DENTAL HYGIENE PROGRAM GRADUATES’ EXPERIENCES WITH TRANSITION INTO PRIVATE PRACTICE: A PHENOMENOLOGICAL STUDY

A Thesis

Submitted to the Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

For the Degree of

Master of Education

in

Adult Education

University of Regina

By

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Regina, Saskatchewan

September, 2019

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Sharman Woynarski, candidate for the degree of Master of Adult Education, has presented a thesis titled, *Dental Hygiene Program Graduates’ Experiences with Transition into Private Practice*, in an oral examination held on August 26, 2019. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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ABSTRACT

This qualitative study examined the transition to private practice experiences of recently graduated dental hygienists (DHs) from a dental hygiene program. A hermeneutic phenomenological approach was taken to understand the lived experiences of six study participants as they progressed from novice students to competent clinicians. Participants were invited to submit personal journals that expressed their experiences throughout the first six months of practice. These graduates also participated in individual semi-structured interviews in order to elaborate on their transition experiences discussed in their journals. Four key themes emerged from the data collected regarding the importance of: a support system or mentor; a workplace practicum; developing program curriculum to enhance graduate transition; self-assessment and self-directed learning in the development of competence. Informed by this data, several recommendations are made to private practice employers and Dental Hygiene Program faculty to facilitate the process of transitioning future graduates to practice. On this basis, further research should be undertaken to expand on the findings of this study.
I am thankful for the tremendous guidance and advice I have received from my supervisor, Dr. Abu Bockarie. His suggestions and support have been a great help to me throughout this study. His patience, advice and expertise were so valuable throughout this research process and I am glad to have worked with him.

I am also grateful to my thesis committee members, Dr. Abigail Wickson-Griffiths and Dr. Netha Dyck. I felt lucky to have such great support and feedback from each of them. I can honestly say they helped me to stretch my thinking. Their feedback was so valuable. I appreciate all the hours they spent reviewing my research.

I also want to express my appreciation to the research participants “Arin,” “Kelly,” “Blake,” “Kris,” “Maysen,” and “Alex” for sharing their experiences of transition with me. They were all enthusiastic and willing to share openly with me throughout the study, and I would not have been able to conduct this research without them.

Finally, I want to express my gratitude to my family who have supported me through this process. I appreciate all of the support, love and encouragement in so many ways throughout the process of completing this study. Whether they were giving me quiet time to work, or taking on extra responsibilities at home, they were a huge help to me and I will always be grateful.
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List of Abbreviations

Canadian Dental Hygienists Association (CDHA)

Dental Hygienist (DH)

Recently Graduated Dental Hygienist (RGDH)

Saskatchewan Dental Hygienists’ Association (SDHA)

Self-directed learning (SDL)
Chapter One: Introduction and Background

The Research Problem

A dental hygienist (DH) is an oral health care professional that promote preventive oral care as a part of overall wellness for clients and the community (Canadian Dental Hygienists Association [CDHA], 2010). Dental hygiene emerged as an allied health profession around 1906 out of a need for greater focus on preventative care. Initially, DHs were trained on the job and later became a regulated practice by several Professional Dental Associations (Richardson, n.d.). However, in the last 20 to 30 years, dental hygiene has evolved to become an independent and often self-regulating profession (CDHA, 2014). In Canada, advancement in dental hygiene practice has resulted in the development of provincial and national professional associations such as the Saskatchewan Dental Hygienists’ Association (SDHA) and the CDHA. There has also been an increase in the scope of practice of DHs over the past 30 years, which is partially due to an increased awareness that oral health and overall health are intricately linked (Grater-Nakamura, Acquilina-Arnold, Keates, & Lane, 2010). The advancement of the profession has necessitated changes to educational requirements for DHs, including those for continuing competency. Competency requirements vary by province but in Saskatchewan, DHs must attain 50 points and complete a Jurisprudence course per three-year reporting period. Further, members must complete yearly self-reflection and assessment paperwork that must be submitted to the SDHA if audited.

In Canada, dental hygiene educational programming have variable requirements. Programs offered by post-secondary education institutions vary in length from a 20-month diploma to a four-year baccalaureate degree. It is common for post-secondary and higher education institutions to prepare their students to be successful in dental hygiene
theory and clinical practice, often by utilizing critical thinking skills and evidenced-based theoretical knowledge. As with many other professions, a DH must successfully pass a national certification exam prior and maintain licensure with a provincial association to practice in countries such as the United States, Australia and Canada (International Federation of Dental Hygienists, 2019). In order to maintain licensure as a self-regulating profession, DH must keep a record of continuing competency requirements for licensure by demonstrating practical ability and lifelong learning (Shokar, Shokar, Romero, & Bulik, 2002).

Upon graduation, dental hygienists must navigate through the challenges of a new dental office as they transition into professional practice. A DH can work in a variety of settings including private practice, the public health sector, long-term care facilities, military, educational institutions, and independent practice (Saskatchewan Polytechnic, 2017). However, the most common workplaces for a recently graduated dental hygienist (RGDH) is private dental practice (CDHA, 2017).

While some professions like nursing (Field, 2004) and medicine (Kalén, Ponzer, & Silén, 2012) have established mentorship programs to assist new graduates transitioning into the workforce, the dental hygiene profession does not have a standard procedure for integrating new graduates into practice. In general, the induction of RGDHs into the profession is the responsibility of their place of employment, which does not have a standardized approach/protocol for all offices. From experience, dental workplaces use different policies and procedures to transition new dental hygiene graduates into private practice, which suggests that graduates do not receive a consistent transition to their professional practice.
Purpose of the Study

The purpose of this study was to explore the transition experiences of RGDHs of Saskatchewan Polytechnic into private practice. The study sought to give voice to these graduates by documenting their individual experiences and asking them to identify the factors they associate with their successful transition from student to clinician. The findings of the study revealed suggestions for best practices that will enhance the transition experiences of future graduates.

This study was designed to answer a central question: What factors do RGDHs from the Saskatchewan Polytechnic associate with their successful transition into private practice? To answer this central question, four subsidiary questions were developed:

1. What factors do recent graduates from the dental hygiene program at the Saskatchewan Polytechnic perceive as likely to increase their competency levels for entry into private practice?
2. What challenges do recent graduates perceive as having influence over their competency levels for entry into private practice?
3. What strategies do recent graduates find useful to enhance their transition experiences into private practice?
4. What suggestions can the participants offer to enhance the transition experiences of new dental hygiene graduates into private practice?
Definitions of Key Terms

It is important to define the relevant terms that are essential to the study.

**Competence.** For the purposes of this research, competence is defined as the ability to confidently carry out the tasks of a DH, established by the provincial regulatory body, within the confines of professional practice (SDHA, 2013).

**Dental Hygienist (DH).** A primary health care provider who is responsible for a client’s oral and systemic health and who is licensed to practice with the provincial regulatory body. A DH will assess oral health, provide a dental hygiene diagnosis, plan treatment to prevent, reduce or eliminate oral disease, implement treatment or referral to other appropriate health care providers, and evaluate the efficacy of the client’s treatment (SDHA, 2012a).

**Dental Assisting Student.** A student in the Saskatchewan Polytechnic Dental Hygiene program who has successfully completed an accredited dental assisting program before entering the dental hygiene program.

**Direct-Entry Student.** A student in the Saskatchewan Polytechnic Dental Hygiene program who enters the program without first completing any previous dental education program in Canada (e.g., Dental Assisting). Direct-entry students may vary from having no post-secondary education to a previous certificate, diploma or degree.

**Private Practice.** A dental practice owned and operated by a dentist(s) who hires or contracts a DH to perform dental hygiene services for the dentist’s clients (patients).

**Professional Association.** The regulatory body that is responsible for the governance of its members. Two professional associations related to this study are the SDHA, and the CDHA.

**Recently Graduated Dental Hygienist (RGDH).** For the purposes of this study,
RGDHs are DHs who have graduated from the diploma program at Saskatchewan Polytechnic, have been in private practice for less than one year, and are considered novice clinicians.

**Self-regulation.** Self-regulation refers to a profession’s ability to regulate or license peers for public interest (Richardson, n.d.).

**Significance of the study**

The study is significant in that it contributes to the understanding of Saskatchewan Polytechnic RGDHs’ transition into private practice. This awareness is key for educational institutions that offer dental hygiene programs, as there is limited research available that explores this topic. In addition, the findings of the study and the recommendations offered directly contribute to the Saskatchewan Polytechnic administration’s efforts to maximize program outcomes with respect to student transition into private practice. The results help to ensure the program directly benefits the graduates as well as other dental hygiene stakeholder groups. The study would also interest institutions that offer dental hygiene programs in other provinces, given the factors contributing to successful workplace transition would be common for all graduating DHs.

The study is beneficial to dental hygiene faculty at Saskatchewan Polytechnic, as they may find the participants’ insights useful when revising their curriculum and may use it to adapt their instructional strategies to enhance student learning. Further, the study participants may use the insights gained from this study to raise critical questions about themselves, the structure of the dental hygiene program, as well as the support available within their workplace. In addition, the study might also be of value to current and future
students in the dental hygiene program in their continuous effort to maximize their learning at the institution.

**Limitations and Delimitations of this Study**

The first limitation of the study relates to the constraints on transferability and utility of the findings. This study explored the experiences of RGDHs at the Regina campus of Saskatchewan Polytechnic as they transitioned into private practice; therefore, the study findings are limited to the views of the participants in that setting. In other words, the findings of the study do not claim transferability; the utility of the results are best determined by those who wish to apply the findings to their own situations (Merriam, 1988). The study focused on understanding the experiences and perceptions of only RGDHs from the Saskatchewan Polytechnic. Thus, the views of other dental hygiene stakeholder groups, such as faculty, college administrators, and policy makers were not incorporated in the research.

The study did not explore the views of RGDHs who work in other settings such as public health, independent practice, educational institutions, and military or long-term care facilities. Further, the study was based on the experiences and perceptions of six volunteer participants, thus the study sample was not representative of all RGDHs from Saskatchewan Polytechnic. Data was collected through one-on-one semi-structured interviews and participants’ journals; the extent of the data reviewed was limited, as participants’ employment records or other related documents were not accessed due to confidentiality. Given the study’s focus on the participant’s experience, the research design employed exclusively qualitative data gathering methods. Quantitative data was not collected to accompany the data collected through interviews and journals.
The study did not explore the imposter syndrome (Goman, 2018) concept and its implications for participants’ transition into practice experiences. Goman indicates the syndrome relates to the feeling among employees that in spite of their success, they may not be competent in their jobs and eventually their co-workers would find that to be true. Thus even though employees may be very competent in what they do, the syndrome may prevent them from enjoying their job. It is likely that some of the concerns the participants expressed in the interviews and in their journal entries might be attributable to the imposter syndrome. However, the syndrome and its possible implications for participants’ transition into private practice experiences was not explored in the study. Finally, my own personal experience as a DH and dental hygiene graduate, my current role as a dental hygiene faculty member and administrator and my familiarity with issues relating to workplace transition are likely to have influenced the interpretation of the research data.

The key delimitation of this study is related to the conscious exclusionary and inclusionary decisions that impacted the development of this thesis. The findings of this study are delimited by my decision to recruit six participants only from the Saskatchewan Polytechnic Dental Hygiene program. The decision was driven largely by resource constraints for fieldwork.

**Researcher Experience**

Merriam and Tisdell (2016) assert the importance of understanding reflexivity in a study. They note that it is essential to understand how the involvement of the researcher influences the study, and conversely how the study affects the researcher. Further to this point, Savin-Baden and Major (2013) suggests, “Researchers position themselves in relation to their philosophies, whether consciously or unconsciously, as they determine
how to undertake their study” (p. 53). Considering these statements, it is important to note that a researcher’s positionality and views may influence the results of a study.

I have been a part of the dental profession for twenty years: ten years as a dental assistant, and ten years as a DH. I have observed changes in the field of dentistry as links between oral health and overall health have shaped the need for more comprehensive client care. Further, DHs must maintain current knowledge of new technology to enhance client care. Additionally, clients are increasingly knowledgeable regarding treatment options; therefore, DHs must continue learning to satisfy client needs. As a DH, I consider this study significant as I seek ways to give back to my profession. I value this opportunity to improve the conditions for fellow DHs, as I aspire to be a part of the profession’s continued advancement.

As a dental hygiene educator, I consider this study beneficial to the teaching process as it deepens my understanding of my students’ needs, as they become novice clinicians. As a program administrator, I am responsible for ensuring the curriculum at Saskatchewan Polytechnic meets the practice standards set out by the profession. In relation to this research, my experience as a dental hygiene faculty and program administrator has provided me with additional perspectives into students’ behaviour. A challenge of this research was collecting data from past students because of the perceived power imbalance resulting from both a teaching and administrative role. Though it was not fully apparent, I sensed some hesitation with some participants when discussing aspects of feeling unprepared for practice and when discussing suggestions for the improvement of curriculum to assist in the transition to practice.

I have witnessed students’ anxiety grow as graduation draws near. Students have expressed concern regarding their transition into private practice. For example, one
concern was that students in the dental hygiene program complete numerous hours of practice in the clinic conducting comprehensive care for each client, which deviates from the standard one-hour appointment they normally have for client care in private practice. Other concerns mentioned by students included utilizing digital charting systems, and understanding the flow of a dental office. Reflecting on my personal experience in the first year of private practice, I can easily relate to these anxieties. As a graduate, I struggled with the time constraints, and was concerned about compromising client care due to the fast paced demands of private practice. I worried that I could not effectively utilize technology that differed from that which I used at school, including digital software. I remember feeling concerned that I would be perceived as incompetent in the eyes of the client, the employer, and co-workers. These personal reflections have been added to the research findings, and are acknowledged to have introduced bias into the research results.

From my experience, most RGDHs seem to settle into their careers after the first year but the process of becoming confident in private practice has not been well researched or documented. Accordingly, understanding the experiences of RGDHs as they transition into private practice is beneficial to future students, as well as institutions providing dental hygiene education.
Chapter Two: Review of Relevant Literature

The literature relevant to this study was examined. The literature review begins with an explanation of the concept of a profession in relation to dental hygiene. The review includes an explanation of what constitutes a profession, the self-regulation of DHs, what attributes can be expected of a professional, the competencies related to the profession of dental hygiene, and how they influence the transition into private practice. Secondly, the literature review examines the area of concerning competence, why it is important to organizations, and how competence is essential in health care professions such as dental hygiene. Thirdly, the review discusses the concept of mentorship used in other professions to assist in the transition to professional practice. Finally, the review visits the concept of self-directed learning (SDL) and how it relates to the RGDH’s integration of the dental hygiene profession. It is important to note that dental hygiene literature on some of the topics is limited; therefore, the literature review draws on research from other health professions such as dentistry and nursing. Nursing literature is more commonly used in dental hygiene research as the Dental Hygiene profession is on a similar educational trajectory as nursing. Thus, that body of literature is currently referenced in Dental Hygiene Education.

Concept of Dental Hygiene as a Profession

The concept of a profession has been described by researchers either in terms of standards or attributes, or by the degree to which the attributes are accomplished (Merriam and Brockett, 2007). Adams (2003) describes a profession as one that includes the establishment of expert knowledge and identity construction. Quock, Al-Sabbagh, Mason, Sfeir, and Bennett (2014) define dentistry as a profession due to the educational rigor and mastery of the skills required of practitioners. Quock et al. suggest that
professions are characterized by continued scholarship, advancement of knowledge and utilization of evidence-based clinical practice. Richardson (2004) defines a profession by the way in which the public views it. Further, Richardson supports that the Canadian government views dental hygiene as a profession, and most dental hygiene associations advocate for DHs to consider themselves professionals. Historically, dental hygiene originated out of client need, and initially lacked formal training. As such, Greenwood (1957) indicates that dental hygiene was not considered a profession in its inception, as it did not meet the qualities of a profession.

However, as dental hygiene evolved, it is now classified as a profession. Greenwood (1957) states that a profession encompasses five key attributes. These elements are “use of systematic theory, professional authority, sanction of the community, regulative code of ethics, and professional culture” (p. 45). DHs rely on evidence-based theory to provide optimum care for clients, and they are committed to the community they serve. In Canada, DHs belong to a provincial regulatory body and are encouraged to register with the national governing body that adheres to a set of practice standards and code of ethics. In Saskatchewan, self-regulation of the profession was initiated in 1997 through the provincial government. The SDHA is the regulatory body that adheres to the guidelines of the Dental Disciplines Act (Dental Disciplines Act, 2000). The SDHA regulates its members through licensure and enforces a continuing competency program to ensure members are maintaining evidence-based practice (SDHA, 2014).

Greenwood’s (1957) understanding of a profession is still important, and others have supported and built upon his theory regarding attributes of a profession. Christensen (1999) regards a profession as an occupation that involves specialized training, beyond
the scope of comprehension for a layperson to perform. Christensen continues that a profession has a defined code of ethics and a professional body that enforces regulations upon its members. In addition, Dean (1995) refers to a profession as one that maintains “professional autonomy, commitment, collegiality, extensive education, service orientation, and special skills and knowledge” (p. 28). Further, Dean suggests that a professional is socialized into the norms of the profession.

