

# Experiences of early-career nurses working in specialist adolescent/young adult cancer units: A narrative inquiry

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## Abstract

**Aim:** To explore the experiences of early-career registered nurses working in specialist adolescent/young adult cancer units.

**Design:** Narrative Inquiry.

**Methods:** A purposive sample of nine early-career registered nurses from six specialist adolescent/young adult cancer units in the United Kingdom participated in online in-depth narrative conversations between October 2020 and January 2021. Data were analysed thematically using Clandinin and Connelly's (2000) metaphorical three-dimensional narrative inquiry approach focussed on commonplaces of temporality, sociality and place.

**Results:** The intensity and complexity of the nursing work associated with young patients and their families, over protracted periods, impacted the nurses personally and professionally. The similarity of age between patients and nurses was shown as having benefits as well as posing risks. The complexity of four types of nursing labour was highlighted: emotional, cognitive, physical and organizational providing justification for the provision of specialist training and support.

**Conclusion:** This study presents unique insights into the complex work of early-career nurses in specialist units that reveal challenges in caring for the distinct needs of this cancer patient population.

**Impact Statement:** Better understanding of the experience of adolescent/young adult nursing work is revealed. Nurse managers could use these findings to consider the level of expertise on cancer units and ensure a spread of ages and experience. Managers and funders should also consider the clinical supervision and well-being needs of nurses so that they can thrive in these unique environments. Educators could use findings to develop curricula and reinforce messages of self-care, reflection and boundary management. The findings of this study may be transferable to other areas where early-career nurses care for younger age groups.

**Public and Patient Engagement and Involvement in Research Statement:** No patient or public contribution was requested or required as this research wanted to examine nurses' experiences and not those of patients or the public.

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## KEYWORDS

adolescents, cancer, early-career nurses, narrative inquiry, teenage, young adults

## 1 | INTRODUCTION

Understanding the impact of cancer on an adolescent/young adult (AYA) (age 15–25) challenges nurses to consider the uniqueness of their age-related needs during cancer treatment and survivorship. These specific needs focus on neurocognitive, social and emotional changes that occur during adolescence which differ significantly between children and adults (Gilmore & Meersand, 2019). Given the transient phase of life that adolescents navigate, greater attention involves taking account of the young person's support system which usually, but not always, includes their parents and/or partners. It may also include friends, particularly as adolescents may only just have separated from their home environment and lack social support systems. Cancer types in adolescents differ from children and adults and the impact of treatment on adolescents needs to take into account specific factors less often seen in the care of adult or child oncology, such as oncofertility preservation, shared clinical decision-making, disruptions to friendship groups and education/employment status, survivorship and end of life care (Chisholm et al., 2018).

The specialism of AYA cancer care (AYACC) has developed in the United Kingdom since the 1990s with the support and drive of many stakeholders including charities, patients/families and healthcare professionals, including nurses. Specialist AYA cancer programmes now exist in Australia, United States and other western countries. Models of service provision vary. However, all have been informed by a wide variety of elements including qualitative research findings, studies of unmet needs and patient-reported experiences of care, service user feedback and expert opinion (Osborne et al., 2019). This specialism is built on the foundation of multidisciplinary healthcare striving to meet the age-related, and unique needs of this patient group (Cable & Kelly, 2019).

This study took place in the United Kingdom where 28 specialist adolescent/young adult cancer units exist within National Health Service oncology settings. These specially designed units were developed with financial and political support from the charity Teenage Cancer Trust (TCT). Nurses who work in these units can be a Registered Nurse (RN) (Adult) or RN (Child), unlike most other clinical areas where adults can only be cared for by an RN (Adult) or in paediatrics where only RN (Child) can practise. These units usually care for AYA with cancer (AYAC) between the ages of 15–24 years old. Specific differences between these units include the built environment which tends to have a youth-focused design process applied and encouragement of youth participation within clinical environments. The education of staff who work in the units to consider age-related needs is another feature (Taylor et al., 2019). TCT fund additional specialist roles including Clinical Nurse Specialists in AYAC and Youth Support Co-ordinators whose primary function is

### Summary Statement

#### What Problem Did the Study Address?

Existing literature, guidelines and service planning tend to focus on nurses who care for older adults or younger children with cancer. Few address the needs of early-career nurses in these settings.

#### What Were the Main Findings?

Early-career nurses are often similar in age to adolescents or young adults which can be perceived to enhance relatedness but has associated risks for blurring boundaries. Their work in these settings is emotive, complex and highly pressurized with inconsistent levels of personal and professional support provided, which may lead to poor adaptive coping mechanisms and attrition from the specialism as well as the profession.

#### Where and on Whom Will the Research Have an Impact?

This study contributes to an understanding of developmentally appropriate nursing care in these specialist cancer settings. It should help guide early-career nurses, their managers, educators, researchers and funders to strengthen nursing support systems so that young cancer patients receive effective care from a well-educated and motivated workforce.

to support patients retain the youth element of their lives and help them navigate through the psychosocial aspects of life during cancer treatment.

The role of nurses within this specialism has received little attention in the literature. There is even less knowledge about the work of early-career nurses at the clinical interface of AYACC care delivery, which is under similar service and workforce pressures to any other specialism in the current healthcare climate. This study aims to redress this balance by exploring the work of early-career nurses in these settings.

Given the variation in terms that can be used and seen in the literature, adolescent and teenager are taken to mean the same and are used interchangeably, thus AYA/AYAC is synonymous with TYA/TYAC.

## 2 | BACKGROUND

The international need for generalist, specialist and advanced roles in cancer nursing is ever-present. Challinor et al. (2020) advised that, in addition to the implications of the COVID-19 pandemic, the global challenges of sustaining a robust oncology nursing workforce persist. These include nursing shortages, recruitment barriers (e.g. perceptions of a demanding speciality with complex care and hazardous work environments), and risk of burnout. Cancer nursing recruitment can be difficult because the specialism is documented as being emotionally, physically and cognitively demanding. This has resulted in stress being recorded as one of the most prevalent workplace issues among adult and paediatric oncology nurses (Gribben & Semple, 2021).

Causes of stress and burnout in cancer nursing are multifactorial. They can include the nature of the disease, complexity of cancer treatments, high-acuity patients, dealing with death, communication issues, intense patient needs and family involvement, interdisciplinary conflicts, ethical challenges/decision-making, end-of-life (EOL)/palliative care issues, role strain and workload and workplace environment issues (Mazzella Ebstein et al., 2019). These do not include any personal or intrinsic factors that nurses may also experience.

