthcare managers.

Results A theory of role transition is proposed through a model representing the 'who', 'what', 'where' and 'how' of role transition, through four concepts of centring identity(ies); focusing role(s); enacting role(s); and shaping role(s). Identity was regarded by the participants as being the role, the person, and as part of a group. Current and anticipated role foci directed enactment of role within given contexts and resources, while shaping of role involved a balance of role loss and role expansion.

Conclusions This article presents a theory of role transition for primary care professionals.

Keywords: change management, health, role, workforce

How this fits in with quality in primary care

What do we know?
We know that role change is inevitable and a constant dynamic of being a healthcare professional. We know this is stressful, is not co-ordinated and is often inadequately supported.

What does this paper add?
This paper adds knowledge of the 'who', 'what', 'where' and 'how' of role transition, so that individuals and employers can use the information on role development and progress towards the implementation of healthcare initiatives that impact upon the roles of the workforce charged with delivering changes to improve care and health outcomes. It is hypothesised that identification of a role-transition framework and processes will allow role transition to be shaped and developed by nurses and healthcare professionals in collaboration with mentors and managers, to manage the health of the workforce and to meet changing healthcare objectives for users.

Introduction

This paper is part of a wider study comparing and analysing role transition in hospital and community contexts, and focuses on data relevant to nurses working in primary care. It focuses on role transition, as experienced by nurses going through changes to existing roles, or parts of roles or multiple roles, held singly or with others.

My work may be regarded as an attempt to clarify the 'who', 'what', 'where' and 'how' of role transition, through four concepts of centring identity(ies), focusing role(s), enacting role(s), and shaping role(s). The 'why' and the 'when' to undertake role transition are set by the organisation/company and then engaged with by the individual or team.

Constant change

Over the past quarter of a century we have seen increasing privatisation of health services provision alongside a move away from long-term hospital-based care provision, towards care in the community with an increasing focus on primary healthcare.[1] Management reorganisation and changes to nursing education have been more or less continuous since the 1980s, and for nurses (and other health professionals) have resulted in many role, context and cultural changes. Each change claims to be for the benefit of patients and to prepare nurses for meeting contemporary and projected healthcare needs, and then a few years later more changes aspire to redrafted but similar goals. In the 1990s these changes included further NHS reforms, development of internal markets, differing approaches to management, audit and contracting, hospital and community health trust formations, patient choice and consumerism, needs assessment, and multidisciplinary team work. Aspects of these continue today amidst practice-based commissioning, choose and book options, and continued structural changes to the NHS, with constant political and professional debate with regard to finance, workforce planning and further reforms, such as the Exploring New Roles in Practice (ENRiP) project which was carried out for the Department of Health.[2]

This rapid and relentless pace of change in primary and community care means that nurses are trying hard to adapt to recent ideas and structures, while more current changes or revised systems are being implemented. Indeed, many practising community nurses will have seen four major reorganisations of health service structures during their careers, changing working practices, employers, pay and conditions.[3] Change is a regular aspect of the health service and leading on initiatives offers the potential for positive benefits and opportunities for community nurses to expand and develop their roles through examples such as professional self-regulation, skill mix and team working, and nurse prescribing, personal medical services, nurse-run practices, and practice-based commissioning. New and evolving posts in case management, specialist community public health nursing roles, specialist community children's teams, nurse practitioners, as well as changing foci with regard to first contact care, continuing care and public health all emphasise the importance of understanding how nurses change roles.[4]

Role theory

A wide source of role literature has been explored, including classic texts in this field, which cite eminent theorists such as Mead, Merton, Davis, Sarbin, Goffman, Parsons, and Strauss.[5–7] These have developed knowledge of role entry, role exit, stress and conflict research, role change outcomes, policy, identity and personality effects from role change. The organisational impact of role change has been considered, and strategies to manage this suggest preceptorship and training to be able to undertake roles, with support of the individual by attempting to reduce conflict and stresses for example. A preceptor in this context would be a colleague with knowledge of the organisation and clinical practice, who could teach, motivate and support the development of an individual through a period of role change.[8–10] However, the available literature falls short of insight into what role transition consists of and how this affects the individual experiencing a role change; accordingly, the literature cannot provide direction to the preceptor or preceptee.

Within the setting studied, preceptorship and training focused on outcomes of undertaking a role and meeting role descriptors. These did not describe how to change or what occurs in transition to facilitate effective role transition and development. The importance and values of reforms and ensuing role transition are expressed in terms of patient benefit, improved outcomes, and organisational effectiveness. However, the impact on the workforce and the individual and his/her values or what the role means to him/her is not evaluated in the literature, nor are the context variables that impact on knowledge of role being derived. I am concerned that the NHS workforce needs are not addressed or are considered to be of less importance than the user and carer outcomes that the workforce enables.

