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Crossing the 'flaky bridge' – the initial transitory experiences of qualifying as a paramedic: a mixed-methods study

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Abstract

Introduction: Newly qualified paramedics (NQPs) may experience emotional turbulence as they transition to professional practice. This may negatively affect confidence and have an adverse effect on attrition. This study highlights the initial transitory experiences of NQPs.

Methods: The study utilised a mixed-methods convergent design. Qualitative and quantitative data were collected simultaneously and triangulated to more fully interpret participants' experiences. A convenience sample of 18 NQPs from one ambulance trust was used. The Connor–Davidson Resilience 25-point Scale questionnaire (CD-RISC25) was administered and analysed using descriptive statistics. Semi-structured interviews were conducted simultaneously and analysed using Charmaz's constructivist grounded theory approach. Data were collected from September to December 2018.

Results: There was a range of resilience scores, with a mean of 74.7/100 (standard deviation 9.6). Factors relating to social support were scored highly, and factors relating to determinism and spirituality were scored lower. Qualitative data constructed a process whereby participants were

navigating a new identity across three spheres simultaneously: professional, social and personal identity. Attending a catalyst event such as attending a cardiac arrest was a trigger for starting to navigate this process. Participants had different pathways through this transitional period. Participants who found this process particularly turbulent seemed to have lower resilience scores.

Conclusion: The transition from student to NQP is an emotionally turbulent time. Navigating a changing identity seems to be at the centre of this turbulence, and this is triggered by a catalyst event such as attending a cardiac arrest. Interventions which support the NQP in navigating this change in identity, such as group supervision, may improve resilience, self-efficacy and reduce attrition.

Keywords:

emotions; paramedic; resilience; self-efficacy; socialisation; transition

Introduction

The pathway from student to qualified healthcare practitioner can be difficult, with several studies identifying the initial transitory period as being a particularly emotionally turbulent time (Devenish et al., 2016; Duchscher, 2009; Kennedy et al., 2015). For example, people may encounter a 'shock' when their conceptions, and perhaps even idealised views, of their profession meet the 'reality' of healthcare practice, and on discovering that their beliefs may be in conflict with values in the world of work (Devenish et al., 2016; Kramer, 1974). Those undergoing a process of adjustment to new roles and new organisations often describe experiencing disorientation, foreignness and sensory overload (Louis, 1980, 1983). Health Education England (2018) acknowledged that newly qualified healthcare practitioners have a 'rollercoaster of experiences and confidence levels during their first year of employment'.

There are currently concerns about the recruitment and retention of healthcare practitioners in all areas across the United Kingdom, with initiatives such as the Reducing Pre-Registration Attrition and Improving Retention (RePAIR) project (Health Education England, 2018) seeking to address issues of attrition in nursing and allied health professions. Health Education England used the term 'flaky bridge' to describe the experience of newly qualified practitioners (NQPs) during the initial period of transition and socialisation from healthcare student to practitioner (Health Education England, 2018). This project found that there is a need to decrease

anxiety and increase confidence in clinical decision making among newly qualified healthcare practitioners. A report looking at NQPs highlighted that they are likely to be facing the same difficulties (Health Education England, 2021). At the start of their clinical career, NQPs can be unsure that they can manage patients in a safe and effective way. They may have doubts about their own ability, or perceived self-efficacy, which if not understood and supported may have an impact on their resilience and contribute to attrition (Health Education England, 2021). It is claimed that this experience of transition shock may impact the attrition of many NQPs (Kennedy et al., 2015).

The transition to becoming a paramedic has been documented by Devenish et al. (2016), who described the phases of socialisation for paramedics in Australia, noting that further research is needed to understand the underpinnings of transitory shock experienced by many NQPs. In this study, we highlight the experiences of NQPs as part of their initial journey across the 'flaky bridge', and in so doing capture the emotional turbulence of their transitory experiences.

Methods

Study design

A mixed-methods convergent study design was used. Qualitative and quantitative data were collected simultaneously, in order to view participants' experiences from two angles and triangulate findings. Qualitative data constructed meanings of participants' experiences and quantitative data provided insight into the quantifiable aspect of those experiences, providing a basis for comparing participants. In this way, the transition journey could be understood more fully than any one method could provide.

The quantitative element of this research studied a snapshot of the resilience of participants as a basis for further illuminating the qualitative findings, and a basis for comparison between participants.