Research has explored the emotional impact on nurses who care for adult and paediatric cancer patients (Aburn et al., 2021; Bowden et al., 2015; Cañadas-De la Fuente et al., 2018; Pfaff et al., 2017), which are known to be fraught with emotional entanglement and challenges. Yet little is yet known about the experiences of ward-based, early-career nurses who care for AYAC and any emotional challenges this may bring. This study sought to fill this gap so that there is a better understanding of the needs of ward-based, early-career nurses who care for AYAC. The reason for focussing on these nurses was because they deliver direct clinical care as opposed to that of higher grades of nurses whose additional responsibilities take them away from the daily patient-nurse interface.

## 3 | THE STUDY

### 3.1 | Aim

The aim of this study was to explore the experiences of early-career nurses who care for adolescents/young adults with cancer in age-appropriate specialist settings.

### 3.2 | Design

Narrative Inquiry methodology (Clandinin & Connelly, 2000; Kim, 2015) was used to explore early-career nurses experiences of working in this care setting. This approach values individuals' stories and is based on the work of Dewey (1938) who notes

that experience is understood to be relational, interactional, continuous and social. Narrative Inquiry is an overarching phrase that encapsulates personal and human perspectives of historic experience and acknowledges the relationship between cultural context and individual experience (Clandinin & Connelly, 2000). Its underlying philosophy and accessibility aim to illuminate the stories of real people, in real settings, by acknowledging human experiences as dynamic and persistently in fluctuating states of change. Furthermore, it helps to give understanding to issues such as personal identity, life course development and the cultural/historical domains of the 'narrator', in this case, nurses, which fits with the experiential perspectives that were to be explored.

There are multiple ways in which theory can be used to frame a study, primarily either by testing an existing theory or by theory building, and in narrative research Kim (2015) sees this as an intellectual activity that links lived experience to scholarship and practice. In this study, no hypothesis or existing theory was to be tested. In an earlier paper, a postmodern position was taken (Cable & Kelly, 2019) to consider the development of the AYACC specialism so some concepts and themes were identified through a process of induction. In this instance, existing theory was to be used to guide the sensemaking of the stories being told by these nurses.

### 3.3 | Recruitment and participants

Invitation to participate in the study was via Twitter. The inclusion/exclusion criteria are outlined in Table 1.

A large cohort of research participants was not anticipated for this study, which was an important factor in selecting narrative inquiry as a methodological approach. The narrative of individuals is what yields rich data as opposed to looking for larger sample sizes to generalize results (Kim, 2015). The aim was to gather data from 8 to 16 nurses representing specialist units from at least four different locations.

TABLE 1 Inclusion/exclusion criteria

Inclusion Criteria were:

- UK Agenda for Change Band 5 Registered Nurse (Child or Adult field)
- At least 6 months post initial registration as a nurse
- Continuously employed within specialist AYAC clinical in-patient or ambulatory care settings in the United Kingdom for at least 1 year
- Willing and able to give written consent and participate

Exclusion criteria were:

- Registered nurse who is less than 6 months post initial qualification
- Registered nurse with less than 6 months experience of working with adolescents and young adults with cancer in specialist adolescent and young adult cancer care settings.

### 3.4 | Data collection and management

Data were collected between October 2020 and January 2021 via individual online conversations, using a semi-structured schema (see Table 2), which were video recorded (with MC) using Zoom technology from a licenced account. Conversations in the online space were held in the nurses' and the researchers' own homes, respectively, so confidentiality was maintained. Conversations eliciting their experiences lasted between 45 and 90 min. These conversations were then transcribed by MC and verified by DK. Nvivo11 was used to help manage the data, although manual data handling was also employed. Participants were made aware that the conversations would be video recorded, and that data would be stored on a password-protected cloud account and would be destroyed after 5 years.

### 3.5 | Data analysis

The primary researcher (MC) moved between the stories gathered from the conversations in light of the research questions and considered the literature review whilst following the methodological approach of Clandinin and Connelly (2000). Regular meetings with the supervisory team (DK, TW and CR) prompted discussion and analytic decisions. Polkinghorne (1995) considers two main analytical approaches in narrative inquiry: paradigmatic and narrative modes. The former tends to recognize categories and patterns. The narrative mode of analysis advocates that the researcher relates to participant stories in a more congruent way. By adopting Polkinghorne's narrative approach, the focus was on whole stories, and considering aspects of the experiences being relayed, taking account of context, feelings and interactions in the retelling. Keeping stories intact preserves their uniqueness and by identifying open codes across the stories (initially by MC) led to the creation of a thematic typology across the data (Bengtsson et al., 2020). This thematic approach identified common and diverging elements between participant's narratives. We ensured that this reflected the narratives that

TABLE 2 Conversation schema

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Confirm understanding and agreement to continue.  
Can you tell me about how you came to become an AYA Cancer Nurse?  
Can you tell me a bit about your daily work? What does it entail?  
Can you recall a memorable episode of caring for an AYA with cancer that you may have found particularly memorable and why?  
What strikes you about working in this environment?  
Further prompts could include:

- What was your primary goal during that interaction/period?
- What was/is it like?
- What would have helped you?
- What would you have done differently?

Can you tell me about your coping techniques?  
Can you think of any training or support initiatives that might help?  
What aspects of your work makes you want to stay in caring for AYA with cancer?  
How do you see your future in nursing? Will it be in AYA cancer care?  
At end of the interview, check that they feel ok and safe.  
Would they like a check in call or email in a week or so?

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were revealed, thereby taking a holistic perspective (Holloway & Freshwater, 2007) of the data.

In strengthening the narrative analytical approach, we followed Clandinin and Connelly (2000) who suggest working in a relational way with data. They speak of the three-dimensional space (referred to as commonplaces) within which all stories occur. These commonplaces comprise dimensions of temporality, sociality, and place, and were used as an analytical framework to find meanings and interpretations from these coded participants' stories. The 'temporality commonplace' refers to time/continuity, including the past, present and future elements of an experience. The 'sociality commonplace' relates to personal and social aspects; whilst the 'place commonplace' addresses place or places where experience occurred (Clandinin & Connelly, 2000, pp. 50–51). Table 3 details the themes and sub-themes that were identified using the three commonplace approaches.