Cruess, Johnson, and Cruess (2004) argue that previous literature has not described the elements of a profession very well. The authors indicate previous definitions of a profession were limited to a set of common traits or characteristics. The authors suggest the following definition of a profession:

An occupation whose core element is work based on mastery of a complex body of knowledge and skills… Its members are governed by the codes of ethics and profess a commitment to competence, integrity, and morality, altruism, and the promotion of the public good within their domain. (p. 75)

The themes among these definitions appear to be similar and relate to the profession of dental hygiene. A review of the dental hygiene code of ethics suggests a practitioner should abide by five key principles. These principles are beneficence, autonomy, integrity, accountability, and confidentiality (CDHA, 2012). Adhering to ethical principles are considered part of being a competent professional. The code of ethics provides DHs with a generalized framework from which to practice, and they may provide a form of guidance for RGDHs in the first months of private practice. Further, the dental hygiene program at the Saskatchewan Polytechnic has five key outcomes for students to achieve prior to graduating into the profession, all of which address the
CDHA competencies. These outcomes were developed at the onset of the program and are responsive to the advancement of the dental hygiene profession:

1. Practice client-centered care according to the dental hygiene process of care model and the CDHA code of ethics.
2. Utilize preventive, interceptive, therapeutic and continuing care procedures in dental hygiene practice.
3. Work collaboratively with clients and health professionals in a diversity of settings.
4. Incorporate an evidence-based approach to promote health and provide oral health care.
5. Apply self-assessment and leadership skills. (Dental Hygiene Manuals, 2019)

As an accredited program, the Saskatchewan Polytechnic addresses the CDHA competencies with a blend of lecture, lab and clinical practice. The program has an onsite dental clinic in which students engage in 495-hours practicing professional competencies with clients. Further to this, the students are required to attend a three-day practicum to assist in the transition to private practice. As the education of D Hs is comprehensive and inclusive of the aforementioned traits, it is evident that dental hygiene is an established profession.

**Competency in Entering Professional Practice**

Competence is a key element in the practice of a professional. Hager and Gonczi (1996) describe competence as an individual’s knowledge, abilities, and attitudes as demonstrated in professional practice. For most scholars, competence is measured against some form of standard (Hager & Gonczi, 1996). Christodoulou (2003) reports that being competent at an occupation means being skilled by maintaining current and
relevant experience. Further to this, Christodoulou suggests that training is an essential component to competence. In addition, Richards (2017) states that an employee or professional must have the following competencies to be successful: intellectual, interpersonal, leadership, organizational, and self-management. With respect to the dental hygiene program, the CDHA (2010) Competencies and Standards are taught as part of the curriculum. The CDHA Competencies and Standards state that a DH should prove competence by:

- Knowing how to access relevant and credible information;
- Incorporating current theory in practice;
- Providing information to increase awareness of oral health and dental hygiene services;
- Reducing barriers to access to oral health care;
- Participating in initiatives to increase access;
- Reviewing emergency response plans of the community and regulatory authority;
- Managing personal health;
- Ensuring her/his practice is based in theory and evidence and meets all relevant standards and guidelines;
- Providing, facilitating, advocating and promoting the best client care possible;
- Sharing dental hygiene knowledge and expertise with others;
- Supporting legislation meant to increase access.
- Recognizing gaps in knowledge and taking steps to acquire this knowledge. (p. 32)

Further to this, graduates of the program are expected to be competent in the areas of assessment, diagnosis, planning, implementation and evaluation in order to practice in
the province (SDHA, 2014). A DH must have an in-depth professional knowledge to apply to private practice. A DH must have strong interpersonal skills to be able to work with diverse clients and diverse teammates. A DH is also expected to be a leader in prevention and client advocacy, as well as amply organized in order to effectively manage daily tasks. Finally, a DH must be effective at self-management, as the professional is largely responsible for managing career goals and achieving complex clinical cases.

Pitagorsky (2016) warns that incompetence in an organization can cause a widespread negative impact. Further, he suggests that one incompetent member of a team can negatively affect the rest of the team and client well-being. Bowling, Cooper Kellish, Kubin, and Smith (2018) report that competence in nursing is the ability to process information, look for abnormalities, and synthesize information required for care. From an oral health care standpoint, it is important that every team member is competent to avoid potentially life-threatening situations. Lee, Milgrom, Starks, and Burke (2013) provide evidence of such an event in a review of the literature related to pediatric dental client deaths in the United States. The research suggests that several of the deaths resulted from deficiencies in care, such as lack of proper monitoring and medical evaluation, as well as improper drug dosage. In dental hygiene, a failure to competently assess a client’s health history can lead to a medical emergency or severe complications following treatment. Additionally, the failure to competently follow infection and prevention control procedures can potentially cause the spread of disease. DHs are bound to follow CDHA’s entry-to-practice competencies and standards, which serve as a guide for continued competence throughout their career development, and are the foundation for dental hygiene education (SDHA, 2014). RGDHs leave the Saskatchewan Polytechnic
demonstrating all of the competencies required for entry to practice and are asked to reflect on their perceived successes and failures in each competency throughout their careers to ensure proficient practice.

One challenge with the concept of competence is to understand the process by which competence occurs. Richards (2017) suggests that some competencies can be learned on the job as experiences arise. This approach seems to imply that learning can be situated and competencies can develop over time. Bowling et al. (2018), report that there is no definitive amount of hours that formally demonstrate when competency is reached, and hours of clinical or simulated practice are not the best indicators of competency. Pitagorsky (2016) acknowledges that not every employee will be fully competent in all the required skills for a particular position, which suggests some need for continued learning throughout a DH’s professional practice. Further, it appears that most professions mandate some form of continuing competency requirements for their members. For example, Fletcher (2007) discusses the importance of continuing education for health care practitioners despite economic challenges. According to Fletcher, “there is evidence that education improves the confidence and competence of practitioners, and changes to practice due to education have been documented” (p. 189). Although Fletcher acknowledges more research is needed to correlate continuing education with improved patient outcomes, the importance of continuing education and competence is well noted in the literature. Mahood (2010) reported the importance of continuing competency requirements for physicians. Research findings indicated, continuing competencies ranged from recertification to self-assessment and demonstrated competence and all were shown to achieve positive outcomes with respect to client care. Continuing competency requirements for dental hygiene professionals is critically important. As oral health care
providers, DHs are required to maintain continuing competency requirements. In Saskatchewan, DHs are required to attend continuing education seminars, lectures, or workshops in order to ensure professional development in the profession. Further, DHs in Saskatchewan are required to fill out a personal learning tool that demonstrates the learning achieved in the education session, and how the learning relates to the national Competencies and Standards (SDHA, 2012). While continuing education is mandated and audited by the association, RGDHs may be just beginning to understand the process as they venture into private practice.

**Transition to Practice**

Documented studies of the DH’s transition to professional practice are scarce but informative. The literature suggests a gap exists in identifying a timeline during which a RGDH is likely to feel more like a professional practitioner, and the specific elements that assist in the transition.

A review of the literature highlights the concern that new graduates may not be adequately prepared for the demands of private practice. RGDHs who are transitioning to private practice can experience a disconnect between the emphasis on comprehensive client care during their studies and the focus on production geared toward generating profit with time constraints in private practice. In addition to individual as well as institutional and workplace factors, systemic factors might influence RGDHs transition into private practice. In other words, structural factors, such as class, gender, race, and ethnic group, interact with individual as well as institutional and workplace factors to influence their transition to private practice. Thus, transition to private practice can also be understood in terms of these broader systemic processes and structures. The way RGDHs think about themselves, their self-esteem and self-confidence and the way
they express themselves may become significant elements in their transition to private practice. It is likely that social structure rather than individual and workplace factors might reveal some very different explanations about RGDHs transition to private practice.

According to Beerwald (2014), dental hygiene graduates have felt less competent in clinical practice, and they lack effective communication with experienced contemporaries. In an email correspondence with Beerwald in 2018, she stated that her blog post for the British Columbia Dental Hygienists’ Association webpage was based on her (2014) unpublished phenomenological study involving eleven participants who had recently graduated from various dental hygiene programs across Canada. She interviewed participants via telephone, and each shared their anxieties over their progression from novice clinicians to experienced practitioners. A common concern of the participants was the apparent lack of control over appointment scheduling and office procedures. Beerwald (2014) concluded that dental hygiene program graduates often felt a drastic difference in support when they left the security of the educational institution. These challenges do not seem unique to dental hygiene practice as Ali, Tredwin, Kay, and Slade (2016) highlight similar experiences for dental students in the United Kingdom. Semi-structured interviews were conducted with sixteen participants including dental students, dental academics, foundation trainers and dentists. The researchers stated “time management in the face of increased workload, and expectations of clients and trainers were the key challenges perceived by dental students…” (p. 67). Results indicated that a mentored year might be of benefit to recently graduated dentists.

In addition, Guay, Bishop, and Espin (2016) conducted a grounded theory study to understand the transition of ten nursing graduates twelve months after taking part in a
new graduate orientation program. The researchers used semi-structured interviews for data collection, and developed a theory of “discovering professional self” (p.39). Within this theory, the researchers describe the participants’ processes of being able to survive without the safety of a preceptor, and the steps toward feeling like an experienced nurse. The results suggest that unfamiliarity with routines and protocols can affect the new nurses’ transition experiences, but as the nurses become more familiar, the process of discovering the professional-self advances. The study suggested that having a stable position, having a support nurse, and building on knowledge as strategies to improve transition success. Whitehead’s (2001) study of new nurses in London, England reports similar findings. The study involved six semi-structured interviews with six novice nurses. The findings revealed the participants felt a sense of uncertainty, a lack of confidence and support, fear of being accountable for their actions, and a shortage of knowledge and training to do the job. Whitehead recommended that more time with an experienced nurse would be of benefit to newly qualified nurses. With all that there is to learn about clinical dental hygiene practice, it seems plausible that graduating DHs enter practice with some lingering apprehension similar to that of other health professions. This apprehension is likely to be reduced by increasing their exposure to experienced clinicians.

**Mentoring in Health Care**

The concept of mentoring is widespread in health care and is often considered important for career satisfaction and professional retention (Furgeson et al., 2008). Field (2004) acknowledges the importance of mentors in a literature review regarding nursing education. Field indicates that the process of moving from novice to experienced nurse should involve situated learning with an experienced clinician. While other health care
professions may have access to peer supports or mentors for novice practitioners, such support appears to be lacking in the dental hygiene profession. According to Grater-Nakamura et al. (2010), mentorship in the profession is a challenge due to the independent work of the DH. If a dental practice does not employ more than one DH, it is unlikely that the RGDH will have another peer support person in the office to offer guidance. In essence, RGDHs may leave school with a set of professional ideals, which may be contradictory to the norms of private practice. Guidance from a more experienced clinician may be a strategy to bridge the gap between education and practice. Pang, Anderson, and Moffat (2012) affirm these perspectives in their study of a Bachelor of Oral Health (BOH) program in New Zealand. This program prepares graduates of the program for clinical work similar to any Dental Hygiene program in Canada though it has an inclusion of restorative skills as well. The study examined BOH graduates’ employment options as well as employer and host therapists’ views of the BOH graduate attributes in relation to practice. The research found that graduates of the program could use more real world employment experience in relation to time, equipment and materials management. Further, the recommendation to the BOH program was to increase practical experience for students prior to graduation. The results of the study appear to indicate support for a mentoring model.

In a review of literature, Grater-Nakamura et al. (2010) provide evidence for mentoring in dental hygiene practice. Their review suggests that positive mentoring relationships could be instrumental in facilitating the transition into private practice. In addition, the authors suggest that the opposite could be true if mentoring relationships are not positive. Further, they define a successful mentoring relationship as a mutually beneficial relationship for both mentor and mentee, whereby the mentee is open to the
The guidance of the mentor. The mentor would benefit by acquiring information about current trends and issues in the dental hygiene profession such as acquiring leadership skills as well as in advances in professional development. The mentee would be exposed to new employment experiences, have the opportunity to increase professional competence, and develop professional identity (Grater-Nakamura et al., 2010). In contrast, a negative mentoring relationship can be created by a lack of desire to work collaboratively or an unwillingness to dedicate appropriate time and energy to the process.

The literature suggests other health professions provide support for a mentorship initiative. For example, Kalen, Ponzer, and Silen (2012) discuss the importance of mentoring in the medical profession. Their qualitative study sought to develop an understanding of the benefits that mentoring provides to mentees. The researchers conducted semi-structured interviews with 12 medical students, and they found that a mentoring relationship resulted in three themes, which were “Space, Belief in the Future, and Transition” (p. 393). They note the concept of space allows the medical students a safe place to express feelings of concern that would otherwise not be expressed openly for fear of being chastised in the profession. In the study, mentors conveyed the positive aspects of the medical profession, which helped develop the mentee’s belief in their future as practitioners. Finally, a transition appeared to happen as a result of the mentorship, as the mentees felt they were a part of the larger medical community rather than isolated students.

Guay et al. (2016) explored the process of becoming a professional among new graduates and registered nurses in Ontario, Canada. They utilized grounded theory to research the experiences of new graduate registered nurses’ as they transitioned into the
profession after a preceptor relationship with an experienced registered nurse. The researchers conducted ten semi-structured interviews with new graduate registered nurses’ and their findings resulted in a model they labelled “Discovering Professional Self” (p. 39). The model suggests that there appears to be a gradual progression to feeling competent as an RN. First, the new graduate registered nurse begins with the first fearful experiences of working without a preceptor, and then continues with the ability to work things through, and finally, the new graduate registered nurse feels more competent to work alone. The researchers suggest that took approximately twelve months to go through this process, and the guidance from other more experienced registered nurses was helpful.

**Self-Directed Learning for Transition into Practice**

SDL is widely discussed in the adult education literature as planned learning that one undertakes out of curiosity, personal fulfillment or need (Tough, 1971). Tough reports that adults engage in learning to “create major changes in his feelings and attitudes, in his cognitive knowledge, or in physical skills and overt behaviour” (p.35). Houle’s (1984) work on participation in learning, more specifically about learning-oriented participants, suggests that adults will seek out SDL opportunities. Similarly, Tough argues that adult learners prefer to direct their own learning experiences. Tough reports that adults will naturally self-direct their own learning in day-to-day tasks. At the same time, Knowles (1975) suggested that SDL is often self-initiated, and the learner often assesses, plans, implements and evaluates the learning process. SDL implies that the learner is initiating his or her own learning, which may be formal through an organized institution or informal using personal research (Shokar, Shokar, Romero, & Bulik, 2002).
Clardy (2002) states the importance of motivation in SDL by suggesting that those that are motivated to learn will seek SDL, which can enhance their workplace performance. Furthermore, workplace SDL endeavors to induce synergistic, voluntary, and scanning classifications, which, the author notes, are relevant to professionals. For example, he indicates the induced SDL classification relates that learning is delegated from an authorized source, like a regulatory body, but the learning plan is left to the individual to undertake. Additionally, the voluntary and scanning classifications suggest that an individual will seek information to improve workplace outcomes. Clardy indicates these SDL classifications can be seen in healthcare through the continual research of new medications and conditions to provide improved care to clients.

Murad, Coto-Yglesias, Varkey, Prokop, and Murad (2010) conducted a systematic review of SDL in health care professions education. The purpose was to determine the effectiveness of SDL in improving learning outcomes for health professionals. Murad et al. searched numerous databases with the final analysis comprising 59 studies. The study found that advanced learners were more effective at using SDL strategies, and those that were allowed to choose learning resources used SDL more effectively. The researchers indicate that “[m]oderate quality evidence suggests that SDL in health professions education is associated with moderate improvement in the knowledge domain compared with traditional didactic teaching and may be as effective in the skills and attitudes domains” (p. 1066). Basanti (1999) also reports on the unanticipated benefits for the students following the implementation of SDL in a nursing program in the 1970s. These benefits were an increase in empowerment for those exposed to SDL and expressed competence in “self-assessment, peer assessment and the creation of a learning plan” (p. 38). In essence, Basanti’s study provides evidence for the
implementation of SDL in formal education, which may improve competence in future professional practice. Cadorin et al. (2012) conducted a comparative cross-sectional study to evaluate researched SDL competence in experienced registered nurses and radiology technicians compared to student nurses and student radiology technicians. Eight hundred and forty-seven participants answered the Self Rating Scale of Self-Directed Learning questionnaire. The results suggest that experienced practitioners demonstrated higher levels of SDL competence when compared to students. Those with higher education levels tended to demonstrate a slightly higher competence for SDL over those with less education, which suggested that nurses scored slightly higher than the radiology technicians did in both the student and experienced practitioners, though the differences were not significant. The researchers concluded that strategies to increase SDL is essential to include in curriculum in order to foster SDL competence in students prior to entering practice to ensure continuing professional growth and competence (Cadorin et al., 2012).