The qualitative element of the study followed a constructivist grounded theory approach (Charmaz, 2014). Grounded theory is an inductive process that seeks to construct theory about issues that are important to people's lives (Corbin & Strauss, 2008). Grounded theory mainly describes an approach to analysing data, in which there are no pre-conceived ideas or hypotheses. There is a process of conceptualising and constantly comparing data to data, and concept to data, to ensure theories that emerge are grounded in the data (Glaser & Strauss, 1967). Constructivist grounded theory differs from earlier versions of grounded theory because it asserts that theories are not discovered in the data, rather researchers construct, and co-construct, theories through interactions with people, perspectives and research practices. This identifies the researcher as part

of the process, not an objective observer, but a co-creator (Charmaz, 2014). Rigor was ensured by assessing credibility, originality, resonance and usefulness (Charmaz, 2014).

The study was weighted towards qualitative methods with quantitative data used to reveal further insights arising from participants' experiences. Quantitative resilience scores were considered alongside the individual participants' pathway through the transition process, and compared to other participants. This allowed researchers to gain further insight into the extent to which their specific experiences may impact resilience. For example, two participants might have very different pathways through the transition process, and triangulating these experiences with resilience scores provides an insight into pathways which may support or reduce resilience. Furthermore, researchers were able to compare question-level scores on the resilience scale which, when triangulated with qualitative findings, may identify specific areas of resilience that are of importance to the cohort.

Participants

The sample size was drawn largely from consideration of the qualitative aspect of the study. Quantitative data were not intended to be analysed statistically, and not intended to be generalisable. Constructivist grounded theory literature emphasises the need for judgement when considering sample sizes (Charmaz, 2014). Although fewer participants may have sufficed, it is difficult to know this at the outset of the study. A slightly larger cohort also allowed for any reasonable attrition from the study to not impact the development of a theory.

A single NHS ambulance trust was contacted to approach NQPs in their trust. Convenience sampling was used, with potential participants approached at their corporate induction. Participants were eligible if they were an NQP taking up their first post as a paramedic. Potential participants were given information sheets at the induction and asked to sign and return a consent form by email if they wish to take part in the study. Once the consent form had been returned, the principal researcher contacted the participant by email to arrange the interview.

Data collection and analysis

Data were collected between September and December 2018 because NQPs started their employment during this period.

Quantitative data were collected using the Connor–Davidson Resilience 25-point Scale (CD-RISC25) (Connor & Davidson, 2003). This questionnaire is a self-assessment of resilience. Participants respond to 25 statements on a Likert scale from 0 (not true at all) to 4 (true nearly all of the time).

Marked out of 100, a higher score indicates higher resilience and a lower score indicates lower resilience. Examples of items included in this questionnaire are: 'I have at least one close and secure relationship,' and 'When things go wrong sometimes fate or God can help.' CD-RISC 25 has a good reliability and validity. It has a high construct validity, with those scoring high on CD-RISC being less likely to develop post-traumatic stress disorder (Mealer et al., 2016) and suicidality (Liu et al., 2014). It has a high test–retest reliability (Connor & Davidson, 2003) and acceptable convergent and divergent validity (Karaırmak, 2010).

Participants were given time to complete the questionnaire on a computer immediately before the interview took place, without the researcher present. The questionnaire was completed online using the Bristol Online Survey. Quantitative data were analysed descriptively using SPSS version 28. The Shapiro–Wilk test of normality was used to establish normal distribution.

Qualitative data were collected using semi-structured interviews lasting roughly one hour. Interviews were conducted at the individual participants' ambulance station in a private room. They were conducted face-to-face, audio recorded and transcribed verbatim.

Interviews were analysed initially using initial line-by-line coding with a focus on making codes action-based (Charmaz, 2014). Focused coding then took place, which is a process of identifying initial codes that appear frequently or have particular significance within the data, grouping and synthesising codes to form analytical and conceptual ideas. Focused codes were constantly compared to data to ensure that the coding accurately accounted for the experience of participants. Memos written by the researcher were used as an informal process to capture thoughts about data and comparisons between data. Memos are used as an informal adjunct to coding, providing a space for the researcher to converse with themselves. Memo-writing helps to crystallise ideas, understand links between ideas and to raise the analytical level of analysis (Charmaz, 2014). Diagramming was undertaken to raise the analytical level of the codes and move towards theory generation, which is a core outcome of grounded theory. Diagramming is the process of representing theories in visual form, and helps to form more concrete ideas and understand relationships between ideas (Charmaz, 2014). NVivo Pro 12.5 was used to transcribe and code interviews. Memos and diagrams were handwritten.