Using a framework matrix within Nvivo 11, the initial codes were collapsed, and narrative themes were then identified in a relational way within the three commonplaces, and are described in the findings section. Interconnections were made between and across the commonplaces and stories, and became referred to as 'common strands'. It is these strands form the basis of the discussion section.

### 3.6 | Ethical considerations

Ethical approval was sought and obtained from the Cardiff University School of Healthcare Sciences Research Ethics Committee. A participant information sheet was provided and, following the agreement to progress, a simple electronic signature confirming consent was gained by email as guided by the Health Research Authority (2019). This proved efficient as this study was undertaken during the COVID-19 pandemic, thus removing the need for any physical handling of research materials by participants. All data were anonymised (and pseudonyms were given to each nurse) for the purpose of research reports and publications.

### 3.7 | Trustworthiness

Each participant was sent the full transcript of their storied conversation for verification of accuracy to help ensure the trustworthiness and credibility of this research. Each storyteller was given a voice to ensure that they were an authentic representation of the experience (Clandinin & Connelly, 2000). The Four-Dimension Criteria (FDC) was used to establish trustworthiness (Lincoln & Guba, 1986) as outlined in Table 4.

## 4 | FINDINGS

### 4.1 | Participant descriptors

Nine nurses came forward from six different United Kingdom units. This research was conducted during the COVID-19 pandemic when nursing and healthcare were under unprecedented pressure. The

TABLE 3 Themes and sub-themes

Temporality	Sociality	Place
<ul style="list-style-type: none"> <li>• Becoming an AYA cancer nurse</li> <li>• Shift work</li> <li>• Being part of the AYA cancer journey</li> <li>• Beyond</li> </ul>	<ul style="list-style-type: none"> <li>• Personal               <ul style="list-style-type: none"> <li>• nurse age and experiences</li> <li>• nurses' emotions</li> </ul> </li> <li>• Social               <ul style="list-style-type: none"> <li>• AYA Cancer specialist care</li> <li>• The multidisciplinary team</li> <li>• Nurse support systems in the workplace</li> <li>• Nurse support systems outside the workplace</li> </ul> </li> <li>• Culture</li> </ul>	<ul style="list-style-type: none"> <li>• The specialist units               <ul style="list-style-type: none"> <li>• Physical environment</li> <li>• Relaxed atmosphere</li> <li>• Social spaces</li> </ul> </li> </ul>

TABLE 4 Key FDC strategies adapted from Lincoln and Guba (1986)

Rigour criteria	Purpose	Strategies used
Credibility	To establish confidence that the results (from the perspective of the participants) are credible and trustworthy	Discussion with supervisory team that MC was a capable interviewer Regular discussions with supervisory team Participants had opportunity to check transcripts for accuracy Supervisory team reviewed themes independently and these were discussed as a group Observation notes from conversations were recorded by MC
Dependability	To ensure the findings of this inquiry are repeatable if the inquiry occurred within the same cohort of participants, coders and context	A study protocol was developed prior to commencement Rich description of methods is outlined Digital recordings of conversations were transcribed immediately and checked for accuracy by research team against video and written formats Codes were checked by the supervisory team
Conformability	To extend the confidence that the results would be confirmed or corroborated by other researchers	A reflexive journal was kept by MC There were regular documented supervisory meetings
Transferability	To extend the degree to which the results can be generalized or transferred to other contexts or settings	A scoping review was completed (MC) to check that this study had not been undertaken previously or repeated elsewhere Detailed descriptions of experiences documented Final report written to include data extracts to provide evidence to support analysis

researchers felt enough data had been achieved, and that it would be futile and irresponsible to seek more, given the pressures on clinical services, and on nurses, at the time. None of the nurses refused to participate, or dropped out, after learning more about the aims of the study. Table 5 outlines demographic data.

## 4.2 | Commonplace—Temporality

Temporality can reveal how change occurs over time and serves to remind us how past experiences influence how current and future events are perceived. As these nurses' stories of practise were re-told, similarities that gave rise to several temporal themes to illuminate common or shared experiences were recognized and are now described.

### 4.2.1 | Becoming an AYA cancer nurse

Each conversation opened by inviting the nurse to tell how they came to be working in AYAC care, signalling an early-temporal aspect to their story.

Six of the nine nurses gained insight into haematology, cancer or AYA cancer from having been on a nursing student placement in these settings, which had then fuelled an interest in working in the specialism. Claire recalled:

As a part of that placement, I got to spend two weeks in the teenage young adult cancer unit... and I just really, really enjoyed working there and enjoyed the fact that I could use paediatric skills and adult skills.

TABLE 5 Demographic data

Name	Age	Gender	Full Time (F)/Part Time (P)	AYA unit	Adult, children's or dual qualified	Years qualified	Years working with AYAC
Brian	25	M	F	1	A	2	1
Jade	23	F	F	2	C	2	>0.5
Anna	28	F	F	3	A	7	6
Claire	23	F	F	4	A&C	1	1
Jessica	24	F	F	2	C	2	1.5
Jemma	25	F	F	5	A	2.5	1.5
Lauren	48	F	F	6	A	1.5	1.5
Rachel	28	F	F	6	C	6	1.2
Amy	25	F	F	6	A	4	0.8

Most nurses felt that it took about a year before they became clinically competent in AYACC. Once they had undergone in-house training and achieved a level of competence as assessed by senior colleagues, they would often be assigned as the senior nurse on the ward, especially out of hours on shift patterns. They delivered complex clinical care and were expected to make clinical and management decisions, despite their junior career position. For some, this was very challenging, as Lauren's words suggest:

I feel like a fish out of water in the actual job because you've got so much health stuff to learn, you know, and in particular the skills bit ...

#### 4.2.2 | Shift work

All the nurses cared for patients over the 24-h period through shift work. Jemma acknowledged that she was often left in charge out of hours which could be stressful. Her story highlighted the pressure of staffing challenges across different shifts and times:

If I'm the only chemo giver sometimes on days or on nights.... It is quite stressful to share the workload. If you're working with someone who is quite newly qualified.... in my head I was like, I'm the newly qualified!! Like, how am I looking after someone who's, ... you know... can't do that with me, the division was so short staffed.