Similar to other health care professions, nursing has had to meet the changing health needs of the population, resulting in a continuing demand for higher education. In a literature review, O’Shea (2003) finds that nurse educators should engage in facilitating SDL over the traditional lecture based methods. O’Shea’s (2003) research suggests that in order to maximize student nurse success; the nurse educator should guide the students in the process of SDL. A potential first step would be to assess levels of SDL by using a Self-Directed Learning Readiness scale proposed by Gugliemino in 1978 (Hiemstra, 2003). In summary, SDL is important to building of the confidence of future health care professionals.
As the dental hygiene profession is highly focused on continuing competency, it may be assumed that inexperienced DHs would be motivated to fit into the new private practice surroundings, and may be more inclined to seek SDL opportunities to improve performance. In a study of learning organizations in the medical profession, Confessore (1997) acknowledges that physicians must be proficient in SDL in order to maintain success in the profession. This concept holds true for dental hygiene, as practitioners are required to assess the need for and identify the types of learning experiences that are of professional benefit (SDHA, 2017). Further, Shiner and Howe (2013) studied the learning needs that emerged for novice physicians as they sought to become more experienced using grounded theory methodology. They interviewed nine participants, followed by a focus group of four additional participants in order to examine theories that emerged from the interviews. The results revealed that most learning resulted from an immediate need during work time and the learning was considered self-directed and experiential. The same learning style is recognized as beneficial for RGDHs as they seek to learn new knowledge about the practice they are in, and the policies and procedures involved in the day-to-day private practice setting. The concept of SDL was implied in my pilot study as participants discussed looking up unfamiliar medications and conditions via Internet resources, reference texts, or consultation with an experienced DH (March, 2017). Additionally, the participants indicated they would seek out another team member to assist with knowledge acquisition about unfamiliar procedures if required.

The above review of the literature examined the concept of a profession and suggested that professions have a set of guidelines, competencies, and regulations to adhere to. Further, the research suggested that professions are run by a regulatory body such as the SDHA and CDHA, which are key to the licensing and scope of practice of its
members throughout their careers. The literature review explored the idea of competence. The research indicated that competence must be achieved to practice but acknowledged that competence develops throughout one’s career. The research also discussed the seriousness of the lack of competent practice. The literature highlighted the importance of mentorship for new practitioners. The research indicated that mentors were helpful in acclimatizing graduates into the professions. Finally, the concept of SDL was examined and is thought to be important to the continuing competence of clinicians.
Chapter Three: Research Design

This chapter provides discussion of the methodology and research design utilized in this study, including the rationale for employing the specified approaches. The qualitative research approach is discussed with accompanying rationale for its suitability as compared to a quantitative approach. Further, the appropriateness of a phenomenological methodology for this research is discussed. Lastly, the processes of participant recruitment, data collection, as well as data analysis and interpretation methods are explained.

The Qualitative Research Approach

Creswell (2009) suggests that qualitative research is inductive in that it often seeks to examine individual cases in order to derive something more complex. Creswell defines qualitative research as “a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (p. 4). In addition, Merriam (2009) suggests that qualitative research is about comprehending how people understand and develop their experiences, and how they attach meaning to these experiences. The purpose of this research was to understand the experiences of RGDH as they enter the workplace; a qualitative research approach was deemed appropriate. Conversely, Creswell indicates a quantitative approach may not adequately capture a phenomenon, as data would be reduced to statistical analysis rather than offering descriptions through rich text. Polkinghorne (2005) supports this assertion stating, “experience has a vertical depth, and methods of data gathering, such as short-answer questionnaires with Likert scales that only gather surface information, are inadequate to capture the richness and fullness of an experience” (p. 138). Based on these assertions, a qualitative approach is well suited to answer the research questions posed in this thesis.
A social constructivist worldview is common in qualitative research. Creswell (2009) explains that social constructivists assume that people have a need to understand their world, and they tend to cultivate individual sense out of their experiences. Traditionally, adopting the social constructivist worldview means complex interaction between the researcher and participants, with a thorough understanding of the participants’ contexts. Walker (2015) describes the social constructivist view as one that is concerned with human experience and interaction, which create meaning. Further, Walker suggests that social interactions between people construct experience and knowledge. Kim (2014) states: “social constructivism focuses on the construction of meaning in terms of the social, cultural, and historical dimensions of understanding in order to make sense of human experience” (p. 541). This research adopted a social constructivist worldview through the underlying assumption that knowledge is socially constructed through the relationship between the researcher and the participant (Savin-Baddin & Major, 2013). This research examines how participants experience their transition to practice, thus the participants must attempt to convey the experiences in a meaningful way to the researcher. Interactions between participants and the researcher occurred via semi-structured interviews and journals. Through the semi-structured interview, the research and participant collaborate to construct the experience of transition to practice. Further, the participants’ journals were written in their own unique way, which helped them to describe the process of transition.

**Hermeneutic Phenomenology Methodology**

This research utilized a hermeneutic phenomenological approach. As there are several different approaches to phenomenology it is important to understand the basic concepts. van Manen (2007) suggests that phenomenology seeks to find the essence of a
lived experience of a particular phenomenon. Phenomenology originated from the work of Edmund Husserl and was later reformed by Martin Heidegger (Elliot, 2005). In contrasting Husserl’s and Heidegger’s perspectives on phenomenology, van Manen (2007) suggests that phenomenology can be compared to hearing a sound or tone amongst the quiet. In Husserl’s interpretation, the researcher would hear the sound without preconceived notion of what the sound was. In essence, the researcher would bracket, or hold back, his or her thoughts or beliefs about the experience to avoid preconceptions or bias. van Manen (2007) indicates this approach is in contrast to Heidegger’s hermeneutic phenomenology, which implies that the researcher cannot separate his or her thoughts and beliefs about a certain experience. Hermeneutic phenomenology assumes that individuals are not isolated from their context or culture, and the uniqueness of that individual’s experiences is rooted in their own interpretation (Wojnar & Swanson, 2007). Heidegger’s perspective seems logical, as humans, by nature, interpret the world around them according to their own understanding (van Manen, 2007). Thus, going back to the sound example, using hermeneutic phenomenological approach, the researcher would hear the essence of the sound and interpret it as a bird singing.

Phenomenology has been commonly used in health and social science research. According to Creswell (2013), phenomenology is utilized when a researcher wishes to explore participants’ experiences of a particular phenomenon, and thus, was considered the most appropriate for this study. In this context, I explored the experiences of RGDHs as they transitioned into practice. While some phenomenologists follow Husserl’s approach to phenomenology by attempting to bracket out the researcher’s experiences (Moustaka, 1994), I believe the addition of my own perspectives further enriched the
findings of this study. As I had already been through the transition to practice, it was not
going to be possible to bracket out my experiences. Thus, hermeneutic phenomenology
was utilized in the study, as the methodology sought to find meaning in common life
events, based on each individual’s experience of such events (Larkin & Thompson, 2012).
Researchers utilize interpretive phenomenological analysis to examine how
people understand their experiences and this approach served as the guidance for this
study. Larkin and Thompson indicate one of the assumptions of hermeneutic
phenomenology is “to engage in with other people’s experience, researchers need to be
able to identify and reflect upon their own experiences and assumptions” (p. 103). As I
have also had some experience of being a novice DH transitioning to practice, I co-
constructed the knowledge to help produce a more meaningful interpretation (Wilson,
2014). This approach provided data that was pertinent to the field of dental hygiene, as
the lived experience can facilitate a more robust understanding of an event over a
quantitative research approach (Mapp, 2008). Larkin and Thompson’s approach utilizes a
verbatim transcript, and may use written accounts as well. As semi-structured interviews
were accompanied by participant journals, this approach was chosen. According to
Larkin and Thompson, smaller sample sizes are suitable and focus on the quality of the
data over quantity.

**Recruitment of Participants**

As phenomenological research requires collecting deep, saturated descriptions of
experience, it was important to ensure that the sample recruited for the study reflected the
intent of the study. According to Creswell (2009), qualitative research approaches utilize
purposeful sampling for the recruitment of participants. Patton (2002) suggests that
purposeful sampling “yields insights and in-depth understanding rather than empirical
generalizations” (p. 273). The selection criteria for participants required that they were RGDHs currently working in private dental practice with less than one year of experience. For this study, six RGDHs were recruited from a cohort of direct entry students in the Dental Hygiene diploma program at the Saskatchewan Polytechnic. The six participants were those that responded to the study’s participation invitation.

Recruitment occurred through an advertisement in SDHA newsletter that was mailed to potential participants targeting the 26 graduates of the 2017 Saskatchewan Polytechnic graduating class. Students meeting the inclusion criteria were invited to participate in the study based on first response basis. During the semi-structured interview, further demographic data was collected on the participants, which is described below. As the graduating class was nearly exclusively female, it is not surprising that all six participants were female. Furthermore, the majority of Dental Hygienists in practice are female which makes the sample representative of the population. The age of participants varied from nineteen to thirty years. All participants were classified as direct entry dental hygienists, having no previous dental education prior to entering the program. It should be noted that four participants had other post secondary experience prior to entry into the dental hygiene program and two participants entered directly from high school. Ethics approval was obtained from the University of Regina Ethics Board (REB) prior to recruiting participants (See Appendix A). Participants were informed of the study through the SDHA website and interested participants were invited to contact me via phone or email.
Data Collection Methods

The aim in choosing data collection methods in hermeneutic phenomenology was to understand the participants’ experience and to convey what it is like to be a RGDH. The research data was collected in multiple ways, as supported by a hermeneutic phenomenological approach. Larkin and Thompson (2012) indicate that it is important to augment interviews with participant journals or other data collection instruments to enrich the data. The use of journals can provide participants with a way of communicating more detail regarding an experience when compared to an interview. The intent was to collect rich contextual data that reflected the real experiences of the RGDHs. Participant journaling can be a rich source of data if it is implemented appropriately. The literature recommends using strategies such as specifying a period to write about and offering guidance for follow-up with the researcher (Hayman, Wilkes, & Jackson, 2012). Thus, the participants were asked to journal any thoughts and feelings about their experiences of working within the first few months of practice (please see Appendix B for the suggested reflection questions). The rationale was to capture the initial experiences in the transition to practice rather than evaluate the progression throughout the year of practice. In this study, the participants were given one month to complete the journal process. The participants were asked to write one entry that encompassed their own experiences of transition limited to the first few months of practice. Further, I checked in with participants twice during the journaling process to ensure that they felt comfortable, and to answer any questions that arose during the process. Finally, it was essential to ensure the participants were aware of the confidentiality of their journal entries (Hayman et al., 2012). Therefore, I informed participants that their journals would be kept in a locked cabinet at the Saskatchewan
Polytechnic with any other data that I collected. I also assigned pseudonyms to their journals to further protect their identities. The participants submitted the journals electronically via email and they were printed for review. The emails remained under a password-encrypted computer in a locked office for further security.

In addition to journals, semi-structured interviews were conducted with the six participants to elicit deep discussions about their transition experiences into private practice (Larkin and Thompson, 2012). Interview questions are listed in Appendix C in front matter and conclusion. Smith and Osborn (2008) suggest that phenomenological methodology lends itself well to the use of semi-structured interview as it attempts to capture verbatim the experiences of the participant on a particular topic. Further, semi-structured interviews permit some flexibility to add more questions or dig deeper in areas of participant experience based on their responses. The interviews facilitated participant rapport, which, according to Smith and Osborn, is essential to obtain rich text. In addition, as Savin-Baddin and Major (2013) suggest, the emphasis in the interviews will be to maintain flexibility as the natural flow of questions is likely to garner more in-depth data. All interviews were recorded by an audio recording device and transcribed verbatim with each participant being interviewed once. As the participants were few in number, this study relied on Creswell’s (2013) notion that phenomenology is more centered on the quality of the data rather than the quantity. As semi-structured interviews involve in-depth data collection, the interviews were approximately 30 minutes in length (Merriam & Tisdell, 2016).

Merriam and Tisdell (2016) state that triangulation of data strengthens the validity of the findings of a study. Therefore, to ensure credible findings, attempts were made to observe participants’ non-verbal actions, tone of voice, and mannerisms, and
recorded them in field notes during the interviews (Savin-Baddin & Major, 2013). The observations of participants during the interviews supported the researcher’s interpretation of the participants’ experiences. In particular, the researcher observed facial expressions, as well as other non-verbal body movements. In addition, the researcher was mindful of her own experience as a DH and she augmented the study findings by sharing her thoughts on the participants’ stories, in support of the interpretive approach (Larkin & Thompson, 2012). Further, phenomenological studies should always involve participant follow-up to improve the validity of the research (Kafle, 2011). Thus, follow-up correspondence allowed the participants to review their own transcripts to ensure that I had accurately documented and interpreted their experiences. I allowed for participants to provide feedback and make additions or subtractions to their interviews as needed. This additional contact also provided an opportunity for further dialogue with the participants in case they had more to share on their experiences; however, in this research there were no further comments.

**Data Analysis and Interpretation Procedures**

The data analysis and interpretation for the research followed the interpretive approach by Larkin and Thompson (2012). Analysis of hermeneutic interpretive phenomenology requires that the researcher attempt to immerse themselves in the data to be able to interpret the first person experience (Larkin, Watts, & Clifton, 2006). In part, interpreting the experience is done by providing a robust, detailed description of participants’ views and situating those views into the proper context (Larkin et al., 2006). Additionally, Larkin and Thompson maintain that interpretation of qualitative data requires an organized and transparent account of exploring emerging patterns. In this study, transcripts from the participants’ interviews were reviewed systematically, and
copied verbatim with the use of an Apple recording device. Drawing on the work of Pringle, Hendry, and McLafferty (2011), a holistic review of each transcript was conducted by reading it several times and making notes in each of the transcripts during the process to reflect any key words, reflections or concerns that emerged from the participants. Common words and phrases that emerged from the transcripts were highlighted. After each participant’s experiences were coded, the data was reviewed as a whole to see if common ideas became apparent, which would later inform the development of the themes. A similar process was followed for the review of the journal transcripts.

Larkin et al. (2006) suggest that the interpreter’s perspective helps shape the meaning of the phenomenon, but that this may be revised as subsequent readings illuminate more knowledge. This study required the interview transcripts be reviewed several times to assist the researcher in reflecting on her personal experiences of transition to practice. Similarities and differences in the transcripts were compared to the researcher’s own experiences, also noting that my experience could be different due to my previous dental assisting experience. Further, the data was examined line-by-line looking for key themes that emerge (Creswell, 2009). To do this, notes were reviewed for each participant’s transcript and highlighted the common ideas or experiences. After doing this for each case, I reviewed the data as a whole looking for similar patterns (Larkin & Thompson, 2012). It was at this stage that common themes began to emerge as common ideas were joined. It was important to interpret the general meaning of the interview transcripts while considering the parts or themes, in relation to the whole data set (Savin-Baddin & Major, 2013).

To confirm the validity of the transcripts, follow-up e-mail correspondence with
participants occurred to ensure accuracy of the interpretation of each participant’s experiences (Larkin & Thompson, 2012). In this case, the transcripts were shared with individual participants, and later brief summaries of the common themes were sent for validation by the participants. Any changes or requests for omission of pieces of content were honoured. Only one participant requested such a change. This participant requested that the location of her practice be omitted to avoid being identifiable. To triangulate the data, each source of information was used to fully understand the experiences of the participants. For example, individual participant journals were used to inform how semi-structured interviews were conducted for each participant. As an example, aside from the research questions that were asked, participants were asked to further explain concepts expressed in their journals, which provided a more detailed description of their experiences. To further define the experience, notes regarding participants’ non-verbal cues corresponding to their verbal testimonies were added. The emergent narrative was comprised of participants’ journals, interview transcripts, and my own personal reflections and participant observations that I recorded in my field notes.

Interpreting data in qualitative research can be challenging. Merriam and Tisdell (2016) state that data analysis and interpretation “is a complex procedure that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, between description and interpretation” (p. 202). The aim of the data analysis and interpretation for the study was to go beyond a general description of the participants’ experiences and get to the essence of what it was like to be a RGDH in private practice. To assist in making sense of the data, Savin-Baddin and Major (2013) provide several strategies to support the process. The strategies are recognizing organizing principles, recognizing oppositional talk, examining subtext,
looking for metaphors, and comparing findings to literature. Savin-Baddin and Major indicate that recognizing organizing principles examines how participants categorize or define themselves in relation to the object of study. While analyzing the data, evidence regarding how the RGDHs described themselves as new clinicians, transitioning into practice was sought after. In addition, journals and transcripts were examined for evidence of oppositional talk, which is a technique that looks for negative descriptors. This strategy helped define the identification and experiences of the RGDHs and what they felt they were not. A possible example of this strategy was the participants’ view of themselves and their feelings of competence in their skills when they compared themselves to more experienced professionals. Further to these strategies, carefully screening the interview transcripts, journals and field notes was completed to uncover meanings through subtext, such as looking for the types of language, emotion, and enunciation used. This process started in the form of field notes as the interviews were conducted. Some of the subtext was in observing body language and hearing voice inflection. As a novice researcher, this proved more challenging than originally thought; however, the results include these non-verbal cues where possible. Careful examination of the transcripts and journals was undertaken in order to look for the use of metaphors in the texts, though this strategy did not yield results. These comparisons were meant to reveal participants’ implicit meanings in their experiences and several common themes emerged which were initially presented in Chapter four.