An understanding of role arises from an appreciation of the activities of the role holder as these meet the expectations of teams, colleagues, patients and other stakeholders. Although performance in one's actions can be enhanced, this is finite, whereas expectations of healthcare professionals are infinite. This

concept can be expanded by considering that each person can fulfil more than one role on occasion, or as demanded by one's context, and may have roles within roles. Role transition can be viewed as a process of moving from one role to another role through a series of events and episodes. Role transition may be an ongoing developmental process, or may be viewed as a specific response to a trigger event such as a job promotion or move to a different context, or differing focus, e.g. taking on a new responsibility for pain control. The population of nurses who have had a job promotion or move to a different context, or change in focus, is undefined but presumed to be considerable, due to the ongoing healthcare changes referred to above. Indeed I suggest that all nurses are involved in a noticeable role transition at some point every year.

The principal aim of the study was to develop an understanding of role transition in practitioners and managers, from a study of nurses going through changes to their roles or moving to new roles. The purpose of the study was to explore what was going on within role transition, and consider by what process(es) role transition evolves or is experienced.

Methods

Study design

An exploratory research design was developed, which drew upon a contextual constructivist position influenced by grounded theory. Exploratory designs have two major goals; the first is problem discovery, the second is problem definition.[11] Both goals were achieved; however the definition of role transition as it applies to a range of practitioners will require further research to examine the wider or different contexts in which that role is changed.

Population and sampling

The population of research participants from the clinical settings were all Nursing and Midwifery Council registered Part 1 Level 1 qualified general nurses, regardless of age, sex, ethnic origin, grade, length of time qualified, full-time or part-time, who had undergone a role change in the past 12 months. Some were staff nurses and some were designated as ward managers, sisters or charge nurses.

A tiered approach to sampling involved:

- convenience and purposive sampling of settings
- purposive sampling of nurses who met the criteria of being registered nurses who were undergoing role transition or who had commenced a role transition within the past 12 months
- theoretical sampling of data collected from nurses by observation and individual interview and group interview.

The latter is interpreted as sampling data and not sampling participants; I took the position that, once collected, data could be sampled, fragmented and analysed separately from the nurse, yet the nurse and setting provided context to inform analysis. Theoretical sampling allowed me to return and revisit the data numerous times as concepts and theory emerged and directed my comparative analysis of these data.

Observation and interview of nurses individually and in groups produced a vast array of data, and I utilised the principle of theoretical sampling to seek specific data contributing to the emergent theory. Data for analysis were thus regarded as specific information about emergent concepts and role transition, rather than general discussion. It was the participants' contextually constructed knowledge and meanings which were the data and were theoretically sampled and comparatively analysed.

This article draws from a wider study of 27 nurses as individuals and as team members. Specifically this article focuses on data collected from 11 registered nurses working in primary care settings, shown in Table 1. All were female, aged 25–40+ years; three of the role changes studied were promotions to sister/manager roles, four were staff nurse promotions with increased responsibilities, and the remaining four role changes were extending roles into: a pain management role, an intravenous therapy role as 'pump' nurse, a prescribing role, and a rapid assessment role.

Specific, testable correlations were not drawn between the tabulated source information (see Table 1) and the emergent role transition theory. This information was recorded in order to contextualise the data rather than for any purpose of correlation or verification. However, the potential exists for this analysis in the future.

Data collection

The data collection methods for the study were:

- content analysis of job descriptions
- individual participant and non-participant semi-structured interviews
- individual observations of roles in practice
- focus group interviews
- follow-up conversations
- open group discussions of role transition
- group discussions evaluating transition theory.