The primary researcher discussed qualitative and quantitative findings with the co-author, helping to ensure that the theory was grounded in the data and offering perspectives on the mixing of the qualitative and quantitative findings.

Positionality statement

In constructivist grounded theory approaches the researcher is not a neutral observer. The researcher is part of the research process and co-constructs meaning from participants' interviews. Researchers have pre-conceptions which can affect different aspects of the research, but a particular risk is forcing pre-conceived ideas into the analysis of data.

The principal researcher is an experienced paramedic, an experienced lecturer at a higher education institution and a PhD candidate. As a paramedic he had experience of dealing with the same stressors that the participants may be dealing with. His experience with educating paramedics could cause pre-conceptions about the issues that the participants may be facing, and these pre-conceptions may impact the questioning during interviews and interpretation of the data. To mitigate the risk of this occurring, the principal researcher wrote informal memos about their experiences as an NQP, as an educator and as a researcher. This made implicit pre-conceptions explicit to the researcher so that the memos could be revisited at different times during the data collection and analysis. To reduce the risk of pre-conceptions erroneously affecting data, the researcher undertook constant comparison of initial codes to data, focused codes to data, and data to data, that is, at each step of analysis ensuring that initial codes and focused codes accurately represent participants' experiences as seen in the data, and that codes and the theory are accurate when applied across multiple participants as a form of cross-checking. However, one must acknowledge the subjectivity of the qualitative analysis, accepting that there may be multiple interpretations which accurately account for participants' experiences.

Ethics

During interviews, participants were at risk of recalling upsetting events. To mitigate this, the researcher had agreed with the ambulance trust that participants would be given information of their staying well service. All participants were given this information. Participants were made aware that if the researcher thought the participant was an immediate risk to themselves or others then confidentiality would be broken in order to inform the employing trust of concerns. The participant would be informed that this would happen.

Participants were free to withdraw from the study at any time without penalty, but data collected up until the point of withdrawal would still be anonymised and used in the study.

Results

There were 18 participants: eight males and 10 females. Self-reported demographic data can be seen in Table 1.

Table 1.

Participant demographics.

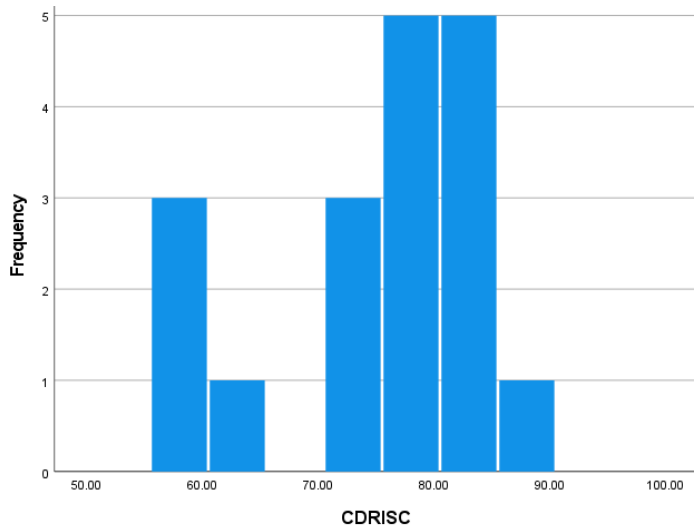
Demographic category	Number of participants (%)
Gender	
Male	8 (44.44)
Female	10 (55.56)
Age	
21–25	7 (38.89)
26–30	5 (27.77)
31–35	3 (16.67)
> 35	3 (16.67)
Marital status	
Single	11 (61.11)
Co-habiting	6 (33.33)
Separated	1 (5.56)
Sexual orientation	
Heterosexual	18 (100)
Ethnicity	
White British	16 (88.89)
Other	2 (11.11)
Disability	
No	17 (94.44)
Yes	1 (5.56)

Quantitative results

The mean CD-RISC score was 74.7 out of 100, with a standard deviation (SD) of 9.6. Scores ranged from 58 to 88 out of 100. The Shapiro–Wilk test of normality had a significance of 0.064, showing a normal distribution of data. All participants were within two SDs. See Figure 1 for a histogram showing the frequency of CD-RISC scores.