Concerning my approach to the presentation of the findings of the study discussed in Chapter four, several authors suggest the findings of a hermeneutic phenomenological study should focus on the presentation of the reconstruction of the inner world experience of the research participants (Cohen, Kahn, & Steeves, 2000;
Hycner, 1999). Therefore, as each individual has his/her own way of experiencing phenomena, the first approach to data analysis and presentation for this study was to offer an accurate description and communication of each participant’s lived experience with transition into private practice. The hope was that the description would capture the experiences from the perspective of each participant in its fullest and richest form. Thus, given the nature of the research methodology, and with my focus on exploring each participant’s experiences with their transition into private practice, I decided to first describe each participant’s experiences with transition by introducing each participant’s data/findings separately. Following that, themes that emerged from the data of all participants would be presented and discussed using the words of the participants as recommended by hermeneutic phenomenologists (Smith, Flower, & Larkin, 2000). In other words, the approach to data presentation adopted in the study was that each participant’s data would be presented first followed by the discussion of the overall themes that emerged from the data from all the participants. Under each theme, the ideas would be defined in elements that describe the theme being named and presented. The ideas in each theme would be illustrated, and each theme would contain quotations from the participants’ data. All the themes would be discussed in relation to how each of them relates to the participants’ transition into private practices experiences. The findings chapter would conclude with a summary of the broad themes that emerged from the participants’ data based on my interpretation of their interview and journal data. The themes would be further presented and discussed much more fully in Chapter 5 in relation to the findings and the relevant literature for the study reviewed in Chapter 2.
Quality Considerations

Lincoln and Guba (1985) state that evaluating qualitative research requires examining trustworthiness, credibility, confirmability, and transferability. As hermeneutic phenomenology is interpretive, validating the trustworthiness of data is important and should be done via participant validation. Confirming the interpretation of data with participants helps to reinforce the trustworthiness of the results (Larkin & Thompson, 2012). Thus, the participants were asked to review the summary of their transcript data and major themes before the work was finalized to ensure I captured their experiences authentically. Feedback was received from participants via email. Participants reviewed their transcripts and agreed to allow the data for analysis. There were no corrections to their transcripts noted; however, one participant requested that I remove the location of practice to ensure her anonymity and this request was honoured. Participants were sent a copy of the emerging themes and confirmed that they represented their experiences.

Credibility refers to the believability of the findings of the study (Jeanfreau & Jack, 2010). The study sought credibility by augmenting the data with supporting literature (Savin-Baddin & Major, 2013). To enhance credibility, I provided detailed extracts from the transcripts to provide a clear view of participants’ expressions (Savin-Baddin & Major, 2013). Confirmability of the research seeks to ensure that the researcher demonstrates reflexivity (Lincoln & Guba, 1985). Based on the work of Jeanfreau and Jack (2010), the study findings included reflections on my personal thoughts and experiences of the resulting data to ensure the reader understands the potential influences on the research itself. Transferability refers to the degree to which the findings of the study are transferable to another study or setting (Merriam & Tisdell, 2016). While the
findings of this study are not generalizable to other contexts such as other dental hygiene programs or DHs, an attempt was made to describe the participants’ experiences in a way that other researchers and practitioners interested in replicating the study might find meaningful. Drawing on Merriam and Tisdell’s work, I provided a rich description of the RGDHs’ experiences to allow readers to decide how the results might transfer to other contexts.

As this study uses hermeneutic interpretive phenomenology as the methodology, it is important to acknowledge the quality considerations that are relevant to this approach. Kafle (2011) suggests that phenomenological research should be measured against four key factors. First, the researcher must be rigorous when delving into the experiences of the participants. In other words, researchers should focus on the details of the participants’ experiences by immersing themselves in the experience when reviewing the transcripts and journals. For this experience, I considered each line in the transcripts and journals to summarize the participants’ descriptions of their experiences. Key words were written on the transcripts and journals and were then combined to form more abstract themes. Secondly, the researcher should look to provide considerable detail for the intended audience to accurately convey the experience. In this research, the aim was to include detailed portions of the transcripts and journals to facilitate the reader’s understanding of the experience. Third, van Manen (1997) suggests examining richness and depth. The author reports that it is important to include rich data that gets deep to the core meaning of the participant’s experiences. Finally, Langdridge 2007 (as cited in Kafle, 2011) suggests that participant feedback is an essential factor in having a worthy interpretation. Therefore, after I transcribed a participant’s data, I sent their personal transcript via e-mail for data confirmation.
As in any research, it is essential to behave ethically by respecting participants’ need for privacy and confidentiality. To ensure confidentiality and privacy of the participants for this study, they were each assigned a pseudonym. Data collected through the semi-structured interviews was stored on a secure I-Pad and remained in a locked cabinet at the Saskatchewan Polytechnic. In addition, transcribed data, journals, and field notes were kept in a locked cabinet at the Saskatchewan Polytechnic. Participants signed a consent to participate agreement to ensure that they were informed of the purpose, intent, and procedures involved with the study.
Chapter Four: Presentation of Research Findings

The purpose of this phenomenological study was to explore the lived experiences of six RGDHs in their transition to private practice. Four research questions were explored in the study:

1. What factors do recent graduates from the dental hygiene program at the Saskatchewan Polytechnic perceive as likely to increase their competency levels for entry into private practice?
2. What challenges do recent graduates perceive as having influence over their competency levels for entry into private practice?
3. What strategies do recent graduates find useful to enhance their transition experiences into private practice?
4. What suggestions can the participants offer to enhance the transition experiences of new dental hygiene graduates into private practice?

This chapter presents the key findings of the study obtained from the participants’ semi-structured interviews and personal journals. The presentation of each participant’s data begins with a brief description of the participant. A thematic summary of the data is then presented with specific detail related to the literature in Chapter Five.

Demographics

At the time of the semi-structured interviews, demographic data was collected for each of the participants. The following is a summary of this information, which includes the age, gender, and location of practice for each participant. The participants were six females between the ages of 21 and 34 with a mean age of 25. When I inquired about
their location of practice, all of the participants stated that they practiced in various Saskatchewan communities since graduating the previous June. At the time of the interviews and journals, the participants indicated that they had been employed between six and ten months.

The participants were first asked to journal their experiences with transition into private practice, which yielded entries between two and four pages in length. Next, semi-structured interviews were conducted with each of the participants following a review of their journal. The interviews were approximately 30-45 minutes in length and were recorded via an Apple recording device. The audio recordings were transcribed verbatim, and then analysed to draw meaning from the experiences of the RGDHs about the phenomenon of their transition to private practice. As the study intended to capture the lived experience of the RGDH, the findings below provide an in-depth description of each participant’s transition into practice, in order to demonstrate the individual experiences. Alex was the first participant to share her experiences.

Alex

I met with Alex in a library to conduct the semi-structured interview. Alex had been working in the same private practice office for ten months, and was the sole DH in this practice. The office had recently changed management causing anxiety in Alex, which was evident in her tone of voice and her raised eyebrows in the interview. Alex self-identified as “book smart” (i.e., educated), which she viewed as an advantage for competency as a DH; however, she expressed some uncertainty in trying to deal with various clinical situations. Her body language suggested her uncertainty as she grimaced slightly. She explained the uncertainty in this way:
Then I guess, when I first started, like definitely very unsure of myself. I felt like I was very book smart, but I lacked like a lot of the hands-on like clinical, I guess, experience.

Alex felt as though she was well educated, and was very good at the theory portion of her dental hygiene education, but she alluded to needing more practical, hands-on experience. She mentioned in the interview and her journal that lack of digital charting knowledge, lack of a well-rounded view of dentistry, lack of knowledge of dental insurance, lack of time management skills, and a new way of doing things were challenges to feeling competent as a RGDH. In her journal, Alex recalled her first day experience by mentioning the challenges of time management and new processes:

On my first day, I was very overwhelmed. I had to learn on my own how to manage one-hour patient appointments when I was used to almost two-hour appointments at school. Everything was different than I was used to at school; the instruments, the scanner for radiographs, the panoramic x-ray machine, the methods of sterilization, etc.

Alex referred to the various skills that she learned as a student in the program and remarked at how all of those important skills seemed to be minimized into just scaling the calculus (tartar) off the teeth. Further, she suggested that the care in private practice felt like an incomplete job due to the lack of time. Alex strongly commented in her interview that the limits to her scope of practice were a challenge for her overall competence. She stated with frustration:

Going into having just one-hour appointments, it felt like I was just kind of jumping into debridement and the main focus was just debridement and everything else like the health history and the cancer screenings and the probing and the targeting and everything was kind of just left behind. It was just ‘go and scale and send your patient out’. I was just fighting against the clock; I think was the hardest part of that.

Alex reported feeling exhausted by work demands. The pace in private practice was drastically different from the pace in school. In private practice, Alex would see
approximately seven or eight clients per day versus having a maximum of two clients per
day in school. In Alex’s case, there was not a scheduled lunch break, which might have
negatively impacted her feeling of competence due to the heavy workload. As she put it,
“I was rarely scheduled a lunch break which meant that I did not stop working for eight
hours straight.” Alex suggested that there was a learning curve to fully understanding the
scope of dentistry. The focus in school was solely on dental hygiene practice with a brief
introduction to common dental procedures. This appeared to leave Alex with feelings of
incompetence, as she was not sure how to proceed in some cases. The following excerpt
from Alex’s journal provides some insight:

I started seeing clinical situations that I had not seen as a student in school. One
patient that stands out to me was a new patient to our office. Before taking
radiographs for a new patient exam, I took a look in the patient’s mouth and saw,
what I thought was, a complete mandibular denture. I told the patient that he
could leave the denture in, as it will help stabilize the sensor plate while I take
radiographs. When I scanned the radiographs into the computer, it appeared that
the patient opened his mouth on all of them. I repeated certain radiographs as
necessary and again it appeared that the patient had opened his mouth before
exposing the plates to the x-rays. It was then that I asked the patient to remove the
denture, which exposed a nearly full set of mandibular teeth that were completely
black. I was taken aback because I was not aware that overdentures were
sometimes used to treat TMJ (Temporomandibular joint) disorders. This patient is
one example of the clinical situations that I learned about on the job as instead of
in school.

In addition, Alex found it challenging to provide dental hygiene care within the
parameters of dental insurance coverage. She explained that receiving DH care through
student practicums at Saskatchewan Polytechnic enabled all clients to have complete care
for $50.00 regardless of the amount of time or appointments required. However, DH
services provided in private practice are dictated by fee guides and/or dental insurance
plans, which set rates according to every 15 minutes (e.g., unit) of care provided. Alex
seemed bothered by not being able to provide complete care in some cases, or having to
ask the clients to pay for services. As Alex was a new clinician, she was not able to accomplish as much in one appointment compared to a more experienced clinician. Alex mentioned the issue in her journal:

I found it difficult to provide appropriate dental hygiene care to some of these patients, as many had limited insurance coverage. I was often unable to finish hygiene care within their available units of scaling provided to them by insurance. At first, this upset me because I did not like telling patients that they would need to come back for another appointment, or multiple more appointments, to finish their cleaning. I felt like it was my fault that these patients were not completed in one appointment. Finances also became an issue. In school, $50 covered all of a patient’s necessary treatment. In private practice, I have some D4 patients who, through insurance, have two to four units of scaling available per year, which is not enough for me to finish. I have had difficult conversations with patients explaining that their insurance does not provide enough coverage for hygiene, and that they will need to pay out of pocket for additional units of scaling if they wish to finish their cleaning.

The literature supports the stress felt by Alex in keeping with one-hour dental hygiene appointments. Beerwald (2014) lists time management as one of the primary concerns dental hygiene students face toward the end of their program. Time management is considered a problem for all dental hygiene practitioners regardless of their years of practice, and so it would seem logical that Alex would find it more challenging to keep pace. Belinski and Kanji (2018) found that DHs listed time constraints as a factor in failing to provide services such as extra oral cancer screenings, vital signs, nutrition and smoking cessation counselling. Further, they suggest that lack of time management skills is also a reason why DHs fail to perform procedures beyond hygiene. It is possible that Alex would not perform essential procedures because of time constraints. Further, in a study of nursing graduates’ experiences, Ankers, Barton, and Parry (2018) found that the increased work demands, skills and efficiency required for patient care were considered overwhelming to new nursing graduates as they entered the workplace. This nursing literature was used, as studies on dental hygiene graduate
experiences are scant. Comparatively, Dental Hygiene is on a similar educational trajectory as nursing. It would seem that Alex’s experiences are similar to other new graduate health professionals with respect to the stress in the initial months of practice.

Alex’s inability to complete dental care due to the clients’ lack of insurance and their inability to pay for treatment was difficult. This is a common occurrence in the dental profession. Quinonez and Locker (2007) suggest that dental care is largely privately funded through insurance, and the amount of publicly funded dental care has seen a drastic decline over the years. Indigenous populations and those on social assistance can receive some dental care, but services are limited and complete care may not be attained. In their study, Quinonez and Locker interviewed 1,006 Canadians to determine their opinions about publicly funded dental care. Results suggest that Canadians support the idea of a universal dental care model, as dental coverage is often limited. Receiving optimal care is dependent upon insurance coverage or ability to pay out of pocket, rather than the oral health care needs of the client. According to Bhatti, Rana, and Grootendorst (2007) there is a direct relationship between a person’s income, dental insurance coverage and how often a client accesses dental care. Therefore, those with lower income will access dental care less frequently than their higher income counterparts, often seeking care for the most urgent care over regular preventive care and recommended treatment. Furthermore, Bhatti et al. suggest that Saskatchewan is one of the provinces with the lowest access to yearly preventive dental care, which includes a comprehensive oral health exam, oral cancer screening, and periodontal therapy. This might explain the difficulties Alex had with completing care.

Alex suggested that shadowing a mentor or experienced clinician would have been beneficial to her transition to practice and alluded to the differences between her
school and practice experiences. Alex mentioned that in school there was an instructor to provide feedback on the effectiveness of the dental hygiene care, which differed from the private practice where there was usually no one to provide such feedback. She stated: “In private practice, I guess the mentor, of course, another hygienist at our office even, would have been nice.” In her journal, Alex revealed how nervous she felt about being left without an instructor to check her work. This feeling indicated to me that she would have found a mentor helpful in the first months of practice. She wrote:

When a dentist came to do my exams, I was nervous that I had left calculus somewhere obvious that they would see. I did not have total confidence in my debridement due to the fact that I had gotten so used to an instructor checking for calculus at school and I lacked experience. I had seen fewer patients in two years of school than I did in my first few weeks part-time in private practice.

Alex spoke to the challenges of being the only DH in the office, and described the pressure of that responsibility as a recent graduate. She mentioned that the new dentist who was working at the office was a DH prior to being a dentist, which was a benefit. I interpreted and confirmed that experience to mean that having experienced DH as guides or mentors would be a strategy to improve the transition to practice. Alex stated:

My experience is different from maybe other people just because like I was the only hygienist in that office, and there wasn't even a current hygienist when I started. So I had asked to shadow somebody and just kind of see how he or she wanted me to do things and there wasn't even that person to see.

This comment demonstrated Alex’s desire to have had an experienced DH or an experienced dental professional as a mentor. Further, she stated how she initially found it stressful to practice on her own. She stated:

And so there was kind of, like I said, I think my situation was a little different than most people, but I felt like there was a lot of I guess pressure on me because I was the only hygienist there. I was supposed to see every single in that office and as a new grad, I felt like there was a lot of responsibility and I didn't have that person to kind of like bounce questions off and things. It was stressful at first.
A positive element for Alex was that there was a dentist with previous experience as a DH who provided some guidance:

There were two associate dentists at our office at the time, and I started being scheduled with both of them. The female dentist had been a hygienist before becoming a dentist, so I was able to ask her questions about anything hygiene-related.