Table 1 Details of the 11 participants and data sources

Sex	Age (years: 20–30, 30–40, 40+)	Nursing education	Length of time qualified as RN (years: 0–5, 5–10, 10–15, 15–20, 20+)	Time in prior role (years)	Role transition; post	Full-time/part-time	Context	New or existing environment
Female	30–40	RGN plus two courses	15–20	5	Promotion to junior sister	Full-time	District/community	Role transition involving move to *new* environment
Female	20–30	Diploma plus four courses	5–10	5	To DN from hospital; senior staff nurse	Part-time	District/community	Role transition involving move to *new* environment
Female	40+	Diploma plus four courses	5–10	6	Extending prescribing role; senior sister	Full-time	District/community	Role transition within *existing* environment
Female	40+	Degree plus 2 courses	20+	4	Promotion to senior sister/manager	Full-time	District/community	Role transition involving move to *new* environment
Female	20–30	Diploma plus 1 course	0–5	2	Extending assessment role; senior staff nurse	Full-time	District/community	Role transition within *existing* environment
Female	20–30	Degree plus one course	0–5	2	Senior staff nurse	Full-time	District/community	Role transition involving move to *new* environment
Female	20–30	Degree plus two courses	10–15	2	Senior staff nurse	Full-time	District/community	Role transition involving move to *new* environment

Table 1 Continued

Female	30–40	Diploma plus one course	10–15	3	Promotion to senior sister/ manager	Full-time	District/ community	Role transition involving move to *new* environment
Female	20–30	Diploma plus two courses	5–10	2	Extending intravenous therapy role – 'pump' nurse; junior sister	Full-time	District/ community	Role transition involving move to *new* environment
Female	20–30	Degree plus two courses	10–15	3	Senior staff nurse	Full-time	District/ community	Role transition within *existing* environment
Female	30–40	Diploma plus three courses	10–15	4	Extending pain-management role; senior staff nurse	Full-time	District/ community	Role transition involving move to *new* environment

Comparative analysis and conceptualisation

Within this study, comparative analysis and conceptualisation to theory occurred alongside each other, and at times together with data collection. The process of comparative analysis is considered to be a general method and generates conceptual categories, conceptual properties, and generalised relations among the categories and properties.[12–14] The method of constant comparative analysis enables an evolving focus of the research to emerge as the data or evidence become clearer, and in role transition this accommodated the changing data source as the participants continued in their role transitions while participating in the research. Therefore, the study captured role transition at differing stages for most of the individuals, and identified the processes that the role holder was going through.

Data were comparatively analysed and triangulated to conceptualise and saturate core themes, which were discussed and developed with participants and healthcare managers. The methods were influenced by grounded theory, although the study and theory are not presented as examples of grounded theory research.[14–17]

Comparative analysis included analysis of:

- part of an interview compared with another part of the same interview
- each interview compared with other interviews
- part of an observation compared with another part of the same observation
- each observation compared with other observations
- and follow-up conversations compared with interviews and observations.

Data were critically analysed by asking questions of the data (not the participant) such as:

- what is happening in this incident?
- what role transition issues are there for this nurse?
- what aspects of role transition are suggested by the data?

In addition:

- a return to the same data might ask what these data now reveal of an emergent concept (for example: shaping role)
- subsequent analysis of the same data might then seek whether the data explained variation (for example: why similar nurses have differing priorities).

Results

From integrated data collection, analysis and concept development, a theory of role transition is proposed which integrates four core variable concepts and subconcepts, which are explored below, through brief data examples.

Centring identity(ies) of role-identity, self-identity and group-identity

It was conceptualised from the data that identity was changing and that the individual going through a role transition process would go through a process of centring her identity depending on the specific role, action or behaviour engaged in, the people she was working with, or the context she was working within. The concept of identity includes personal factors such as the learning and education of the nurse, her physical, psychological and social health, public and private attitudes and values held and expressed by the nurses. This assumes a position on self, in which personal identities such as spouse or parent, and social identities such as neighbour are essential qualities that make a person distinct from others and are not left behind when going to work. Similarly this assumes a position of cross-over whereby an individual's role identity as a nurse in the workplace is not left at work but is an intrinsic component of the individual's personal life and home identity. The concept of boundary crossing supports this notion of co-existing identities, and role change at work will affect the individual's home and social roles and work–life balance.[6]

A community sister stated:

'Who am I to know all of the answers … Only a short time ago I was a staff nurse. It seems that as you change role there is a sudden expectation immediately to have all of the answers that people want … but then they want more.'

This was comparatively analysed with another response:

'Do you think they really want the answers of me as a person … they want the answers of a sister so I've become the person that they want me to be and in so doing you lose so much of yourself.'

This shows the importance of role identity, and the danger of losing self-identity. Centring identity was also seen at times to be negative in a blame culture, for example:

'Mrs G has developed a pressure sore, her family are very upset and I think that they are blaming me for it. It was only last week that the family didn't want Mrs G moved because she was in too much pain and now because she has a pressure sore we're suddenly getting the blame.'

This shows 'I', 'me' and 'we'; it highlights the quandary of accepting responsibility which this nurse was going through in her transition to a higher grade, and the need to share that responsibility once blame arose.