Anna also alluded to staffing levels and feeling unsafe out of hours, which she felt compromised the quality and satisfaction of care she gave:

I think sometimes staffing can be quite a hindrance to being able to provide really good quality care. And so, if you are unsafely staffed through either vacancies or sickness or lots of different factors,

that can be a real impact because perhaps you feel that you can't give such a high standard of care and you can't achieve for those patients because of these constraints, because it's unsafe and that really impact at times.

Amy and Jade spoke of the value of quieter times, especially on night shifts, when they could 'get to know' patients better:

I'll go in, especially in a nightshift when you've got time.... go in and have a chat with people and some patients I could sit with for an hour and just talk to them and then you go to the next patient.

(Amy)

#### 4.2.3 | Being part of the AYA cancer journey

All nurses spoke about getting to know patients and families over long periods of time as patients and families were repeatedly admitted to these units whilst they progressed through cancer treatments. Jade reflected:

I feel that you get to follow a lot of the patient's journey... and you're sort of there all the time... Yeah, definitely I think that it's such a long process that maybe you didn't realise until, until you're faced with it.

The observation of witnessing young people's transition into adulthood was another temporal feature; such was the length of time over which they got to know and work with AYAC. Rachel and Lauren noted that the relationships with patients and families developed over months or years through having had multiple conversations, but that the counter to this was that these conversations also posed a risk as a result of patients wanting to know more about their personal lives of nurses:



Because you are spending so much time with them [patients and family's] ....they do want to know more about you.

(Rachel)

#### 4.2.4 | Beyond

Eight nurses stated that they wanted to undertake further academic study in AYACC, so that they could be better at their jobs and progress their careers. As Jemma stated:

It's nice to say in five years' time, I'd love to have done a couple of courses in specific areas and maybe be a Band 6 or be a specialist nurse.... everyone can't just stay as a Band 5.

Six nurses (Claire, Anna, Jade, Jess, Jemma and Amy) aspired to become Clinical Nurse Specialists in AYACC, possibly in outreach works, clinical trials, palliative care or AYAC in general.

### 4.3 | Commonplace—Sociality

Narrative inquirers must also attend to the 'social' dimension of their participants which draws attention to how personal (feelings about their experiences), social and cultural experiences or conditions influence their narrative (Clandinin & Connelly, 2000). Analysis from the narratives relating to this commonplace are now presented.

#### 4.3.1 | Nurses age, experiences and emotions

A striking feature of the nurses was their age; 23–48 years. Their mean age was 28 years and the median was 25 years. All except one was 28 years or less, thus not much older than the AYAs that they cared for. All nurses alluded to their age, or the ages of other nurses, in these conversations.

Younger nurses felt that being a similar age was beneficial, particularly in terms of relating better to patients. Jess, 24, saw this as an advantage yet recognized the importance of transience:

It does cross my mind that sometimes they will know whoever's in the, in the charts and whatever, and no one else will know what they're talking about.

Being a similar age was also reported as having risks. Anna, 29, Jess, 24 and Brian, 25, saw the risk of being over-friendly using over-familiar communication styles. Anna had recognized this risk in colleagues:

I think you also risk at times [having] 'over familiarity' with looking after the similar age groups because you think you know you're the same age as me and I can do this, or this is how I would want to talk to you and almost it can, it can blur the language that you use .....sometimes it's actually a fine line.

Brian also noted this risky strategy:

Sometimes you have to treat them as friends to kind of get along with them, particularly as they're your age, rather than treat them as patients, and I think maybe helps.

Lauren, 48 years, worried about her age when she started to work in this setting:

I thought, I don't know that I'm young enough, or trendy enough to sort of hang around with them....but then I thought to myself, you know sometimes you just need the maturity to care and to sort of I think, be able to hang there and sort of say, 'do you want to talk about anything?'

Eventually, she recognized that it was the ability to be able to connect with AYAC patients that was important.

The emotional impact of the early-career nurse's work with AYAC, and their families were notable, particularly when patient outcomes were poor, and especially when the news of treatment having failed is broken. They spoke of managing this emotional load whilst still negotiating clinical care delivery for other patients.

Amy, for example, spoke of the strength of relatedness with one patient and their family when the disease recurred:

With certain patients it's really hard to take yourself away from that. It's important to go through the motions with the patients, of course, and to be able to simply be empathetic towards them. But like this example, at the moment, we're all ... we all basically feel like we're all part of the family for this one patient.

Lauren also recognized this sense of turmoil:

There are moments where you're in that space and it's emotional, isn't it, and you know that you really care about those people and you want some miracle.

She added that having this emotional connection was important for patients and their families, despite her having to navigate her own way through it:

You sort of have an eye contact with that mum, and you can see her eyes are full and I could feel my eyes were filling and I think that's okay, I think it's okay. I don't think it's appropriate for you to sort of break down and have a good cry or anything, you know, and you don't want any transference of your emotions to go to them.

The emotional burden of their nursing role was carried over to when these nurses were not working, indicating that switching off was difficult. As Rachel said:

You start thinking about it outside of work and ... you start putting all your hopes towards them as well and yeah, you know, it's completely devastating for them when they hear it but... you just, you just do it for them.

#### 4.3.2 | AYAC specialist care and team

Attending to the unique clinical needs of AYAC was a strong feature of the nurses' practice and the social fabric within this work environment. All nurses acknowledged that AYAC required different types of attention to younger children or older adults. Given there were a mix of nurses who were trained to only work with adults ( $n = 5$ ), or with children and young people up to 18 ( $n = 3$ ), with one being dual-trained, they all mentioned distinct differences in caring for AYAC.

It was evident that AYACC was not being delivered in isolation by these nurses as individuals, but within a multi-disciplinary team (MDT) that focused on patients' holistic needs. The nurses valued this mutual support and spoke positively about their colleagues:

My team is the most supportive team that, you know, I've ever met.

(Anna)

#### 4.3.3 | Nurse support

When asked about how they coped with the emotion of it all, six of the nurses signified their journey home, being outdoors and physical activity as being a purposeful and necessary act to de-stress.

Lauren said:

I do think about, you know, on my journeys or when I exercise. I tend to think about what I've done. And sort of be mindful of it.

All nurses, except Brian, were offered the opportunity to attend structured debriefing sessions though this was not mandated:

At the moment, the culture might be just obviously ...'we'll kind of be empathetic to each other'. But there's no specific thing there to talk about it.