The benefits of a dental hygiene mentoring relationship are supported by the research conducted by Grater-Nakamura et al. (2010). The researchers suggest that an effective mentor can provide advice and feedback to the mentee as well as increase their self-esteem and confidence. These benefits are thought to be short and long-term. Other studies about mentorship in health care primary practitioners’ groups found similar results. Egan and Song (2007) researched the value of a formal mentorship program in a health care organization in the United States. One hundred fifty-eight mentor protégé dyads were included in the randomized control trial. The researchers compared high-level facilitated and low-level facilitated mentoring dyads and found both of them to be effective in assisting new employees to adapt to their job. They noted that the high-level group had more job satisfaction and commitment to the organization. Similarly, Tiew, Koh, Creedy, and Tam (2017) evaluated the impact of a three-year graduate nursing residency program in Singapore. The researchers followed 73 participants and found that the mentoring relationship in the nursing environment was effective in assisting with the transition to professional practice. Mentoring would have been important for Alex, as she mentioned wanting more guidance from another DH. While she had some support from the office, it was clear from her interview, and journal that she was interested in having more guidance.
Although Alex did not specifically mention SDL as a strategy for improving the transition to practice, the concept was evident throughout her interview and in her journal entry. She mentioned in her journal that there was a tour of the office by the receptionist, but most of the orientation was self-directed by taking personal notes.

My office did not have a hygienist for a while before I started working there which made it impossible for me to shadow a hygienist in my office. I felt extremely nervous about going straight from school to my first full day of work with eight patients scheduled without having an orientation to the office. I spoke to my managers about this and they allowed me to go into the office to meet some of the staff a few days prior to starting, and I was given a tour of the office by the receptionist. The tour lasted about two hours because I made notes for myself and made sure to ask a lot of questions to help calm my nerves before my first day.

These sentiments were mirrored in her interview. It would appear that Alex used SDL as a strategy to improve her transition to private practice. She noted that accessing the Internet or textbooks was helpful in answering questions regarding a client’s health history or procedures. She stated:

Every day kind of got easier and you'd learn a lot on the job as well. If there was things that I had questions about, I'd dig out my textbooks and read things and go over stuff that maybe I wasn't so clear on or I had forgotten from school.

I asked Alex how she remembered all the medications and she replied competently:

I'd look up the meds. I would definitely ask the dentist as well, because she has more experience. Those are basically like my two main resources. I'd Google, if I forgot about antibiotic prophylaxis, I'd look up on the CDHA or whatever; different reliable resources I'm familiar with.

As stated in Chapter Two, Murad et al. (2010) suggest that SDL in health professions’ education is associated with some improvement in knowledge when compared to traditional classroom models. Knowles (1975) suggests that most adults are self-directed learners, and will plan their own learning based on personal needs and
desires. It would seem that Alex exhibited SDL as a strategy to enhance her transition to private practice.

When I asked Alex about her suggestions to enhance the transition of RGDHs to private practice, her response related to her educational program at Saskatchewan Polytechnic. Alex advised that the program could provide more education regarding digital charting (Referred to as Dentrix in this case), and the restorative component to dentistry. As she decisively recalled:

Starting with school, I think learning more about like the restorative side, like as far as ... we did like modules on crowns and bridges and stuff. I think a little bit more of that would have been helpful for us direct entries anyways. And then of course Dentrix, we did have I think, two classes on Dentrix, but then we didn't get to really practice it or anything. I think that's an issue that's been fixed now.

Taylor (2011) describes the challenges felt by novice DHs in Ontario. She suggested that six of the seven participants mentioned that they felt that they lacked enough information on the use of technology when starting in private practice. Further, the participants were challenged by documentation in private practice. When compared to school, documentation in private practice was seen as minimal and challenging due to the use of technology. When Alex was a student, there was minimal education on the use of digital charting which would account for her concerns in relation to the transition to private practice. It is interesting that she never suggested a mentor although the issue appeared in parts of her data.
Arin

I met with Arin in my office at Saskatchewan Polytechnic because she stated that she felt most comfortable coming to the school, and the office provided a private place to speak freely. Arin had been working in a few private practices since graduating six months prior to the interview. One of her positions was covering a maternity leave for another DH and the other was a permanent position. In contrast to Alex, Arin worked in offices with other DHs. Arin described herself as a positive person that liked to keep the client’s safety and best interests at heart. When I asked Arin about what she perceived as likely to increase her competency levels for entry into private practice, she responded that having experience, receiving feedback and having support was helpful. Arin referred to communicating with another DH in the other office, who reassured her that getting competent as a clinician took time and experience:

I know I talked to the one person and they never really felt 100% comfortable until two years out, so that's kind of nice to know that maybe it's not something you need to be perfect at right away, but you can always continually kind of grow and improve.

Further, Arin discussed how her brief time as a DH has evolved since the first day. She stated:

There's a difference, well even just confidence-wise. I'm starting to feel more and more confident. Even with exploring the teeth. Your tactical sense, I think, is, something you guys always talked about as growing over time. Now, when I'm in the mandibular anteriors, it's like you can tell right away if something's there. It's different that way and I feel like I've only, like, noticed that more so, like, in the past couple months.

Arin mentioned that she had full support from the Dentists and DHs at the office, which appeared to have increased her confidence in her skills and therefore competence. Arin spoke emphatically and kindly of her workmates:
So, they were the two main hygienists I was working with all the time and, like, super good to ask questions with and, like, the dentists were all super friendly. They were all young (age removed for confidentiality) so there was the three main guys that owned the practice. Um, you could pretty much talk to them about anything, so, um, that was all good that way. I felt like it helped huge. They were always, like, super nice, like if you need extra time, they will give it to you and then they were, like, the transition and they ... I think they gave me about a month to get used to everything, and then after that, they were like, "Okay, we're gonna give you less time. Is that all right?..." But, they would always ask me; it's not like they just sprung it up on me.

Arin mentioned these thoughts in her journal where she suggested that she had reached out to her co-workers who reassured her that her skills would come with time. She explained: “I remember talking to a few different hygienists who told me that they did not feel fully confident with their skills until even a year after starting and that it was a learning experience where you can continually improve.”

Arin mentioned that experiencing positive feedback from clients and the dentists she worked for helped her to feel more competent as a DH. In her journal, she recounted these positive comments and tied them into competence:

One of the best compliments I hear from clients is “you are good at what you do,” and I find it to be a huge confidence booster. Being able to influence others health or oral health and hearing others say they appreciated my service, makes me feel like I chose the right career path, especially after going through a somewhat rocky school experience.

In another segment of her journal, Arin indicated:

After a few months I started to ask the dentists if they had any comments or performance feedback for me, or if there was anything I could change. At first, they never really had a whole lot to say other than that they were happy with what I was doing. I found towards the end of my 6-month period, that the dentists, along with the other hygienists would tell me they thought I was a good hygienist and had heard from patients that they thought I was good at what I did. I was super relieved to hear this from them, especially with it being my first job out of school, and it meant a lot to me hearing it from other professionals.

Research indicates that feedback is important for improving competence.

Unfortunately, there are limited studies in the DH profession to draw upon; I have
integrated nursing literature to reinforce the participants’ comments. Fereday and Muir (2006) conducted a phenomenological study of 26 nurse clinicians in Australia to understand their experience of feedback in relation to clinical competence. The participants of the study indicated that feedback from other nurses impacted how they viewed themselves as nurses, and often led to a process of self-assessment as to whether they were competent in a skill or needed improvement. In the end, the process of feedback, self-assessment of competence and improvement led to improved competence. There was little evidence to support whether the feedback should be formal or informal in nature to improve self-assessment or competence; however, the participants noted that feedback could come from other care providers, or clients, which appeared to be a more informal approach. Arin seems to agree with Fereday and Muir about the importance of feedback in enhancing her competency level for entry into private practice.

I proceeded to ask Arin what challenged her feelings of competency when entering into private practice. Arin referred to her struggle with school, and the need for extra help with her clinical skills as a negative impact on her level of competence at the onset of private practice. She also mentioned time management and her own perception of her competence. She stated in her interview:

[My clinical skills have] improved since I've got initially in. I know when I came out of school, I was really feeling kinda nervous about everything, especially because I feel like I did spend so much extra time when I was at school doing all the additional stuff so, just having that alone made me feel uneasy, but I felt like my nerves were kinda calmed once I got into it because when we're at school, you have someone always giving you feedback, always saying this is that way, and then when you get out there, you don't have any of that. So, that was a big change, but clinically wise, though, I do feel much more comfortable than, say, obviously from my first day out. But I do still feel like I'm always gonna be kind of continually trying to improve.
Arin mentioned that even with more time for appointments, time management continued to be a challenge, which impacted her feelings of competence. Similar to Alex, Arin worried about time management and wondered if her clients or employer would think that she was not competent because she was not as fast as her more experienced colleagues. In her journal, Arin mentioned her struggle:

“One of the main things I feared, and somewhat struggled with when starting out, was staying on time.” This fear was reinforced in her interview when she stated:

I was fortunate when starting that the dentists gave me lots of extra time in the first month, but it quickly became apparent that I would have to work to be better with my time management. I wanted to be thorough, but I did not want to upset clients or have them think I was slow, especially if I decided to bring them back.

Throughout the journal and interview, it appeared that Arin was worried about others seeing her as a new graduate, and the perception of others as a result of her being a new graduate. She raised a rhetorical question in her journal: “Would the dentist be rude or unaccepting if I did not meet their expectations? Would I be good enough after struggling with school?”

Arin went on to reflect on her fear of the perception of others about her competency:

One of the other things I was also afraid of was to come off as “new” to my clients, I remember people asking me when I had graduated, and I felt scared of what people would say or think when I replied, “last month, or only a few months ago”. I remember on my first week, my one client made a remark that his appointment seemed longer than usual, which was due to me spending additional time getting used to the process of things.

Arin experienced anxiety regarding the provision of local anesthetic (LA) for the first time in private practice might affect the client’s perception about her competency as a RGDH, but things appeared to have worked out well. She explained her experience in this way:
Another example of a learning experience that I can think of was being scared to initially do LA. I did not have to give any LA until about three months in, which was a little nerve wracking considering it had been a while. I remember being shaky and feeling the same as when I initially felt when I anesthetised my classmate. But again, I found myself surprised how the client seemed to have full trust in my skills, obviously the client not knowing this was my first injection since school.

In her qualitative study of professional competence of new nurse graduates, Oritz (2016) indicates that participants cited the importance of positive feedback and communication with others, including clients, as key factors in enhancing their professional confidence and therefore competence. She concluded that the positive feedback was an important preceptor and that understanding the learning continuum of a newly graduated nurse helps to promote a safe learning environment to further develop professional confidence. Arin’s views were similar to the views expressed by Oritz’s participants.

I asked Arin what strategies she saw as likely to enhance her transition experiences into private practice. She spoke about her experiences with having other DHs in the office to shadow and offer her advice. She also mentioned that making notes and cue cards was helpful in the first months of practice. Arin’s statements about a mentor went as such:

I only went in for a day and I shadowed another DH. So I did the day, and then I think I was gonna come in the next day, but it, it felt like I didn't even need it, just because you kinda saw everything…

Later in the interview, I brought up the issue of observing the other DH, and Arin said:

Yeah, that was definitely helpful. ... I would've been a lot more nervous if I went in without that. so that was definitely nice just to get the grounds of everything and see what was going on.

In her journal, Arin affirmed the importance of having mentors:
It also helped that I worked with two very nice hygienists. They were great mentors and were always so welcoming and easy to talk to regarding any questions that I had.

Research by Thorkildsen and Raholm (2009) examined the professional competence of nursing students. The researchers suggested that a good working relationship with an experienced nurse supervisor and a positive working environment are important factors in improving the professional competence of nursing students. As dental hygiene is a health profession, which is comparable to nursing, the results of this study can be translated using this lens. From the statements mentioned by Arin and the supporting research, I interpret her experiences in transitioning to private practice as positive due to the supportive environment and mentorship that her co-workers fostered for her.

Arin and I continued the discussion about the strategies that helped her transition into private practice. She brought up her use of self-made notes and cue cards to help her keep her appointments organized. It appears Arin used the notes and cue cards as learning tools for self-reflection and assessment utilizing SDL to assist her in her transition. She indicated that she had gone in to shadow another DH to get the flow of the office, and she explained that learning experience in this way:

I was writing down, "Okay, what order do you do everything in? I was asking all these little questions and I had, like, a little paper that I followed probably for a month, and then after that I didn't need it because it just became kind of muscle memory. Yeah, there were lots of little things.

Arin continued:

I brought lots of little cue sheets with me, like stuff that we had in school. Because my last office was digital charting; the office I'm at now is paper charting, so I brought with me, the whole little paper charting symbols, whether it's, like, a PFM or, whatever, those little things. So, having little informational things like that. I have a little thing with the fissure sealants on it because I haven't actually had to do a fissure sealant, so the day that it comes I at least have it kinda ready to go. I feel like having little informational things like that is
helpful. Like with LA, that was one. If it were ever to pop up, I wanted to have it there to be prepared. So, those things were always good.

Self-assessment or reflection of knowledge gaps is essential to DHs’ professional practice. According to DeVore, Fried, Daily, and Qori (2000), self-assessment is particularly vital to DHs due the nature of the work, which is mainly independent of the other employees in the office. Arin demonstrated self-assessment in the knowledge that she had to learn more about the procedures of the office, and she directed her own learning to help her become more comfortable, and competent in her practice.

Finally, I asked Arin what she thought might enhance the transition experiences of RGDHs into private practice. She suggested that the program should provide more information about Dentrix digital charting and dental insurance. Further, she thought it would be important for students to be able complete client care in one appointment with a dental exam included, as that would be more reflective of private practice. She stated:

I feel like the whole Dentrix thing, like I mentioned, learning about that, I feel like, would've been helpful for practice. Also, having a whole start-to-finish experience would be ... I don't know. I guess some of the people have had that. Like, if you were efficient and everything, you probably could've had that in school, but with all the extra things that we do in school, I know that always makes it a little more challenging, but being able to have that flow of private practice would be helpful.

In private practice, the dentist will often conduct an exam in conjunction with dental hygiene appointments. The examination is not reflected in the Dental Hygiene program where appointments are dedicated to dental hygiene care and referrals are made to see the dentist for an examination. As a result, Arin felt ill prepared to handle this deviation from what she was familiar with in school. As Arin mentioned, her education did not concentrate on the business side of a dental office, and she would have had
minimal understanding about dental insurance coverage unless it applied to Dental Hygiene care. Arin stated:

The one thing I wish I knew how to do is dental insurance. If we had a class on how to do that, but then I feel like there's so many insurance plans. Once I talked to the reception people, they always say how there's so many little ins and outs about all the insurances that, it’s hard but, I feel like if you had all of those skills, and dental assisting that’d be, like, the perfect trio.

According to Taylor’s (2011) qualitative research of new DH graduates in Ontario, Canada, participants felt ill prepared to work in private practice. DH students practiced with a client-centered model in mind. In private practice, DHs are confined to the demands of dental insurance, client’s ability to pay out of pocket and the employer’s expectations for production and time management. Often, a private practice office is centered on a business model, with the expectation of fee for services rendered, which contrasts with the comprehensive care received in a DH educational institution regardless of cost or insurance (Taylor, 2011). Arin’s experience relates to Taylor’s research. Arin mentioned feeling that she needed more information on the flow of private practice and on front-end insurance information to work more effectively with clients. This was not something that was stressed in her education.

Blake

Blake and I met in a library to conduct her interview. She has been working in a newer small office for six months. Blake mentioned that she was one of the only DHs on staff, except on two other weekdays when a slightly more experienced DH joined her. I asked Blake what she felt increased her competency level for entry to practice. Blake felt that having a support system in the office to provide guidance or support helped with her feelings of competency. In the interview, she recalled the presence of an experienced
Dental Assistant who offered her words of encouragement and advice that she considered valuable. As she put it:

I think in the first couple of weeks one of the assistants was like, "You know, you're doing really well for a first year hygienist. You're managing your time well, I think that you're trying to learn--" She's an awesome assistant. She's not one to hold her feelings back. If you're doing something wrong, she'll tell you. And if you're doing something right, she'll tell you. So I think that really helped me. Even though she wasn't a hygienist herself, just that motivation from her was helpful to me.

Further, Blake mentioned how the feedback from her clients was meaningful to her. In her journal she wrote:

I had a lady the other day that for her first appointment was almost in tears because she was experiencing so much pain in quad 3 that she wasn’t able to eat and was taking Tylenol like candy, so I froze her and only did that quad and when she came back for her next appointment she was almost in tears of joy because she didn’t have any pain at all and was possibly over eating now that she could eat again. I am so happy to be able to help these people get back on track with their oral health and provide a comfortable experience for them that make them actually want to come back.

Similar to the other participants, feedback was helpful in gauging her confidence, and ultimately building up her competence.

Later in the interview, I asked Blake what challenges she thought influenced her competency level for entry into private practice. She indicated that not being able to effectively remove or tactiley feel the calculus deposits with some clients altered her feelings about competence. I observed the look of frustration and struggle that Blake experienced when she described her challenges with tactile sense. She frowned slightly, but also averted her gaze from me. Blake also considered that her perception as well as that of others was a negative influence on competency. She recalled appointments when she was less effective at removing calculus from the client:

Well there were a couple of times when I would see a new patient who hadn't been to a hygienist in a dozen years. And, I didn't take x-rays before, and then as
soon as we take them after and there’s still calculus visible on the x-rays. That was kind of discouraging. Even if I was counting on having them back again, cause I only completed half of the mouth, I was still like, "What am I doing wrong? Why can't I see that?" Or, "why can't I feel that?"