Figure 1.

Histogram showing frequency of CD-RISC scores.



Mean scores for each question can be seen in Table 2. Two questions that relate to social support had the highest mean score (close and secure relationships) with all participants scoring 4, and the third highest score (I know where to turn to for help). This highlights that participants across the spectrum of resilience scores felt they had good social support.

Table 2.

Mean CD-RISC response per question (ascending order).

CD-RISC topic	**Mean response score***
Sometimes fate or God can help	0.83 (SD 1.20)
Things happen for a reason	2.28 (SD 1.27)
Prefer to take the lead in problem-solving	2.44 (SD 0.78)
Not easily discouraged by failure	2.56 (SD 0.92)
See the humorous side of things	2.67 (SD 1.03)
Have to act on a hunch	2.72 (SD 0.75)
Strong sense of purpose	2.83 (SD 0.99)
Make unpopular or difficult decisions	2.89 (SD 0.76)
I like challenges	3.06 (SD 0.73)
Can deal with whatever comes	3.06 (SD 0.87)
Coping with stress strengthens	3.06 (SD 0.72)
When things look hopeless, I do not give up	3.11 (SD 0.47)
Under pressure, focus and think clearly	3.11 (SD 0.83)
Can handle unpleasant feelings	3.11 (SD 0.90)

You work to attain your goals	3.11 (SD 0.68)
Past successes give confidence for new challenges	3.17 (SD 0.51)
In control of your life	3.17 (SD 0.92)
Able to adapt to change	3.28 (SD 0.67)
Think of self as strong person	3.33 (SD 0.77)
Pride in your achievements	3.33 (SD 0.77)
Tend to bounce back after illness or hardship	3.39 (SD 0.70)
You can achieve your goals	3.39 (SD 0.61)
Know where to turn for help	3.39 (SD 0.70)
Best effort no matter what	3.44 (SD 0.51)
Close and secure relationships	4.00 (SD 0.00)

*The mean response score is measured on a Likert scale from 0 (not true at all) to 4 (true nearly all of the time).

CD-RISC: Connor–Davidson Resilience Scale; SD: standard deviation.

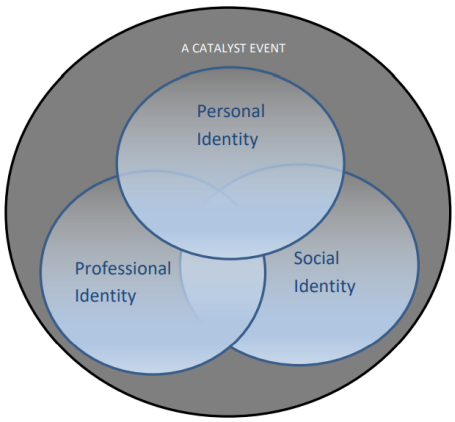
The third question, relating to believing in fate or God, received the lowest average score of 0.83. The second lowest score was feeling that things happen for a reason (2.28). Both of these questions relate to spirituality, faith and determinism/fatalism in Connor and Davidson's (2003) factor analysis, of which the cohort seem to generally reject the notion. The concept of working hard and giving their best effort no matter what (3.44) was the second highest score, which may indicate that the cohort identify with trying hard and giving things their best shot (internal locus of control) rather than relying on determinism or outside intervention (external locus of control).

Qualitative findings: 'navigating a new identity'

A theory was constructed around a central process ('navigating a new identity') (Figure 2). Navigating this new identity was carried out in three spheres simultaneously (professional identity, social identity and personal identity) and triggered by a catalyst event. Each sphere of identity had an influence on the other spheres after a catalyst event.

Figure 2.

Navigating a new identity.



During this initial transitory period there was a common experience among participants where they were trying to negotiate a new identity across three spheres, and this was an emotionally turbulent time. The early trigger for navigating a changing identity was whether they had attended a catalyst event. A catalyst event referred to a callout that was a high-acuity, high stress situation where the patient was suffering from a life-threatening illness/injury. The most commonly cited call was attending to a patient who was in cardiac arrest.