(Brian)

Otherwise, these nurses spoke of active offers of staff support of varying types. Claire, Jade, Jemma, Jess, Amy, and Claire spoke of support sessions, facilitated by a counsellor/psychologist that they could attend if they felt they needed, or wanted, them. These were held weekly or monthly. Some nurses spoke of times at night, often when the most stressful of situations arose, that during or after these shifts, no-one would be available to share with. It seemed to be hit-or-miss as to whether managers checked to see if they were coping with the clinical events they had experienced.

These nurses valued senior nurses checking in on them, not only to see if they were coping, but they also valued learning from those with greater experience and knowledge of cancer nursing. Jess, valued having an opportunity to speak to a counsellor as well as the Clinical Nurse Specialist (CNS):

So, if especially after any death, we can have a debrief or anything like that. We can talk to this lady that comes in to support as well, obviously the CNS is a really good, they help, will help us if we need it.

Eight nurses spoke of feeling supported by people away from work such as partners, family members or friends. At least half highlighted benefits when these people were also from nursing/medical background, as they had some insight into their work and associated feelings.

Anna valued the emotional and practice support from her mother, also a nurse:

I can talk to her really confidentially, so while I won't say any names... it's quite helpful at times to be able to have someone to be able to say 'That's a really valid feeling and how can I help you either offload'

These nurses' families seemed to know and respect that this type of work carried an emotional toll, and at times they may also have become vicariously and emotionally invested in the patients that their own loved one's cared for. One of the nurses said:

Even my mum and dad are asking 'How's the boy doing?' ...so it just shows how involved they are you know and over attached I am to some particular patients.

Jade spoke of her partner (a non-medical background) knowing not to ask any questions of her (respecting patient confidentiality) when it was apparent that she had had a difficult shift. He felt helpless, though he wanted to help. This appeared burdensome for her, and perhaps for him too.



Brian stated that the intensity of death on the ward was enough to make nurses feel they could no longer work in the environment:

It's been quite a bad six months in terms of the number of people who've passed away. And I know that at least a couple of people who are moving on or were thinking about moving on. And that's one of the reasons for it.

These aspects of our conversations suggested that, at times, delivering safe clinical care was a significant challenge. However, amidst mentions of staffing challenges, there was no sense that there were chronic staffing issues per se, and that the MDT cohesion was a highly valued and strong positive feature. Arguably, these nurses may have come to accept that being short staffed was the norm and they now left it unquestioned. The emotional impact of this work in this situation featured strongly as an additional challenge.

#### 4.3.4 | Culture in the specialist environments

In conducting narrative analysis, it is important to also understand the cultural context of the research study. The youth culture and sense of fun existing on these wards was a primary feature experienced by these nurses amidst the chaos and enormity of treating AYAC who were seriously ill. This could suggest there are risks for early-career nurses in inadvertently portraying themselves, or being portrayed by patients and families, as being the friends of patients and families rather than being friendly professionals. This is where these narratives could suggest a risk from the blurring of the role and the person.

Claire recognized that relationships with AYACs and families could be tinged with sadness and awkwardness both by patients and families. She recalled how it felt when she was referred to as 'being a friend' of one boy by his father:

You also have to be really careful about having that sort of nurse/patient relationship whilst also talking to them and chatting to them like you would... for example, like a friend and obviously you're not their friend

There were times where these nurses became involved in creating fun activities such as movie nights (Jemma), playing pool (Brian) or organizing for an AYAC to go to a concert (Anna). The nurses appeared to enjoy that aspect of their work- it was novel, and they recognized it as important in developing relationships with patients. The downside, however, was that the closeness developed was also a risk when things did not go well.

#### 4.4 | Commonplace—Place

None of what has been described could have been experienced if it were not occurring in a particular place. In this case, these locations

are charity-funded built environments based within NHS hospitals. All the nurses referred to the specialist-built environment in some form or another. For some, like Claire, they believed that this promoted a sense of normality where AYA could continue to feel young, and do things that their peers like to do:

I really do think that the environment helps, having the big chatroom with the pool table and the jukebox. And then the teenagers go in there and they've got the music on or they're sat in there they're watching the football with a couple of other young people on the ward....

Jemma also appreciated this environmental perspective that invited young people to share something more of themselves, it acted as a bridge helping them get to know the AYA's life before and during cancer:

I think the environments are quite that big thing.... I think it's quite nice that you go into their space and... sometimes patients make it really homely, and they have loads of pictures of all their friends on the wall and when you're chatting and you're doing some of their stuff like changing PICC line dressings so you're like 'Oh my gosh like that's you with hair and you look so different and like who are these friends?' and they kind of tell us a bit of like life outside which is quite nice.

The physical space was also used to promote relationship development. Anna recognized other important attributes of the physical space enhanced AYAC connectivity with the outside world:

We have free internet access so that's a really big factor for TYA to be able to listen to music or watch films or connect with their friends from their gaming. And that's a really big, important thing for them....

The physical space was a significant reminder that the philosophy of care for these AYAC patients was intentionally different both from a physical and contextual sense from either paediatric or adult cancer services.

It was established that nurses were often talking about similar topics within the dimensions of this analytical framework. Whilst they may have differed in what they said, they each offered perspectives on themes or 'common strands' (expanded on in the next section) which helped in understanding their experiences of caring for AYAC in these specialist settings.

## 5 | DISCUSSION

This study sought to explore the experiences of early-career nurses who care for AYAC in age-appropriate specialist settings. By

examining the narratives of nine nurses who relayed their experiences, it allows readers to rethink and reimagine the working life for these nurses in specialist environments. Thus, it contributes to nursing knowledge in this specialist area. The common strands that evolved from the narrative analysis were matters that were elaborated in these participants' stories, from their unique experiences and these are represented in [Figure 1](#).

## 5.1 | Strand 1—The emotion of it all

This strand represents the prolonged and intense nature of the early-career nurses working with AYAC, and their families, and how this perfused their narratives. Their depictions of working in these specialist units suggested that it was busy and stressful, with acutely ill or dying young patients, requiring the integration of highly specialized technical and human skills. Three distinct elements to this strand were identified: emotional range and labour; connecting with AYAC and families and coping with emotions. These elements contributed to how these nurses contended with and managed the emotional aspects of their work in this field. Their stories gave insight into the intensity of the emotion work involved, and what motivated them to go on doing this work.