Belinski and Kanji (2018) discussed the perceived barriers faced by new graduate DHs and mentioned that the lack of clinical competence gained in a program can relate to feelings of incompetence in the initiation into private practice. Time constraints appear to accentuate the issue as RGDHs are struggling to adjust to private practice, and seem to require extra time for appointments when compared to experienced clinicians. While this may not be generalizable to all RGDHs, it appears to be the case for Blake and the participants in this research. She implied she did not acquire the skillset required to effectively remove or fill calculus deposits in clients from the program. The Dental Hygiene program at Saskatchewan Polytechnic has 525 hours of clinic time, which is adequate for an entry to practice clinician, but an exact number of hours of post-licensure practice to produce a DH that is highly competent has yet to be determined in the literature.

Throughout her interview and in her journal entry, Blake expressed concern about what clients would think of her skills. Whether real or perceived, it seemed that she considered the negative perception of others a challenge to her competency. In her interview, Blake expressed her own worries surrounding what she thought her clients might think of her. Blake got a concerned look on her face and said:

I feel like they might almost judge me on [being a new graduate], like this person doesn't really know what she's doing, but then on the same end of that, I've had people say, "This is really comfortable. This is the best experience I've ever had."

Blake continued with her perceived concern:
But it almost feels like there's a stigma on me, like saying "You're a new hygienist so maybe you're not as skilled as somebody that's been working for more and you don't know what you're talking about." Sometimes I feel in my head people expect to come to the office, see a hygienist for an hour, and then that would be it. And even if it's been 10 years since they've come last, I feel like, sometimes-- I don't know why I feel that. Cause sometimes, it's never really been said to me, like, "Why can't you do it in one?" But I just feel like they expect to be done in one hour. I felt like they would think that I was incompetent, like I wasn't good enough.

Blake also expressed similar thoughts in her journal. She wrote:

As a new grad I was very self-conscious about my skills, I would, and sometimes still, wonder what the person was thinking about, if I was hurting them, if I said “umm” too many times while trying to explain their pocket depths and recession levels and they think I’m dumb. I had one of my colleagues tell me that a patient had told them that I was a little rough, this really upset me because I had explained to the patient, who hadn’t had a cleaning in 3 years, that her gums were swollen and that they might be sensitive and if they were to let me know so I could apply some topical anesthetic or use Oraqix or Local Anesthetic and I say to Every single patient before I start that “if anything is sensitive or uncomfortable let me know and we’ll find a solution to that discomfort”.

I asked Blake what helped in her transition to private practice. Blake suggested organization as a strategy for enhancing the transition to private practice. She talked about getting to the office early to get her operatory ready for the day:

Yeah, I usually get to work about half an hour before I see a person and then-- or, if I have somebody at 9:30 that I'm supposed to start to working at 8:30. I'll just get there at 8:30. And then I sharpened all of my cassettes, all the instruments in my cassettes. And I have four, and then I put some gauze and some floss in there. And then I package a backup and put it in a drawer…And it really helps because then all I have to do is take it out of the drawer and put it on the tray, unpack it and then go from there.

In her journal, Blake stated that having a mentor for support would have further improved her transition to practice.

The office I am working at was nice enough to let me come in for a few hours before I started and the Hygienist showed me around and did a quick intro on the computer program (we use Clear Dent at our office). Having this day to know what I was getting into was nice but she didn’t have any patients that day as the Dentist was away so I didn’t get to see how she worked and what her system was,
which would have been nice. The office I work at was only opened a few years back so it is still expanding and excluding Tuesday’s, when we are open until 8:30 pm when more people like to come in and we have another Hygienist working. I was the only Hygienist there so I didn’t have anyone to talk to about things they do to make working easier or things they’ve learned which was difficult for me at first.

I asked Blake what suggestions she had to enhance transition experiences of recent dental hygiene graduates into private practice. She responded in this way:

There are things in the office that I am still learning about and I wish I knew more about the restorative aspect of everything but other than that I absolutely love my job!

I interpreted this to mean that Blake was learning on the job, and that she would have benefitted from more knowledge of the full scope of dentistry. As an example, Manski and Parker (2010) identified gaps in knowledge for DHs with respect to early childhood caries etiology and treatment when compared to adult caries etiology and treatment. Further, the study suggested that DHs with more experience were more competent in this area of dentistry when compared with a less experienced clinician. Another study conducted by Simonian, Brame, Hunt, and Wilder (2015) suggested that a longer practicum prior to graduation created clinician competence in the areas of time management, patient management, clinical skills and professional judgement. This indicates that learning occurs within private practice outside of the confines of an educational institution.

Maysen

I met with Maysen in a library to conduct her interview. She had been working in a larger dental office for six months. She worked with three DHs and three Dentists. One key feature Maysen mentioned in her journal was that she was a long-term client in the
office, and chose to complete her practicum there. I interpreted that as a potential factor in increasing her competency level for private practice. She stated:

Ironically, I have been going there for my whole life, and I plan on working there for the rest of my working career as well…. It was great for me because I did my practicum at this office and I knew lots of the staff already so I did kind of have an idea how the office ran before I started.

I asked Maysen what increased her competency for entry into private practice. She stated:

I had a lot of ladies … Like, two of the ladies have worked there for 20 years, so they took me in under their wing, showed me the way. And then there's another hygienist there that's part-time/casual. She's also fairly new out of school, so me and her can kind of relate to what was going on…

Having these personal supports in the workplace appeared to be a contributing factor to Maysen’s feelings of competence. In her interview, Maysen mentioned that positive feedback from the clients and her employer helped her feel competent. She stated:

A big thing was having the patients request me already. I see them one time, and there would be a note, "Only wants to see Maysen again." Things like that. Feels awesome. One of the people in the office next door to mine heard the way I was interacting with my patient, and they were saying to the dentist, "I want to see whoever that is. That's who I want for my cleaning." Lots of getting those requests. And then the dentist saying that I was the most confident new grad they'd ever had in their office. That felt awesome, too.

Clark and Springer (2012) researched nursing graduates’ transition to practice. One of the points they made in the qualitative study was that job satisfaction was related to being valued by co-workers, employers and patients. I interpreted Maysen’s feelings of competence as being related to the supportive work environment and having mentors to work with. From analyzing Maysen’s interview and journal, it appeared that she worked in a caring environment with people who were invested in her success.
Further, I came across one of Maysen’s first experiences with a challenging client in her journal entry. I interpreted the entry as a challenging experience of her competency levels for entry into private practice. She wrote:

About 2 months into working at my office I had a patient in for a new patient exam in my chair and they were booked an hour and a half so it seemed like lots of time but boy was I wrong. This patient was basically just a grumpy old man that insisted on fighting me every step of the way by asking me why we needed x-rays and photos, telling me he couldn't lay back all the way in the chair, and not wanting me to use the cavitron on him as well as refusing to let me take his blood pressure or review his medical history with him. I tried my best to educate him on his perio diagnosis but he would not listen and he just wanted me to “shut up and clean his damn teeth already.” I honestly felt so defeated and I was blinking back tears trying to just get through the appointment. I told him that he would likely have to return for a second hygiene appointment as it had been a few years since he had been to a dentist, and then he called me a f@#$ing b*!%#, after that I went and told my dentist what happened and then she came into my room to try and clear up the situation. She let him know it was not acceptable behaviour to swear and then he just sat there with his arms crossed and told me to get on with it but that if I didn’t finish there was no way he’d be coming back. I tried my best with just hand scaling but I knew I missed calculus and I felt so crappy sending him home but I documented everything that happened in order to try and cover my butt. Sure enough this patient called the office a few days later claiming that his teeth didn’t feel as “clean” as he would like and that he would like to come back and see someone who “knew what they were doing.”

I asked Maysen more about this experience in her interview. She stated: “That was in my first month of being there. That was the first big moment where it was terrible. First time I had tears there, for sure.” The impact of Maysen’s first experience with a challenging client seemed significant and really affected her. I then inquired how the dentist handled the client, and what impact it had on the situation. She responded:

She helped. She came in and talked to him. I think she kind of got him to calm down. But then as soon as she left again and I tried to get back to it, he was kind of looking at me as nothing again. He saw her up here, and I was down here in his mind. Yeah.

I interpreted her experience as one that negatively influenced her competence in providing client care, especially since it was so close to the start of her working career.
Just as positive feedback appeared to increase Maysen’s competence, negative feedback and poor client behaviour appeared to decrease her competence.

When Maysen described her first day in her journal, it sounded as though she struggled with a lack of routine, which might have reduced her feelings of competence.

She wrote:

My first day I remember feeling so unsure of myself and luckily I was booked lots of “easy” patients but I still feel like the cleanings I performed were not necessarily up to my standards as I did not have a set routine like I do now, and I kind of felt like I was just fumbling my way through it at first.

Next, Maysen described the lack of time, and how that affected her in the first months of practice. She expressed:

The first 2 weeks I worked I was given an hour and a half for each appointment, which was generous of the office, but I still felt like in some cases it wasn’t enough time especially because I was so slow making my notes and learning the computer system. Then once the appointments switched to 1 hour it was eye opening for me to try and work even faster. I remember feeling like I was drowning and I never had a minute of peace unless I had a cancellation.

It would appear that Maysen felt overwhelmed by the time constraints in private practice, which was different from school. It would follow that not being able to keep pace at work would negatively impact competence. Further, she wrote:

For the first while, I ran behind a lot, which cut into my half hour lunch break so I wasn’t eating or taking a minute to myself as it felt like I was just in survival mode. I didn’t even really value the work I was doing it was just basically like do everything as efficiently as possible and move onto the next person, always racing the clock and half the time losing that race.

In her interview, Maysen verified these thoughts. She affirmed:

At the beginning I felt like I was just trying to get by, trying to do everything as fast as I could, how they wanted me to do it, so I could just keep my head above water for the first little bit. Now I feel confident with the way I practice, and how things are going, and feel okay about things now.
I understood this comment to mean that there was a marked difference between her experiences in the first few months compared to her current practice. What does the literature say; briefly relate this finding to the literature

Another factor that Maysen mentioned as a challenge to her competency was learning the protocols in the office. She mentioned that new protocols and the computer system caused her some degree of anxiety. She said:

One of the first things was definitely just using their computer system and how to use that. That was probably what I found the most overwhelming of everything. And then just different protocols we have for blood pressure, even. Things like that. Where we're supposed to administer epi (epinephrine) in case of emergency. But I didn't really feel comfortable with that, so we talked that through a little bit at one of our staff meetings. What else? I guess even trying to bring someone back for an evaluation appointment. I brought that up when I first started, and that got shut down pretty quickly by everybody. Nobody really liked the idea of doing that. I guess for production. They didn't see it to be productive in the office. Yeah.

Maysen found that the time constraints to complete care were a challenge to her practice. She mentioned how every minute and procedure needed to be tied to making money for the office. This contradicted what was encouraged in school where the client’s needs were given a higher priority than financial gain. She stated:

Definitely money driven out there a little bit, even when I try to ask for let's say a longer appointment for one of those anxious patients, then they'll be like, "Well, what are you going to charge out for this?" And I'm like, "No, they just need some more time to just take a few minutes." I had a lady who was in tears hugging me the other day, telling me how great her appointment went, because we booked her two hours. We didn't even get anything going clinically the first hour. I chatted with her, reassured her about everything. Things like that. But then the front end is kind of looking at that like, "Okay, but you could have seen two patients in that time."

Next, I asked Maysen what strategies she saw as likely to enhance her transition experience into private practice. She mentioned that having a person to provide feedback on her client care would have been a helpful transition to private practice. Maysen did express her gratitude for having experienced DHs to work with, but expressed that she
did not want to bother them with all of her questions. She stated: "I know that I had support available in the office if I needed it but I didn’t want to be running from room to room trying to track someone down to help me.”

Although Maysen never stated that SDL was a strategy to improve her transition to practice, she alluded to the concept in her journal entry. She mentioned in her journal how she prepared for her first day of practice. She had been trying to teach herself to use the computer system. She explained:

I even practiced [the computer] at home and set myself up different scenarios. As the week of shadowing went on I grew more and more anxious knowing that I was going to be on my own very soon.

Another concept that Maysen brought forward was her ability to self-reflect and critique. In school, the students were taught to critique their work and to reflect on what they could do more effectively in future appointments. I interpreted this to be a strategy to enhance the transition to practice. If a RGDH could self-evaluate, it would help them to make a plan to improve. Maysen put it this way:

I do reflections a lot. I would do reflections on myself a lot over the first few weeks, like, "Okay, how did that day go? Okay, next time I see that person, I'm going to try to work on this. I won't bring up this with them, because they didn't like that." Or I'm going to try these instruments instead. Just different little things like that.

DeVore et al. (2000) support the concept of self-reflection or self-assessment in Dental Hygiene. According to them, self-assessment is important to the development of competence in practice and should be considered an essential skill to learn. Their research focused on practicing DHs’ beliefs regarding self-assessment in Maryland and found that the respondents most likely engaged in self-assessment procedures informally without prompting from other influences such as employers or co-workers. Maysen was
demonstrating these behaviours in her practice, which might have helped her transition to practice.

Finally, I asked Maysen for suggestions to enhance the transition to private practice. She stated that she had a good foundation of knowledge, but needed to further develop that knowledge in practice. She explained her transition in this way:

I think a lot of the transition is more so just getting used to the office and then incorporating your skills into there. I feel like I had the knowledge and skills I needed. It was just putting it into practice outside our little clinic that made it a little bit more intimidating, I guess.

For Maysen, lack of education in digital charting systems had an impact on her transition to practice. Maysen stated in her journal that learning more about digital charting systems would have benefitted her. She wrote:

I think one of my biggest worries was trying to learn their Curve digital system which Dental Hygiene school didn’t really prepare me for (it’s great they are digital now though)! It would have been nice if we had time to practice more digital charting and learn some of the different common programs offices use while we were in school.

I followed up on this suggestion in her interview. Maysen was talking about her practicum and what she learned. It was then that I asked what would have helped her in her transition. She had this to say:

Yeah, it was such a glimpse of things. And then lots more, like learning different computer program systems. But I know that would be hard for us to try and teach, I guess, because there's so many out there. But that was probably the thing that slowed me down the most. Like, "Why can't I chart this implant in here? What is going on?"

We spent a lot of time with Dentrix. Well, a little period with Dentrix in there. It would be nice if somehow we could incorporate other systems or spend a little bit more time digitally, which I know they are doing now, which is awesome.

Another suggestion that Maysen mentioned was having another recent graduate to communicate with to discuss strategies and receive advice. She stated:
I think it would have been kind of a neat experience if we could have followed up with some of the recent graduates and get some advice from them, too. I don't know how we'd incorporate that into the program or anything, but I think that would have been kind of helpful there, as well.

Lastly, Maysen suggested longer practicums to assist in the transition to practice. She said:

I think a big thing would be more time in offices, just because we get so used to the flow of our clinic that it's just kind of your mindset, and then you're going into a whole new environment. Where if we had a little bit more time spending the time in those dental offices, I think especially for the direct entries, like me. Well, yeah, I've been to the dentist before, but I don't know all the behind the scenes stuff, so more practicum type of stuff. And we did do a practicum; it was just in and out.

Maysen’s comments reflect the suggestions offered by Belinski and Kanji (2018). They mentioned that practicums have been minimal in Dental Hygiene diploma programs, although that might lead to reduced competence for the transition to practice. Maysen thought longer practicums would enhance the transition experiences of RGDHs into private practice. At the time of the study, the Saskatchewan Polytechnic offered students a 2-3 day practicum in private practice, which was formally set up by the program. Students were encouraged to attend other self-organized practicums as a way of transitioning to practice, though no assistance from the program was given. The national and provincial governing bodies do not specify a length of time for a practicum; however, the associations do expect that graduates will have proved competence in the skills and knowledge relevant to dental hygiene prior to licensure. In reviewing and speaking informally with other Dental Hygiene program directors across Canada, it appears that there is a variance in how practicums are scheduled and lengths of practicums, which may be a future area of research.
Kris

I met with Kris in my office at Saskatchewan Polytechnic to facilitate the semi-structured interview, as she was familiar and comfortable with the space. Kris had been working as a part-time DH for three different private practices for seven months. She described herself as a thorough and informative clinician who wanted her clients’ to be well informed of their treatment and its rationale. I had inquired about what she felt increased her competency for the transition into private practice, and her answer came from her journal. Kris wrote about how she felt school prepared her for work, which I interpreted to mean that she felt like she had a solid foundation from which to work in private practice, and that it was part of feeling competent as a DH. She put it in this way: “Dental hygiene school definitely prepared me for the process of care and what is involved in running appointments…”

Further, Kris continued that although she was prepared, the time constraints were an issue. She continued:

But it was a big challenge to fit that all into one hour with clients. Not because I didn't feel like I was good enough, I just felt like I wasn't fast enough, and not equipped for the way an office runs. The hour-long appointments, the quick set up and tear down…

This comment led me to ask her what challenges she perceived as influencing competency levels for private practice. She mentioned that making minor mistakes, missing calculus, time constraints and being compared to other more experienced DHs left her feeling frustrated and incompetent. In relation to mistakes, she stated:

When a dentist asks me to retake an x-ray, or says we need new x-rays, not another one, because I should have taken a PA (periapical x-ray) here, that makes me feel like, "Oh, man. I should have caught that.”
Further, in her interview she mentioned trying to co-diagnose with her dentist, which is common in private practice. In this case, she felt as though she could not adequately complete the task. She put it in this way:

Another office, he likes me to do co-diagnosis, but I honestly don't, because every time I've ever said, "Oh, I think this one, this one, this one looks like a cavity to me," and I mark it, He always disagrees.