Professional identity

Before attending a catalyst event, participants described a lot of self-doubt that they were able to perform adequately as a paramedic:

> I do worry about going to my first cardiac arrest as a paramedic […] That is my biggest fear until I get that job. So I don't know what's going to happen. I think that that is my biggest worry. (SP55, CD-RISC score: 84)

It was difficult for them to identify as a paramedic when they were so fundamentally unsure if they were able to perform what they perceived to be the key facets of the role.

Participants identified that attending to a critically unwell patient, particularly cardiac arrests, was a key constituent of the professional identity of the paramedic. As such, they placed a lot of weight on the ability to cope with this kind of callout:

> your cardiac arrest is one […] that is most associated with paramedics, so knowing that I can do that … was quite a nice moment. I'd earned my stripes. I can do this. (JT67, CD-RISC score: 84)

Participants who had attended to this type of callout described an increase in self-efficacy and a feeling that they now felt like a legitimate paramedic:

> it is one of the biggest jobs a paramedic attends to and sort of what a paramedic is expected to go to, that kind of emergency and knowing that I'm able to achieve what I need to achieve as a newly qualified paramedic, it was a really big boost of confidence. (JT67, CD-RISC score: 84)

> [talking about a patient who was critically unwell that they managed] Well it made me feel like 'yeah I actually can be a paramedic, I'm not so bad'. (PD85, CD-RISC score: 88)

Conversely, for those participants who had not attended a callout of this nature, they were not able to start to reconcile their new professional identity. There was an emotional vulnerability and self-doubt that manifested as anxiety and sleep disturbance:

> Well, I never sleep well. Never sleep well. And, you know, you wake up a couple of hours before your alarm goes off. And you know, or you take a long time to get sleep and things like that. (FH35, CD-RISC score: 76)

> I've still not attended or run a cardiac arrest on my own. That scares the life out of me, absolutely. And I guess when I think of the anxiety and the panic, that's what drives it. (RN21, CD-RISC score: 58)

Interestingly, participant RN21 had the lowest CD-RISC score (58), highlighting that the emotional turbulence that they are describing as a result of not attending a cardiac arrest may be having a detrimental effect on resilience.

Social identity

Attending a catalyst event as an NQP also had an effect on participants' developing social identity. Participants felt that following a catalyst event they had gained the respect and approval of their ambulance colleagues. This process describes how going through this rite of passage can essentially make the participants 'one of the group'. One participant highlights how colleagues' attitudes changed towards her after they attended a child who suffered a cardiac arrest:

> And all of a sudden when I worked with other people their attitudes changed. It sounds horrible that it took a baby to die to gain a bit of respect, which is horrible isn't it. (BN54, CD-RISC score: 71)

Participants indicated that until they had attended a catalyst event they did not feel like they were part of the group and colleagues would act differently towards them than a more established member of the group. One participant reflected on how they were treated before attending a cardiac arrest and how they were treated subsequently, as a bona fide member of the group, which typifies many participants' experiences:

> when you're new, people kind of just ignore you. And now everyone's like chatting to you more like, oh, how's your day going? They kind of include you, which is quite nice. (BE47, CD-RISC score: 77)

Results from the resilience questionnaire show that social support is a facet of resilience that heavily supports all participants' resilience (close and secure relationships and knowing where to turn for support). Being accepted into the wider group ensures that participants will receive social support as part of in-group behaviour, further strengthening resilience.

Some participants had experiences with colleagues that stopped them from being accepted into the group. One participant had a disagreement with another paramedic, which escalated and seemingly resulted in the established group making work–life very difficult for the participant, and demonstrates typical out-group behaviour:

> But they are watching me and waiting for me to make a mistake. That was really stressful, really stressful. I also had other ECAs refuse to do shifts with me, which is also quite stressful because that reaffirms to other people that I'm a really horrible person. (PD85, CD-RISC score: 88)

Another participant acknowledged the rite of passage in order to be accepted by colleagues but rejected the notion of it. They did not accept that they should have to prove themselves to their colleagues:

> There's enough pressure on my shoulders, generally with the job, it's quite a pressured job to have to prove myself to my crewmates through another shift. (CH32, CD-RISC score: 60)

When faced with a series of difficult interactions with colleagues, this participant was not willing to go against their values just to be validated by the established group:

> Like I'm not here to make enemies. But [I'm also] not here so everyone can come around my house for a cup of tea every day. (CH32, CD-RISC score: 60)

> But if someone introduced themselves to me like that, that kind of rudely, I would say inappropriately to be honest. Just put me on the wrong foot completely to start with and I just lost all respect for them. It was clear that the way they spoke to me meant they had zero respect for me from the start either. (CH32, CD-RISC score: 60)

Participant CH32 had one of the lowest CD-RISC scores (60), which may reflect the difficulties faced around social identity and its effect on resilience.