Focusing role(s) upon current role and anticipated role

The word 'focusing' implies an active process of positioning self and resources within a given context to achieve that which is determined or that which is yet to be established. Associated language from the data included examples such as: 'prioritising' and 'what needs to be done', and 'getting ready', and 'getting sorted', and 'maintaining my/our focus'.

Focusing role was often found in data from nurses looking at their role on a shift by shift basis, while listing what would need to be achieved that day. Most of the participants would tend to describe their current role in terms of being a staff nurse or being a sister and being focused on what they should be achieving within their role. For example, one nurse said: 'as a staff nurse I am expected to deliver care to these six patients quite quickly and quite efficiently', which highlighted the significance of role identity, and gave some detachment, whereas another nurse combined much of her self-identity and said: 'they expect more of me than I can ever deliver', which is a point raised earlier in this paper.

Enacting role(s) in a given context with available resources

Unsurprisingly, enactment of role was a dominant theme within this study, as a participant implied: 'that is why we are here'. Reduced resources were a regularly occurring issue analysed within the data, which affected the participants' new roles and their role transitions. Participants expressed a variety of positive as well as negative viewpoints on this, such as 'give me the time to do my job properly and I would love to' and 'I have been wanting to do this job ever since I came into nursing, but all my other roles stopped me doing it'. Most nurses suggested they could not move forward in the roles they were appointed to until they could get help with resources to enable this to happen.

Enacting role was predominantly expressed in the data as a latent pattern of 'doing' and 'delivering care' and 'looking after (staff and clients)'. This correlates with the basic traditional elements of role, namely the actions and behaviours of the person in meeting patient needs or in response to the expectations of patients, such as 'dressing checks and pain control', as well as the general expectations of them indicated by: 'the patients all demand support, which is their right'. Attempting to enact role within a context with given resources was often expressed in data from all participants as 'frustrating and stressful', partly due to a 'desire to do more, but frustrated by patient need and our inability to fulfil that', which led to group discussion comments such as: 'I feel a sense of burden' and 'I could cry sometimes'.

Shaping role(s) through loss and/or expansion of role(s) or part of role(s)

Expansion and loss of role or part of role(s) were common themes, evident in 70% of the interviews, observations and group discussions. Delegating parts of role to others in order to achieve in remaining or expanding areas was commonly witnessed in the observations. From open group discussions, negative aspects of role loss included: 'I miss finding the time to talk and explain things to my patients', and comments were generally raised as concerns over longer-term implications of loss, and a nurse expressed that losing roles was 'like bereavement'. Common positive aspects of role expansion were conveyed by data examples such as: 'taking on these extra roles and seeing the patient benefits gives me a sense of accomplishment'.

Shaping role was a difficult and often a passionately expressed concept of losing role and expanding within one's role, thereby redefining the role itself. All participants commented they regretted losing aspects of hands-on delivery and of hands-on care, for example: 'I miss my patients' and 'I really enjoy just getting stuck in' and 'I don't really enjoy just sitting in the office all the time but in order to develop you have to lose something'.

Discussion

The simple model in Figure 1 demonstrates an integrated theory of role transition. Although set in an order here, it is not intended to be fixed and may be reordered by users to have any concept in any of the four positions. It depicts each concept as singular occurrences, understood and related to each other. Role transition is considered to range from being a
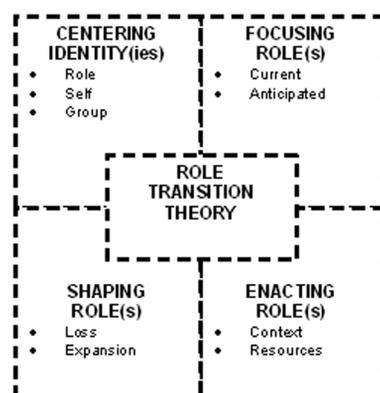

Figure 1 A model of role transition theory

single event through to being a central part of ongoing professional development depending upon the nature of one's work and responsibilities within a given context. This may be triggered by a change to role, person, role set, context or expectations, and is defined by the role holder developing the role actively or passively in response to the given changes. Enhancement of practice could occur by recognising the identity of the person going through role transition and evaluating his/her potential variance in the transition, supporting the individual in focusing the role and supporting/advising the individual and colleagues in managing the shaping of the role around areas of role and role expansion. In addition, ensuring a positive environment for enacting role with other professionals and patients could improve a nurse's confidence.