Kris talked about her feelings of incompetence when removing calculus deposits from a client’s teeth. She detailed an occasion when she had left some behind, and the dentist brought it to her attention. When she spoke, I could hear the frustration in her voice, she reflected:

I wasn't doing a good job at first and the dentist pulled me aside and he's like "You're not removing any calculus on the distal molars." I was like: "What?" And I think he just meant like, there was a little scraping on the distal buccal, like calculus above the gums because I'm so focused on the subgingival calculus.

I interpreted Kris’s comment as a challenge to competency levels, as the skill of removing calculus is one of the foundations of a DHs practice. It also seemed that for Kris, the competency was tied to time management. In her journal, Kris discussed her first few months in the offices she worked at, and expressed her frustration with lack of time. She wrote:

I’ve been lucky that the offices I’ve worked in so far have been accommodating for this and always helped me with set-up and tear-down and checking in on me for the first week or two. But needing so much help made me feel like I wasn’t ready to jump into private practice. Not only was I already worried about staying on time with the scaling alone, but all of the documentation, education, check-up time, setup and teardown had to be done in one hour! I’ve worked in three different offices, and each one was a challenge to learn about. It took me about two months in each place before I started to feel comfortable and confident that I was doing a good job. Those first two months were not only overwhelming, but made me feel frustrated that appointments were so short.

She reflected further upon this comment in her interview:
Not because I didn't feel like I was good enough, I just felt like I wasn't fast enough, and not equipped for the way an office runs. The hour-long appointments, the quick set up and tear down, it was hard. Kris suggested that trying to complete her appointment steps in an hour was difficult.

This issue was mentioned in Beerwald’s (2014) study with RGDHs. One of the main stressors was that as new graduates, they were thrown into practice with one client per hour for the eight-hour day. One of the participants in her study mentioned wanting an hour and one half appointments to start. Belinski and Kanji (2018) alluded to time constraints as perceived barriers to providing skills such as oral cancer screenings and tobacco cessation counselling. They noted that the participants felt that trying to get the debridement and a check-up into an hour was difficult enough, and adding more tasks into that hour proved challenging. One could surmise that a new graduate may find the time constraints more problematic than more experienced DHs.

I asked Kris what strategies could have enhanced her transition to practice. While Kris did not have a list of strategies in mind, she did mention that in one office she shadowed a DH to get better acquainted with the process expected of her, and how being without an instructor was difficult in the beginning. She said:

My first day, I was just covering originally for a friend at that office. So, she stayed there for the morning, and helped me with setting up, tearing down, writing everything down. So it was actually okay. But it was really nerve-wracking to just not have anyone standing over your shoulder.

I took Kris’s comment to mean that she thought having a mentor, or a way to ease into practice with some educational support, would have been helpful to her. Further, she suggested:

It was helpful while we were doing the practicum, for sure, to have a hygienist there to be like, "Okay, just move along. You're spending time on nothing there."
And to have someone over your shoulder, because in school you go over everything so thoroughly in school because it's getting checked. And you don't want to have calculus left….But in real life, you can't have that time, so you just have to do it the first time right.

I asked Kris what would have assisted her in her transition to practice, and she focused her thoughts on school. She felt that having more practice with radiographs, shorter appointments at the end of school, more practicum time, and a well-rounded view of dentistry would have been beneficial. As I had read in her journal, Kris discussed her challenges with radiographs and how that differed from her private practice experiences. In school, the emphasis was taking radiographs when required to diagnose disease. Often, this was completed after the client had gone through a thorough assessment. In private practice, many offices routinely take radiographs prior to any other procedure.

She expressed her thoughts in these words:

Now I know this can’t really change in school, but taking bitewings everyday was terrifying at first because we didn’t have that much opportunity to practice on real people in school. Not only that, but trying to capture the 8’s on a PA [periapical radiograph] is difficult on many patients, and it is almost embarrassing to ask assistants of other hygienists for help when you haven’t been able to get them. There have been times when I’ve taken radiographs for bone loss and hygiene as well, and the dentist said, (in front of the patient) “why did you take this,” even though there was advanced bone loss and tooth mobility, and no previous radiographic record of it.

It appeared that Kris was attempting to follow protocols outlined at school, which did not match the demands of private practice indicating a need to gain more private practice type experience prior to entering private practice. Kris also mentioned struggling to take radiographs in private practice, as they often did not have the same film holders as they did in school. She stated in her interview:

I still feel pretty bad at taking bitewings, like, on the left side. I can never get them correct on the left side. And I've reread notes and I've tried to change things what I'm doing, and I sometimes get it and sometimes don't. Definitely better now, but this is a year out of school and it took me 8 months to feel comfortable
with it. PAs I'm still not good at either. I can get them sometimes, but other times, no. And I don't use the holders, I should say. Because we're pretty limited on our supply for holders.

Next, Kris discussed how shorter appointment times at the end of the program would have helped make the transition to private practice more easily. She noted the time difference between school and private practice, and how that difference made her feel.

She explained:

In school, it would have been helpful to have shorter appointments at the end with a bunch of D1s (easy degree of difficulty) because that's what you typically see. D1s and D2s (more challenging degree of difficulty). Going from a two and a half-hour appointment to basically 50 minutes if you have to, because not including set up and tear down and turn over, I guess. It's still stressful. Like, it still stresses me out. It still makes me sick when I'm running behind.

Belinski and Kanji (2018) reported that Dental Hygiene diploma programs were not often implementing clinical practicums as a way of transitioning students into the profession, which differs from other health care professions. While Kris would have had clinical experience in the onsite clinic in the program, the structure of appointments were drastically different from working in private practice. As Kris mentioned, it would have been helpful to have shorter appointments at the end of the school year over the standard two and one half hour appointment times. Further to this, Kris talked about having more practicum time. In her final year, students were required to do a two-day practicum in a private practice of their choice, which felt inadequate to her. Below she alluded to others feeling the same way. She said:

But at least having, or the other thing was, we all have said when we were leaving school was more practicum time….because we get those two days or something, I think we had? It would have been helpful to have had maybe two weeks or even a week.

Finally, Kris felt that a more well-rounded view of dentistry would have been a benefit for the transition to practice. She talked about her circumstances in talking to
clients about fillings and other dental procedures, and not being able to describe the procedures in full detail. She stated:

I know we go over stuff like fillings and everything in class, but when you have only an hour or two on it, it's really hard to remember when a patient asks you six months later, "Now, what's gonna happen for this?"

Kris mentioned that explaining the dental procedures was expected of her in one of her offices, and that she would have to refer to the dental assistants in the office for extra information when needed. She said:

That office [expected] me to discuss treatment with patients. Very thoroughly….Root canals, bridges, implants, crowns, all the various different options? I was expected to discuss with the patient because he didn't want to. He just didn't want to talk to the patient. He's like, "You tell them." And then he'd go on and do his own thing. And I'm like, "Alright." So, I ended up becoming pretty okay at it. I'd ask the assistants for help at first if I wasn't sure about anything.

Overall, it seemed that Kris would have like a little more information regarding other dental procedures aside from Dental Hygiene procedures. The program provides a course for DH students to learn about other dental procedures; however, this may not be considered sufficient to assist RGDH in the transition to private practice.

**Kelly**

Kelly met me in my office at Saskatchewan Polytechnic to facilitate the semi-structured interview as she found it simple to get to. She had been working for approximately eight months at two offices owned by the same main employer with different associate dentists. She initially described herself as a nervous clinician, and a little unsure of herself. She mentioned how that had changed in the last six months of practice. She stated:

I feel like I've actually already changed a lot as a clinician in the last six months. Starting out I felt I was really nervous, didn't really know what to talk to my clients about, was kinda hesitant on my decisions, like if they would be the right
decisions. Now that I've gained experience and I've watched other hygienists in private practice work I'm more confident. I feel like the way I work has definitely improved.

In her interview, Kelly did not mention what made her feel confident as a RGDH, but she did discuss feeling well educated and ready for practice. She wrote:

Leaving the school building on my last day, I felt prepared to begin my career as a DH. I knew I learned everything I needed to know, and had a sufficient amount of clinical practice to begin practicing outside of school. I had been fulfilled with information from several different experienced instructors and been given some tips and tricks for success. I knew I was far from perfect and that I would learn so much more each day I practiced on my own.

I interpreted Kelly’s comment to mean that she felt that she was going to be able to transfer the skills learned in school to private practice. I talked to Kelly about what challenges she perceived influenced her competency levels for entry into private practice. She mentioned a number of things that impacted her. Kelly discussed the negative perceptions of clients, and the differences between school and private practice as factors that decreased her levels of competence. She felt pressure from some clients to be like other DHs, and felt bad when the clients did not accept her way of practicing. She described it as such:

It was really nerve-wracking, because every time someone sat down they were like, "You're not my usual hygienist." I felt like I had big shoes to fill and I didn't want them to hate me right off the bat.

She recounted the following experiences from private practice:

I was just filling in for one girl, and specifically in their notes they were only supposed to see this one girl, and then I show up. They're just like, "I didn't schedule with you." They get into their groove of a person, and they don't want to mix that up because they found someone they like.

Further, Kelly recounted:

Yeah, I've had one that didn't like me right off the bat. The majority of them have. So it's like you get feeling confident and then you have someone who's like, "I don't want you to finish my cleaning, I want to go back to the other girl I had."
Her reasoning, I'm not sure. Everyone just kinda said it was because I was a bit more upbeat than her last hygienist. Her last hygienist was silent and just worked and things like that. Also she knew that I was new and I feel like she didn't like that. I was actually really upset about it when it did happen. I was like, oh, someone doesn't want me to be their hygienist. I feel attacked.

As a RGDH, it would be difficult to be compared to other DHs. Being unsure of the office and the needs of the client would have compounded Kelly’s feelings of incompetence. Further, she talked about the differences between school and private practice, which made her feel unsure of herself. She stated:

The main thing was just that they were overwhelming. Trying to get into the groove of an office. Each office I was at had different ways of doing things. I mentioned there, the one office I was treatment-planning things, whereas that's not something I've ever done. It was just really fast paced. The other one, the one office gave me more time. I felt like that definitely helped me be more comfortable getting used to the adjustments. The other one I still just had the basic hour to do the treatment plan and all this extra stuff that they gave me.

In her journal, Kelly wrote about her struggles in more detail. She put it in this way:

Not being an assistant, I was not very familiar with the procedure terms that the dentist was asking me to plan. We had a class that went over them, but I didn't know very detailed descriptions of them. For example, he had told me to plan a post core crown on one tooth. Not being familiar with the computer system, this was very difficult because I didn’t know what type of crowns this dentist preferred, what a post and core even were, or where to find them in the computer codes. I was also thrown off planning this as hygiene units and scheduling units are different amounts of time.

Kelly had to acclimatize herself to two different offices, which may have contributed to her feelings.

I asked Kelly what she felt would have enhanced her transition experience and she suggested that working with other DHs was helpful to her. She talked about it in the following way:

Just like being around them. Like the one’s right beside me. I hear the way she explains when she's describing the periodontal disease, the way she words it to explain it to the client really helps me because I can bounce ideas off of her. If I
have any questions at any point, I can just look over across the room and she can answer them.

Kelly mentioned that she had shadowed for a day in the offices with the more experienced DHs, which I interpreted as a support system in the office. She reported:

Yes, so I did a shadow day with each of them. I just went in for an afternoon and watched the way they went through appointments, their notes, and they both used different computer systems, so I kinda just wanted to watch them. How they used those.

Beerwald (2014) alluded to the importance of a supportive work environment for new graduates. Some participants in her study expressed frustration with the lack of support in private practice. The suggestion was that these participants felt that they were left on their own to acclimatize to the ways of their offices. Beerwald (2014) concluded that a good support system improved RGDHs transition to practice. Kelly appeared to agree with Beerwald on that issue.

Kelly and I discussed what would have enhanced her transition to practice. She mentioned wanting the offices to give her more time in her appointments in the beginning, wanting the school to teach more digital charting, wanting a longer practicum, and wanting the school clinic to more accurately reflect private practice appointments. Kelly had this to say about time management:

I felt that extra time at my one office really helped me learn how long. Especially if you're just slower in general. You're not like, you check a spot five times over because you're not sure if you got it clean. So the extra time. Even just a little bit of extra time just to give me that base. Trying to figure out the computer was a big one. My one office has two monitors. Some is on one that the patient can see. Another one is what you can see.

This comment also alluded to the struggles around digital charting. Kelly mentioned the importance of digital charting in private practice, and felt her lack of knowledge of digital charting was a barrier to her transition. In her journal, Kelly wrote:
The hardest part about my transition from school to private practice was trying to figure out the computer. In school, everything was done on paper. I wasn’t familiar with the system this office was using. Dental charting was very difficult because I didn’t know the symbols or where to find the subject I was looking for. It slowed me down so much at the beginning and was very frustrating.

In the interview, I had asked Kelly about the digital charting based on the information I had read in her journal. She felt that learning a little about the other systems on the market would have been beneficial. She put it in this way:” Or even learning that there's other software out there. Coming out only knowing Dentrix and the first office I was in wasn't Dentrix.” She then described the processes she followed in the one office where she was working at:

We have the paper and we bring it into the office and we update it there. It’s all digital. You go on health histories on there. All your notes are on there. The sensor, everything is just right on there. The charting, there's little icons that you have to like click and put on the tooth. But when it doesn't actually say what it is, it's just like a picture of a circle on the tooth and you have to just know it's a filling.

Another important factor for Kelly was practicum time. Kelly felt, like some of the other participants. Kelly thought a longer practicum in private practice would be helpful for her transition into private practice. She suggested:

I do think a longer practicum. Even when I did my first day, there was a bunch of people who wouldn't let me work on them. So then you only have like two other days and you're jumping in here and there and you don't really get into it before you're back into the school with the three hours.

Kelly alluded to her two or three-day practicum where some clients felt uncomfortable having a less experienced DH working on them. The mentor for her practicum was in charge of the learning experiences in the practicum, and it would seem that Kelly only had a few opportunities to practice her skills during the practicum.
Finally, Kelly spoke about the routine of private practice, and how it differed from school. She mentioned that she thought it would have been good in school if the routine was more like what DHs would experience in private practice, such as dental exams as part of the dental cleaning. She put it in this way:

Oh yeah, when the dentist comes in, our dentist at school here didn’t come in and do a recall exam and have us write notes on it and stuff or isn't that you see how you have to gauge your time around the dentist and stuff. If the dentist is running late, how it affects you running late.

In the dental hygiene program at the Saskatchewan Polytechnic, the focus was to complete comprehensive Dental Hygiene treatment rather than to complete a dental exam with the dentist in a one-hour time constraints. The process in private practice is built around the dentist or employer’s routine rather than that of the DH. For time and efficiency for clients, a private office will often include the exam and the dental hygiene services in one appointment.

This concludes the participants’ experiences of transition. What follows is a list of themes that emerged from the data. The themes will be further presented and discussed in Chapter 5 in relation to the findings and the relevant literature for the study reviewed in Chapter 2.

**Themes that Emerged from the Lived Experiences**

After reviewing the data from the interview transcripts and the participants’ journals, four themes emerged:

*Theme One: The importance of a Support System/ Mentor*

Throughout the data the participants were in agreement about having a mentor or supportive environment. Participants with mentorship or support mentioned those factors as positive influences
for their transition to practice; alternatively, those without support and mentorship mentioned the desire for those factors.

**Theme Two: Importance of a Workplace Practicum**

The participants seemed to believe that a workplace practicum was a benefit to transition. The common sentiment was that several participants felt that the practicum was too short, and that future students would benefit from more practicum hours.

**Theme Three: Importance of Developing Program Curriculum to Enhance Graduate Transition**

The participants mentioned a few strategies to assist students’ transition into practice. Comments ranged from wanting more education on all facets of dentistry, to more appointments in the school day to be more reflective of private practice. Further to this, more work that is true to the flow of a dental office would have been a benefit. An example would be to include a dentist’s check up at the dental hygiene appointment.