These nurses described a range of basic emotions brought about by working with AYAC and their families. Whilst several theories exist to categorize and explain emotions (Ekman & Cordaro, 2011), early-thinking established six universal categories: happiness, sadness, anger, surprise, fear and disgust, all of which appeared in these nurses stories, to varying degrees. Emotions, as with all human experiences, are relational and arise through processes of interaction and communication. Each are themselves multi-faceted and represented across various biopsychosocial discourses (Theodosius, 2008). 'Story telling' within Narrative Inquiry often involves the recollection of emotions during an experience

(Holloway & Freshwater, 2007); therefore, it was not unexpected that this became apparent during data analysis and was notable in these findings. The intensity of the emotions described by these nurses was striking; when it was sad it was very sad, and when their work was happy, it was joyful.

As can be seen in the findings section, these nurses went through a wide range of emotions with the AYACs and families, brought about by the disease trajectory itself, and length of time they got to know their patients. They were conscious of both managing their outward emotional expression when in front of patients and families, whilst also being responsible for sustaining high levels of cognitive engagement in the delivery of complex clinical care, as exemplified by Lauren when she moved between an acutely ill and a dying patient. This fits with Jackson et al.'s conceptualisation of nursing work that encompasses physical, emotional, cognitive and organizational labour (Jackson et al., 2021) all of which can sometimes seem taken for granted. Physical, emotional and organizational labour have been well established in the literature and Jackson et al. (2021) purport that cognitive labour, referring to the mental workload of nursing, is as complex and skilled as any other aspect of nursing work. In their meta-narrative review, they identified that cognitive labour included learning, thinking, stacking and cognitive loads, all of which form a considerable part of nurses' work. This was evident for these nurses who were managing all four aspects of nursing work from this very early-point in their careers.

Caring for young patients who are dying clearly requires emotional labour for all nurses, which is in keeping with the literature more broadly concerning adult and child end of life cancer care (Aburn et al., 2021; Cañadas-De la Fuente et al., 2018; Gribben & Semple, 2020). Other authors acknowledge that managing distress, suffering, trauma, death, bereavement, anxiety and anger were common sources of emotional labour for haematology nurses (Kelly et al., 2000). The evocative narrative that run through these nurses' stories highlights that emotional labour is an active and demanding

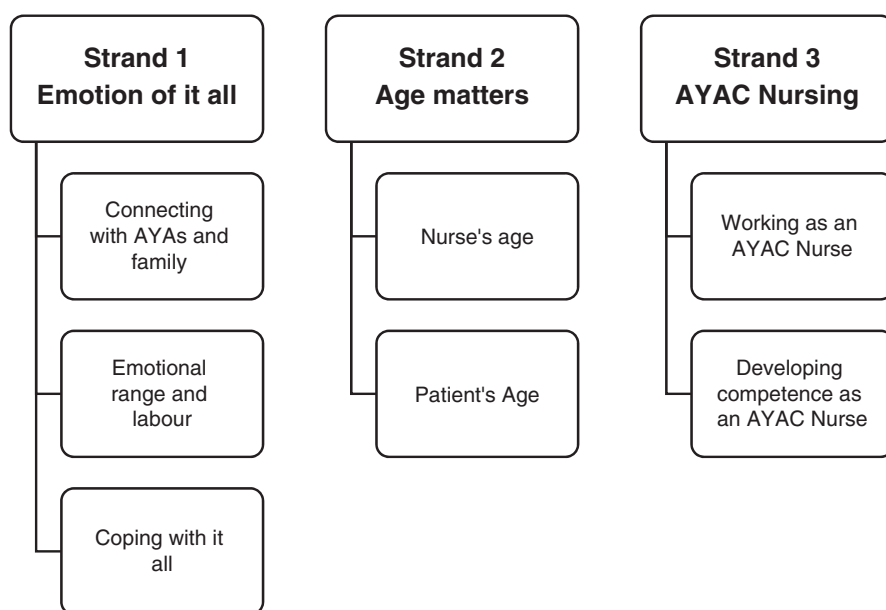


FIGURE 1 Common strands

process. This study confirmed its nature for these early-career nurses.

A striking temporal narrative retold in all these stories related to the connections or attachments the nurses spoke about with patients and their families that had developed over prolonged periods of time, often years. A similar feature was identified in the early-research of Kelly et al. (2004) on the first UK specialist AYAC unit.

Connection with patients and families is an integral component of all health and social care work. Because of AYAC age, they cross the legal threshold of having autonomy in a legal sense, whilst grappling with developing an independent relationship from their parents (Chisholm et al., 2018). Whilst there are arguments for and against the presence of parents and time alone for AYAC, there is no doubt that separating them for all communication is unhelpful. In the accounts shared here, the AYAC's parents featured heavily. The intensity of parental input may have come as a surprise to some nurses, particularly those trained as RNs (adult) compared with those trained as RN (child) nurses, especially when they had first worked in the specialist setting as described by Gemma and Rachel.

All these nurses reported positively on the general support offered by colleagues, particularly from more experienced nurses when emotions were running high on these units, as described by Jess. Rachel, for example, referred to the normalcy of distress that can be felt by staff, and that they automatically recognized this in each other, and then offered support. This was interpreted as meaning that she felt both confident and safe to express her feelings; a phenomenon described by other researchers who found that colleagues' support could enhance nurses' resilience (Boyle & Bush, 2018; Cameron & Brownie, 2010).

The notion of structured organizational support was recounted in several of these nurses' stories. Little seemed to occur on the units specifically, with some advocating for valued support from more experience colleagues which was not always offered. However, the majority were offered access to psychological help as a self-selecting activity by nurses to undertake. In the NHS England (2017) policy document *Next Steps on the NHS Five Year Forward View* it is stated that NHS staff health and well-being must be a priority for the NHS as it struggles to cope with rapidly ageing populations, burgeoning chronic disease burdens and events such as the recent COVID-19 pandemic. It states that interest in improving both the mental and physical health and well-being of healthcare professionals is paramount. Interventions to improve healthcare staff health and well-being have tended to focus on supporting or improving individual coping skills rather than affecting the workplace environment such that it promotes healthier behaviours (Brand et al., 2017). To some degree that is what these early-career nurses also report: there are support mechanisms, but the nurse must be self-motivated to access them. They also reported that organizational support mechanisms (e.g., group support sessions) were reduced during COVID-19, just when they were most needed. It is argued that NHS clinical environments, whether funded by the NHS itself or part-funded by charities, as is the case of AYAC, have a responsibility to place staff well-being needs as a priority. This should be acknowledged by strong visible

leadership at senior management and board level and focussed on improving the health and well-being of staff working in such emotive environs.