The transitory experience of participants here is of colleagues (the established group) watching participants' performance over the first few months of their employment, and either accepting them into the group, affirming their professional identity as a paramedic, or of not

accepting them into the group, resulting in a lot of stress for participants, who may feel like an outsider. For some participants, they were unwilling to follow the established social norms in order to fit in, particularly where doing so would go against their core values. But for the majority of participants, how they were viewed by the established group had a direct effect on how they viewed themselves professionally and personally.

Personal identity

This change in identity caused some participants to question their sense of self. Being a paramedic was not just part of their evolving professional identity, but was a part of who they are as a person:

> The problem is that being a paramedic is what I am now, it's everything I've been working for, so if I can't do that then I'm not really sure who I am. (RN21, CD-RISC score: 58)

The emotional turbulence, for some participants, caused a friction between the way the world viewed their identity and the way that they viewed themselves. One participant in particular summed up the experience of many:

> They all view me as 'the paramedic' as if that's what I am, but I sure don't feel like a paramedic, I'm not even sure I can do it. So then what am I? (FW99, CD-RISC score: 61)

Therefore, the challenges faced in navigating professional identity and social identity, and the emotional turbulence that is evoked, affected their fundamental sense of who they are in the world.

Discussion

The initial transitory period of NQPs, as they cross their professional 'flaky bridge' is indeed an emotionally turbulent time. The present study shows how a changing identity is at the centre of this turbulence. The findings showed a mean CD-RISC score of 74.7. During this transition period, participants were navigating a new identity across three spheres: professional, social and personal identity. This was triggered by a catalyst event, most commonly attending to a cardiac arrest.

There is limited published CD-RISC data from similar cohorts of paramedics for comparison. Two existing studies which used CD-RISC on paramedic populations found mean scores of 73.8 (SD 15.1) (Froutan et al., 2017) and 65.06 (no SD or range given) (Fjeldheim et al., 2014). Another study applied the CD-RISC to a student paramedic population with a mean of 72.6 (SD 13.2) (Safori et al., 2021). The cohort in the present study demonstrated similar mean resilience to two of the above studies, and greater resilience than the other. Direct comparisons are difficult because existing

studies researched paramedics and student paramedics in different countries (Iran, South Africa and Australia) who may face different types of stressors.

Locus of control is the extent to which people feel they have control over events in their lives. The two poles are internal and external locus of control, and people will sit on this continuum. Internal locus of control is where people feel their lives are dictated by their own intent, ability, purposefulness. External locus of control is where people feel their lives are dictated by outside forces, randomness, other people or a higher power (Shanava & Gergauli, 2022). Questions relating to determinism/fatalism had the lowest cohort mean scores, therefore highlighting that the cohort generally rejected an external locus of control. Those questions relating to control had high mean scores, suggesting that the cohort generally sit more towards an internal locus of control on the continuum. Studies have found that an internal locus of control is protective against adversity and associated with greater resilience (Rajan et al., 2018; Cazan & Dumitrescu, 2016; Montes-Hidalgo & Thomas-Saturday, 2016; Munoz et al., 2017).

Transitional anxiety is perhaps inevitable when entering professional practice. There may be an existential anxiety when we are unsure of a new world we are entering into (Neimeyer, 2001). Membership of social groups can ease some of this anxiety, therefore it is natural that NQPs should seek out support from more experienced paramedics (Brown, 2000).

Social identity theory describes how membership of groups is a significant source of pride and self-esteem. It is posited that people strive to achieve and maintain a positive social identity, and that this drives self-esteem (Brown, 2000). Participants demonstrated how social support enhanced their resilience in the quantitative data, and social identity with the in-group is likely to support this further. Evidence demonstrates how group membership and a feeling of belonging to a social group has been shown to reduce the risk of stress-related disorders such as burnout (Avanzi et al., 2015), can increase resilience (Koni et al., 2019) and increases self-efficacy (Avanzi et al., 2015), which can help to give confidence to the NQP.