Further work with participants has resulted in bespoke tools and models to assess and facilitate their role transition. The model in Figure 1 is a starting point for that work. This theory gives back to the nurses an explanation of their progression through role transition when a role change occurs and, by appraising the integrated concepts, each nurse will have a basis from which to manage that process. This gives an opportunity for nurses and managers to compare and contrast their perceived sets of expectations and behaviours within their roles and work together with the role transition concepts. From this, nurses can evaluate differences and similarities to their current roles and thus understand role to greater depth as a precursor to further action and ongoing development.

A developing knowledge base of what occurs within role transition will have the potential to guide individuals, groups and organisations to effectively manage role transition and support those within this change process. The UK nursing workforce is but one large example of data source and potential application of theory, especially due to the rapidity of change experienced by this occupational group in the NHS. It would seem likely that role transition theory has wider use and application to most workforces, as regular change, re-skilling, re-training, expansion and development into new products and new services is at the core of organisational life across the world.

The application of this theory may guide managers and preceptors to offer support and improve this area of organisational change. The following is a working draft of a preceptorship strategy integrating the proposed role transition theory from this study.

The preceptor of a role transition could:

- explore with the preceptee the range of expectations required from the perceived role set
- support the preceptee to understand the identities they use within their role and the effect of these on transition and interactions with colleagues and patients

- assist in recognising skills and knowledge as resources, and organisational skills in utilising other resources to enact role within varied contexts
- support the preceptee in establishing role focus and adapting to differing and changing priorities
- provide opportunity to discuss and explore role loss and expansion effects upon the individual
- evaluate one's own role transitions against the role transition theory, adapt to one's own experience and discuss with the preceptee to foster role transition analysis
- support the individual in centring identity(ies) and focusing, enacting and shaping role(s) and discuss the relationships between these concepts
- promote an understanding of role transition behaviours and expectations, and evaluate performance in these (NB criteria to be established per organisation)
- explore opportunities for further courses, and study to enhance role progression
- discuss role in action contrasted with organisational job description and others' expectations
- maintain regular contact and opportunities for the preceptee to discuss progress and concerns openly.

Such a strategy would require equivalent commitment from the preceptee and the employing organisation.

Planned NHS reforms for 2006 and beyond will involve further role transition for thousands of employees, from new appointments and new roles, to re-applying for one's own job with modifications and being relocated into different contexts with different resources and foci.[18] Role transition theory can be adapted to guide development in these widespread changes, such as increasing practice-based commissioning, new NHS foundation trusts and more independent sector treatment centres. The latter will create new roles for implementation by 2008, and will therefore create new role transition to be supported and managed. The roles of healthcare professionals will change to address national targets and local delivery plans (LDPs) and target life expectancy, cardiovascular disease, cancer mortality, suicide, smoking, obesity, sexual health, improved primary care, drug treatment, and improving the quality of life and independence of vulnerable older people. Each innovation in this list will require a changing workforce to implement, deliver and maintain these, and each will involve numerous role transitions. The application of role transition theory could support these workforce changes and organisational change aimed at achieving financial health, reducing costs and improving productivity.

It is often the case that much consideration, consultation and strategic planning is invested into healthcare innovations for end users but this is contrasted with little development or investment into the workforce producing change. Current examples include

staff involved in development of diagnostic centres, community-based general practitioner (GP) with special interests (GPwSI) services, and the large-scale organisational changes of reducing the number of NHS ambulance trusts, reducing the number of strategic health authorities (SHAs), and reducing the number of primary care trusts (PCTs). Within the 2006/2007 NHS in England operating framework under managing the change, the Department of Health (2006) recommends establishing a human resources framework including transition arrangements for staff.[18] This focuses on the SHA, PCT and ambulance trust organisational structures, and reviewing their capabilities by role and staff training needs analysis. Role transition theory could be applied to this and support this analysis by considering role identity, role focus, context and resources for enactment, and role shaping through analysis of areas to lose and expand. Transition leads will be appointed to determine how the above transition tasks are dealt with; however, these transition leads will experience the most extremes of role transition in the coming year and will benefit from this role transition theory and being supported in their own leadership and roles.

ACKNOWLEDGEMENTS

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ETHICAL APPROVAL

Local hospital and community trust research ethics committees did not require the study to have formal ethical approval, as it was agreed that written consent to participate in the research must be obtained separately from each nurse participant as autonomous practitioners. This was followed in addition to adhering to the British Psychological Society's *Ethical Principles for Conducting Research with Human Participants.*[19]

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CONFLICTS OF INTEREST

None.

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