All early-career nurses spoke of the support gained from family and friends outside of work. Those with family members, who were health professionals, spoke of the value of these supporters having a common professional insight into their work. Although family can be considered as a helpful strategy for nurse coping surrounding the death of a child or young person, professional confidentiality remains an issue with accessing this type of informal social support. This is echoed in a literature review which recognized the tensions in the closeness and professionalism between nurses and parents of children in palliative care settings (Brimble et al., 2019). This questions the further need for educating AYAC nurses on the risks that leaning too much on friends and family for support may have for them as professionals, as well as those with whom they share their emotional burden, however confidential their disclosures are.

## 5.2 | Strand 2—Age

The concept of age in the narratives featured strongly. Primarily, this began with patients. The fact that they are being cared for in these specialist clinical settings suggests from the outset that they do have particular age-related needs. It is not the purpose of this study to describe what AYACC should comprise, as this has already been explored elsewhere (Cable & Kelly, 2019; Taylor et al., 2019). However, the age and experience of these early-career nurses themselves were issues spoken of repeatedly, and which have not been revealed elsewhere in the literature.

The nurse participants in this study fall into the categories of Generation Y (born between 1977–1993) or Z (born after 1993), making them similar in age to their patients and their parents. So, they will have much they can relate to in terms of generational experiences. The concept of generational diversity has emerged as an international challenge for workforce design as it seeks to ensure that it attracts both new recruits generations and retains existing generations of nurses (Cole, 2020). Whilst workforce diversity is becoming more heterogeneous than in the past, the nursing workforce literature is aligned with the challenges that managers now face in working with inter-generational groups of nurses who may have differences in attitudes and values from the majority of the workforce (Bennett et al., 2021). In this study, there may have been signs of a mismatch between older managers and these early-career nurses about the significance of such differences.

We were reminded of both the extraordinariness and vulnerability of these young nurses caring for equally young dying cancer patients, especially as these nurses told of how much their age enhanced their sense of relatedness with patients and parents. Exposure to prolonged death, and repeated deaths of young patients to whom the nurses feel close, and to those with an potentially incurable disease, has long been associated with increased stress and emotional exhaustion in health professionals (Aburn et al., 2021;

Boyle & Bush, 2018). This is not an aspect that was established in depth in this study, but it does highlight that age and experience may influence how nurses respond to death and dying, as it is noted in the literature that having EOL conversations with AYAC can be difficult for many professionals (Avery et al., 2019; Sansom-Daly et al., 2020). This narrative study highlights this as a particular challenge for early-career nurses, their colleagues and indeed their own families, in part because the death of someone so young is not a regular or expected occurrence.

### 5.3 | Strand 3—Conceptualizing AYAC nursing

Not only were these early-career nurses striving to learn about nursing in this specialism, but also about how to survive and thrive within it. This study was conducted amidst the COVID-19 pandemic where nursing recruitment, already facing a global shortage, could not have been more challenged. It was felt that these nurses sought two main foci in their learning and development during their early careers: (1) developing competence as an AYA Cancer nurse and (2) working as an AYA cancer nurse.

Narratives from the nurses suggest that once they had achieved basic clinical skills and competence to be able to deliver clinical care, they aspired to learn more through in-house and more formal education. They recognized that AYAC have different needs but did not always articulate this very clearly at this stage in their career. What is not contested in the literature from both United Kingdom (Gibson et al., 2012; Taylor et al., 2016) and Australian (Bradford et al., 2018) studies is the need for professionals in AYAC to have specialist education. These studies propose content that might be included in educational courses. Caring for this group of patients requires both generic and specialist understanding of cancer care as well as AYAC needs (Cable & Pettitt, 2018). Arguing for specialist education in this niche field, however, competes with other greater service demands and sometimes appears difficult to mandate and implement.

These early-career nurses operated within and across many occupational, departmental, organizational and age-related boundaries. Through this narrative study, we have strengthened the view as to the specific AYAC-related knowledge and skills that underpin this area and propose a new conceptual framework for AYAC nursing. This framework builds on the work of Lea et al. (2018; holistic competence in AYACC) and Jackson et al. (2021; four types of nursing labour) and is outlined in Figure 2.

Underpinning this framework is the need for:

1. A supportive cancer care environment where the holistic, social and developmental needs of AYAC, their families, peers and supporters are considered.
2. Recognition that a range of specific AYAC nursing knowledge and skills that include clinical, technical, psychosocial, critical appraisal, leadership/management, collaboration, reflection and self-caring ability.

3. Recognition of the need for emotional support, continuous professional development and career development opportunities in AYAC nursing.
4. An ability to plan and measure quality and safety outcomes that consider the unique nature of AYA nursing practice, patient care and service improvement.
5. Recognition that physical, organizational, emotional and cognitive dimensions of AYAC nursing are of equal importance across the career trajectory.

The construct of this proposed model serves as a starting point for discussing the work of AYAC nurses, particularly for those still early in their careers. Whilst the model may be perceived as linear, it is important to acknowledge that AYAC nursing work is more dynamic and complex. For now, it is based on the work of early-career nurses and has the potential to be extended for other levels of nurses as they progress their careers in AYAC. The model highlights the complexity of the type of work that these nurses do and the complex adaptive systems within which they exist.