Role identity theory describes how someone occupying a role within society builds an identity around that role by adhering to its key functions and attributes (Mausz et al., 2021). Dealing with a catalyst event cements their own feeling of professional identity. Moreover, the role of a paramedic in society is seen as significant and important, and as such the attributes and identity of ‘paramedic’ can be so salient that they become an important part of personal identity and sense of self (van Ingen & Wilson, 2017). The role identity of a paramedic is about more than a set of skills, it is a framework of values that underpins the paramedic (Reed et al., 2019). Therefore, it is inextricably linked to personal values and personal identity.

It is interesting that many participants identified life-threatening calls, such as a cardiac arrest, as the catalyst event which would trigger them to navigate their identity. Life-threatening calls, including cardiac arrests, make up an extremely small proportion of ambulance work in the United Kingdom (Henderson et al., 2019). Patients experiencing chest pain, difficulty in breathing and abdominal pain are much more frequent calls (Henderson et al., 2019) which paramedics are required to manage. However, participants did not talk about these types of incidents as helping them to negotiate their new identity. Indeed, the scope of paramedic practice is broad, with paramedics working in many healthcare and non-healthcare environments other than the ambulance service, that it is difficult to identify and define the role of a paramedic (Williams et al., 2022). Further research could focus on whether framing the paramedic role more clearly during the education of paramedics (such as underpinning values) may support their transition, or whether participants' view of paramedic practice enables NQPs to better navigate their new identity.

Health Education England's (2018) RePAIR project identifies that there is a need to increase clinical confidence to reduce attrition. This study shows that for NQPs there is a more fundamental social process at play that is making their transition emotionally turbulent. Supporting NQPs to navigate the identity change, may increase self-efficacy, increase resilience and reduce emotional turbulence. These factors may, in turn, help to reduce attrition.

Clinical supervision for NQPs could support their transition and alleviate some of the emotional turbulence. Stacey et al. (2020) implemented a group resilience-focused supervision model in a cohort of newly qualified nurses. They found that it supported participants' feelings of belonging and validation, which may support a developing identity. Francis and Bulman (2019) identified the benefits of group supervision in a cohort of hospice nurses in supporting resilience, particularly in improving self-awareness of emotions and self-efficacy. Wallbank (2013) demonstrated how group supervision can have a wider effect on resilience, increasing compassion satisfaction, and reducing burnout and stress in a small cohort of health visitors. The evidence suggests that group supervision could help with developing a social identity, in developing a strong professional identity and in improving self-efficacy, among other beneficial effects. A barrier to delivering supervision is the clinical and operational pressures that staff face, and the need to educate supervisors/facilitators in how to manage group supervision. Delivering group supervision is more time effective but would still need investment from employing organisations. Further research could consider and test models of supervision in the context of NQPs.

To prepare NQPs for the transition to practice, institutions that educate paramedics could consider how issues around identity could be supported during the programme. Encouraging

students to reflect on the role identity of the paramedic and the important aspects of professional identity may help to prepare students for the challenges during the transition period. Curricula may need to be altered to consider how issues of identity are embedded, discussed and role-modelled throughout the education programme (Johnston & Bilton, 2020), making identity an overt aspect of programmes. There is a paucity of literature on this topic.

Limitations

Quantitative data were analysed descriptively, therefore inferences made would require further research using bigger samples to interpret them fully in the context of the wider NQP population. The study describes the experiences of 18 participants from one ambulance trust, therefore caution should be exercised in generalising the findings to other ambulance trusts.

Conclusion

The transition to NQP is emotionally turbulent, as paramedics navigate a new identity. This new identity is fundamental to their sense of self, and interventions to support NQPs in navigating this turbulent period may improve resilience, self-efficacy and reduce attrition.

Author contributions

PP designed and conducted the study, gained ethics approval, transcribed and analysed interviews, and prepared drafts for submission. ST supported the design of the study, helped with context and theory of analysis, and prepared drafts for submission. PP acts as the guarantor for this article.

Conflict of interest

None declared.

Ethics

Ethical approval was granted by HRA (ID 224086) and Bournemouth University (ID 16624). Sponsorship and approval from the ambulance trust's research and development department was gained as part of the HRA ethics process.

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