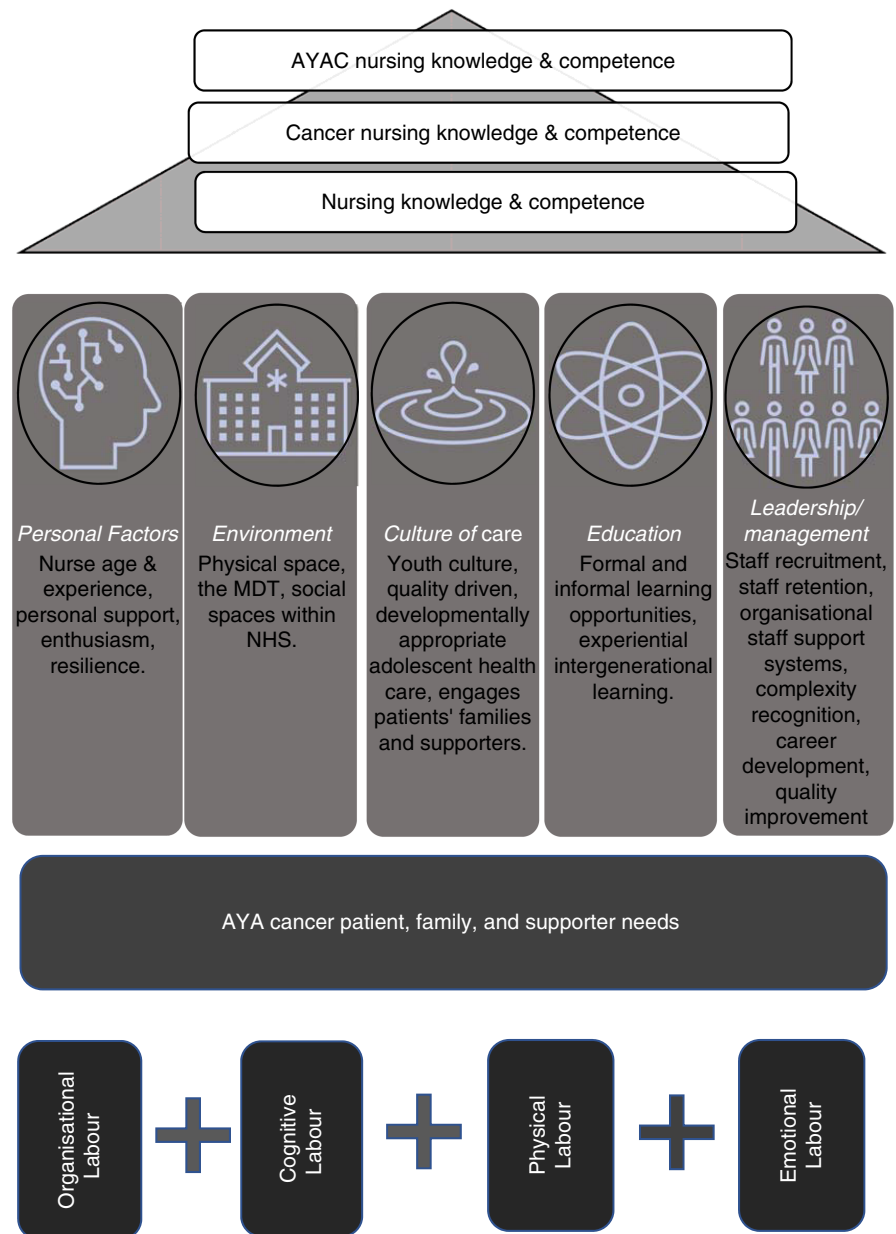
These findings would suggest that any specialist education initiatives should reflect the types of labour involved in AYACC, including emotional labour, managing professional boundaries, AYAC developmental needs, preparation for holding difficult conversations and supporting AYAC, their supporters and staff, in particular during EOL care. Given the paucity of nursing research in this field, it is recommended that the proposed model of AYA cancer nursing is tested for use across the span of nursing roles and in various settings; both nationally and internationally. Longitudinal evaluation of the emotional impact on early-career nurses, and those who are more established in their careers in AYACC, should be undertaken to assess its impact and consider strategies to support these colleagues further.

### 5.4 | Study limitations

This inquiry was limited to the stories of experience told by nine participants across six different hospitals and may not be representative of nurses' experiences in AYAC units across the rest of the United Kingdom or internationally, or indeed for nurses who care for AYAC outside of specialist units. With a highly gendered sample, all but one identifying as female, we accept this as a potential limitation, although it is representative of nursing where around 90% are women (Buchan & Catton, 2020). There is no claim made for generalisability of findings, though aspects of this work may have transferable value to others.

Whilst it is acceptable to have small sample sizes in narrative inquiry, recruitment was severely hampered by COVID-19, which could not have been anticipated. All recruitment to non-essential research in the UK NHS, such as this study, was stopped. Recruitment by other means, such as gaining ethical approval to recruit more directly in the units, may have yielded more participants.

**FIGURE 2** Conceptual framework of adolescent/young adult cancer nursing



## 6 | CONCLUSION

This study has demonstrated that AYAC nursing work for early-career nurses is uniquely challenging, and the findings confirmed four types of nursing work as described by Jackson et al. (2021). It is demanding, complex work that these nurses engage in, and take accountability for, from the point of registration onwards. The relationships that these early-career nurses have with AYAC patients and families are powerful, yet transient and often may never reach a sense of closure without emotional costs. Therefore, nurses can live with a sense of ambiguity and transience and may struggle to spare the time, energy and emotional maturity to move towards a more subjective stance/position with AYAC and their families. If early-career nurses, or indeed any nurse's, goal is to strive to completely understand the practice of AYAC nursing, they will be faced with having to cope with such ambiguity and transience. They must also

recognize the risks and tensions between positions of empathy, neutrality and distance, as part of this work.

The stories told in this study have contributed to a new understanding and cultural narrative about the nature of AYAC nursing. What is important is that we look after our young—both patients and nurses—for they are all deserving of a bright future. How we do so will bear great consequence for their long-term potential, for if we do not look after early-career nurses, then young cancer patients will also struggle to receive the unique care and support that is needed.

This study offers new perspectives on the work of early-career nurses in AYACC in the United Kingdom, as well as insights into the uniqueness of this work and we anticipate that it may act as a springboard for further discussion about this specialism in the United Kingdom, and beyond. It is recommended that the findings also serve as foundation for researchers, managers and curriculum designers



of post-registration education to consider content development and support mechanisms that reflect the full range of knowledge and skills needed for those delivering specialist AYACC, taking account of the different emotional and cognitive skills required to make this work rewarding for nurses with commitment to this unique specialism.

## AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet the following criteria.

1. Substantial contributions to conception and design (MC, TW, CR and DK), acquisition of data (MC) and analysis and interpretation of data (MC, TW, CR and DK)
2. Drafting the article and revising it critically (MC, TW, CR and DK)

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## CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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Research data are not shared.

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