**Theme Four: Importance of Self-Assessment and SDL in the Development of Competence**

The participants did not directly use the term SDL; however, their descriptions of self-learning, and self-reflection for the need to improve and making a plan to improve are indicative of self-directed learning. The RGDHs often took it upon themselves to make cheat notes, look up medications or information on complicated health histories. In essence, they planned learning activities for themselves to improve their practice.
Chapter Five: Discussion, Implications and Recommendations

The purpose of this study was to explore the transition to private practice experiences of RGDHs from the Saskatchewan Polytechnic; more specifically, the factors they associated with a successful transition. The goal was to understand the factors that participants perceived to have increased their competency levels and enhance their transition experiences into private practice. The study also sought to understand the challenges that participants perceived as influencing competency, and for participants to offer suggestions for future graduates as they transition from school into private practice.

I used participant journal reflections and semi-structured interviews from six dental hygiene graduates of a provincial program to understand the nature of their transition.

The findings revealed that four themes emerged as important in the transition of RGDHs. The first two themes are the importance of a mentor or support system with a thorough practice orientation, and the importance of a practicum. These two themes are directed towards private practice in that it informs those working in practice as to the needs of RGDHs. The other two themes are the importance of transitional support from faculty, and importance of self-assessment and SDL in the development of competence. These two themes are geared more toward the educational institution to assist educators in planning learning experiences to help students prepare for the leap into the profession.

In this chapter, I will discuss the research findings in relation to the literature, make recommendations based on the research findings, discuss the implications and offer some suggestions for further research.
Discussion of the Research Findings

**Theme One: Importance of a Support System/Mentor**

The findings of this study suggest that a mentor or support person played a role in the successful transition of RGDHs to private practice. Participants who did not have a support system or mentor in their office mentioned the desire for that type of relationship, and those that had a support system bolstered the benefit of the relationship. As suggested by Grater-Nakamura et al. (2010), the benefit of a support system and mentor to a new graduate is that the mentee is exposed to new employment experiences, has the opportunity to increase professional competence, and supports development of professional identity. In addition, Beerwald (2014) suggested that mentoring helps improve retention in the profession as RGDHs feel a part of the profession, and feel supported in their role as a clinician, which leads to career satisfaction. For the current study, it is important for RGDHs to have mentoring to assist them in their integration into practice and to assist in retention in the career. The participants in the study felt that a mentor was important for their success. Similarly, Hill, and Sawatsky (2011) relayed the importance of mentoring support for nurse practitioners. They concluded that the mentor is vital to the mentee’s socialization into the work environment, and those with a supportive environment reported thriving in the profession compared to those who did not have a supportive environment of a mentor.

The results of this study align with the literature with respect to a mentor or support system. To illustrate, Kelly described the importance of the mentor relationship with the other DH in her office. She suggested that she felt more comfortable having a more experienced clinician working beside her, as it was good to overhear the more experienced DH speak to the clients. Kelly further supported the concept of mentoring
when she discussed shadowing the other DH in the office. Kelly’s data support the findings of Hill and Sawatsky’s (2011) research on nurse practitioners (2011). Hill and Sawatsky (2011) emphasized the importance of mentors and a supportive work environment as among the key factors in the successful transition of new dental hygiene graduates into private practice. Like Kelly, Maysen also remarked on the importance of a mentor. She had the opportunity to shadow the other DHs perform tasks with which she was not familiar.

The participants identified that mentoring support would have been beneficial to their transition and could be provided by other employees in the office, including non-dental hygienists. Specifically, Blake stated that having an experienced dental assistant, as a guide was helpful to her transition. Blake went on to discuss how the dental assistant provided her with positive and corrective feedback, and how this confirmation was motivating in her transition.

In contrast, Alex and Blake state their desire to be mentored by an experienced mentioned DH. Alex expressed that she did not feel that she could ask anyone for guidance and Blake would have liked another DH in practice with whom to share questions. Hill and Sawatzky’s (2011) research supports the claims that new health care practitioners desire a mentoring relationship to assist with the transition to professional practice. The findings of this study support that contention. The participants agreed that having a support system or mentor at the beginning of professional practice was a valuable tool for the successful transition to private practice.

**Theme Two: Importance of a Workplace Practicum**

The findings from the participants in this study revealed that additional experiential learning in private practice would have improved their transition into private
Each participant cited struggling with time management when transitioning to private practice as compared to their experience in school. Further, they felt that they lacked knowledge in the full scope of dental practice, which appeared to be a barrier to their successful transition to the profession. These perspectives support the findings of the research by Smith, Lennon, Brook, and Robinson (2006). These researchers reported that dental students benefit from practicum placement as they have “contact with typical and diverse patients, improved clinical confidence and speed, the development of communication and team working skills, a wider appreciation of dentistry and other healthcare services and increased social responsibility” (p. 44).

The findings of this study support a desire for the DH program at a Saskatchewan Polytechnic to consider offering a longer practicum, which the participants perceived would have eased their transition to private practice. The Saskatchewan Polytechnic offered two to three days of scheduled practicum time to understand the flow of a workday though the suggestion was for additional days. The participant, Kelly wanted a longer practicum, stating that having only three practicum days provided her a marginal view of private practice. Kris also mentioned wanting additional practicum time and alluded to this being a common desire amongst her classmates. Kris mentioned that a practicum of a week or more would be beneficial.

The research completed by Smithe et al. (2006) found that the dentistry, DH, and dental therapy students found external practicums to be more in line with professional practice, and fostered their socialization into industry. This alignment between the literature and the findings of this study suggest that a longer practicum would be helpful in the transition to private practice. Currently, the students have a two-three day practicum, which has been stated as inadequate by the participants. Acknowledging that
research specific to the transition of graduates to the dental hygiene profession does not exist, it is likely that increasing the length of the practicum would assist the RGDHs to become more fluid in their skills. As a result of this study, the program at the Saskatchewan Polytechnic has considered longer practicums throughout the program to determine if the repeat exposures to private practice will be more impactful for the transition. Further research will be required prior to such a determination.

**Theme Three: Importance of Developing Program Curriculum to Enhance Graduate Transition**

The findings of the study reflect several of the themes identified in the literature. The participants expressed the need for the DH program at Saskatchewan Polytechnic to directly assist students with their transition into private practice. More specifically, the participants mentioned the need to implement a longer practicum to be more inline with private practice experience. As an example, dental hygiene students are not asked to perform an exam with the dentist in conjunction with dental hygiene care. This differs from private practice, as an exam is part of the client’s visit. The participants also thought it would be important to incorporate more private practice centered content into the curriculum. Common suggestions were to incorporate digital charting in the program, and to strengthen the students’ knowledge of restorative dentistry. As these participants did not have previous dental experience prior to initiating their DH program, they felt inadequate when explaining a procedure to a client. In particular, Blake felt that this was something that should have been emphasized in the DH program.

Further to this, the participants were concerned about their time management, as well as the amount of time allocated to complete procedures. Taylor (2011) mentioned that the work pace in private practice is incongruent with the pace in school, which might
be problematic for RGDHs. The participants consistently expressed feelings of being overwhelmed with the pace in private practice, and suggested that instruction specific to time management strategies during their educational program would have been beneficial to their transition to practice. Kelly felt that the time management required for practice was difficult to adjust to coming from the program. Further, Blake suggested that as students progressed closer to graduation they should be given shorter appointments and be expected to see more than one client in assigned clinic time. Currently, the students are given two and a half to three hours to provide care for a client in a single clinic appointment, which contrasts with the expectation in private practice see care for two or three clients in that same time. Further, the leading expectation is that the majority of clients will be complete within that time in private practice when compared to the dental hygiene program with the opportunity to see the same client for multiple appointments.

Beerwald (2014) made the following comment on the transition process that dental hygiene students go through after leaving the educational institution:

“Transitioning from student to practitioner can be a very isolating, stressful, confusing, doubt-provoking and disorienting time as students leave the structured environment of their educational institutions” (para.2). Further, Taylor’s (2011) study involving novice DHs revealed that they were ill-equipped to handle the discrepancies between school and practice. She reported that novice hygienists struggled with time management, the use of technology, and keeping appropriate records. In addition, Taylor indicated that DHs without a previous dental assisting background struggled with the concepts of restorative dentistry.

The findings of the study support the perspectives expressed in the literature regarding the critical importance of time management skills reported by the participants.
The participants all suggested that time management skills were important in their transition into private practice. Further, the findings revealed the need for educational institutions, to revise the dental hygiene curriculum and clinical expectations to help prepare new graduates for the challenges they might face in their transition into private practice.

**Theme Four: Importance of Self-Assessment and SDL in the Development of Competence**

As students, the participants were required to self-assess their skills throughout the program and to develop an action plan for ways to correct any skill deficiencies they identified. This element seems to have followed the participants into private practice, as they appeared to be undertaking self-assessment and, in turn, engaging in SDL to assist in their professional competence. Often they acknowledged the differences between being a new and experienced clinician, and reported wanting to be more competent. As an example, the participants referenced their struggle with providing care to eight clients per day. This opinion was highlighted by Kelly’s comment about her struggle with the first client on her first day and how, in comparison, she felt the more experienced DHs manage this efficiently. She recalled extreme anxiety and being close to tears at the sense of being overwhelmed on her first day. Maysen also discussed her skills and recounted an occasion when the care she was providing did not go as planned. Despite trying to frame things positively, she identified how she would improve her performance next time, which revealed her ability to self-critique and self-regulate. Further, in her interview, Maysen mentioned that she felt that her education assisted in her in self-reflective practice. Both Alex and Arin talked about writing notes as helpful hints for their practice. In fact, Arin asked to spend time observing another DH revealing how she
took responsibility for her learning. Through these examples, the participants support Basanti’s (1999) claims that those that are capable of SDL are also competent in assessing and planning learning opportunities. Being able to self-assess skills and incorporate SDL strategies is important in the development of a competent clinician.

As mentioned in the literature review, Shiner and Howe’s (2013) study of novice physicians revealed that learning resulting from an immediate need during work was considered self-directed and experiential. The same can be said for the participants in this study. As they were faced with a new challenge in private practice, the participants had to continuously self-assess their learning gap, and develop a plan to acquire new knowledge to address that gap. To that end, the continuous quest for knowledge is likely to strengthen the competence of new graduates as they transition into private practice.

This concludes the discussion of the findings of the study. The section that follows discusses the recommendations arising from the study and suggestions for further research.

**Recommendations Arising from the Study**

The findings of the study will benefit employers of RGDHs by providing insight into the needs of new employees. Creating a supportive work environment is crucial to the self-perceived success of the RGDHs, and employers have a vital role in facilitating the process. Offering detailed office orientation may benefit the RGDHs. Based on the findings of the research, it is noted that RGDHs need to feel empowered to ask for the support they need from their workplace. Furthermore, requiring students to complete additional appointments and reduced time to provide care prior to employment may facilitate their successful transition to private practice. By extension, employers could
afford one and half hours for new graduate’s appointments as compared to one hour for experienced clinicians.

Further, the results of this study inform curriculum review and revision for Dental Hygiene programs. Consideration should be given to a longer practicum (e.g. one week) to ease the transition experiences of the RGDHs. Having more time in practicum would help the RGDHs to get used to the routine expectations of practice. It is important for educators to reinforce the importance of self-assessment and self-reflection skills in clinical practice. It would seem that these aforementioned skills are a precursor to self-directed learning so that recent graduates will plan learning activities based on their own self-assessment and reflection. Educators should consider changing the way that appointments are completed during the final term of the program. Students need to be prepared for the faster pace in private practice, and should attempt to provide care for more than one patient. This could be achieved through the inclusion of time management skills, which are required in private practice.

Lastly, there is a need to disseminate the findings of this study to the provincial and national regulatory bodies in order to inform their decisions about mentorship models to support the transition of RGDHs. Furthermore, the regulatory bodies are an excellent organization to recruit experienced dental hygiene to serve as mentors for RGDHs. Consideration needs to be given to the initiation of formal mentorship programs, similar to those in other health professions. Further, it is recommended that a review of the literature be undertaken to develop a strategy aligned with best practice. It will be pertinent to share the findings with private practice offices to highlight the experiences of RGDHs and to illuminate the importance of a mentor for the transition to practice.
Suggestions for Further Research

The results of the study are specific to the Advanced Diploma program at Saskatchewan Polytechnic. A national research project including other dental hygiene programs will provide generalizable findings. This type of study will inform the national professional body, and perhaps elicit change in the dental professions with respect to collaboration with new graduates. As there is a paucity of literature specific to RGDHs, further research is necessary and a comparative study examining varying cohorts of graduates from diploma, advanced diploma and baccalaureate programs in the transition to private practice. The study could determine if similarities and differences exist amongst the cohorts based on education levels. Divergent findings suggest a need for programs to examine best practice for the preparation of RGDHs entering practice.

I recommend including a comparative study to evaluate RGDHs with previous dental assisting experience prior to completing a dental hygiene program to determine if differences in the transition to practice exist. This type of study would help determine whether a RGDH with dental assisting experience has an easier transition based on the familiarity of practice and having a better understanding of how private practice works. Further, I would suggest a study that incorporates the strategic use of a mentor in private practice to determine the impact on the transition of RGDHs. The data from this study would be useful to assist the educational institutions or regulatory bodies to promote or encourage mentoring relationships for the RGDHs. A comparative study examining the experiences of graduates in private practice versus public health would be interesting to determine if similarities and differences in experiences exists. While the majority of students seek private practice opportunities, future work in dental hygiene may include
working in the public health sector or long term care facilities. As there is minimal dental hygiene literature available on this topic, I would recommend that more research be conducted on the uses of various mentorship models in transitioning a RGDH into private practice. This type of research would provide evidence for or against the concept of mentoring. Further, it would help inform the profession with respect to assisting RGDHs transition into practice.

The study did not explore the influence of social structure on RGDHs transition to private practice. Rather, the key focus in the study was on individual and workplace factors and the way they influenced participants’ transition to private practice. Thus, a study that explores the combined influence of individual, institutional/workplace as well as systemic factors on RGDHs transition to private practice would be beneficial. Some research suggests that exploring the influence of social structural issues, such as economic status and family issues, along with individual and workplace/institutional factors would likely reveal more detailed explanations of the factors that affect RGDHs transition to private practice.

Finally, a study that considers the imposter syndrome and its implications for the transition experiences of RGDHs into private practice may be essential. The findings of this study revealed that the participants experienced some anxieties and fears about their professional identity and their transition into private practice. However, the study did not fully explore the concept and its implications for the transition into private practice experiences of the participants.

**Implications**

This provides an examination of the transition experiences of RGDHs from Saskatchewan Polytechnic in their first months in practice. There are specific
implications for educators, the professional regulatory bodies, and private practice employers.

Strategies demonstrated to be effective in the mentoring and preceptorship from the nursing profession can be applied to the dental hygiene profession. DHs may review nursing evidenced based practice regarding preceptorship until the dental hygiene profession develops a framework for which to follow. As an example, Muir, Ooms, Tapping, Marks-Maran, and Burke (2013) reported on the importance of preceptorship and studied the preceptor’s opinions of their role with new nurses. The research found that preceptors felt that they had an important role to play with respect to orienting new nurses into the profession.

Self-assessment and self-directed learning strategies need to be part of dental hygiene curriculum to ensure that students are graduating with the ability to assess for any skills deficiencies that they may encounter in practice. This is done consistently in the program at Saskatchewan Polytechnic. Further, the students should have strategies in place to direct their learning to ensure they provide safe and competent practice for the public. Jackson and Tipton Murff (2011) studied the value of teaching self-assessment skills to second year dental hygiene students. The researchers found that incorporating a training module on self-assessment assisted the students in seeing the value in performing self-assessment skills for clinical practice. Further, the researchers suggest that self-assessment was valuable for professional growth and development. Self-assessment is tied to SDL as the ability to self-assess an area for learning can lead a student to seek out new learning opportunities (Knowles, 1975).

Incorporating the 2019 Dental Hygiene Association Standards of Practice into DH curriculum will enhance student competence as they strive to meet the standards
prior to embarking on their careers as it serves as a benchmark for clinical success. While this is standard practice in the Saskatchewan Polytechnic, it is important for programs to evaluate the way in which these are implemented within their programs. McFarlane (2015) reported that DHs must be familiar with the standards, bylaws and code of ethics in order to practice professionally. The educational institutions have a responsibility to impart this knowledge to the future generations of DHs.

**Concluding Remarks**

As a DH, I can corroborate the findings in the study. Reflecting back to my first experience in practice, I recall wanting a more experienced clinician to speak to in times of uncertainty. I felt the pressure of trying to complete care in a time sensitive manner, and desired understanding from my employer. I wanted to appear competent to clients and my employer even when I felt incompetent. I spent a good deal of time in practice self-directing my own learning on new medications and health conditions in order to keep clients safe during care. Lastly, I constantly reflected on the care I was delivering, and how that could be improved.

Anecdotal evidence from my conversations with previous students highlights that the transition from graduate to competent professional is variable. However, it is common to hear that RGDHs begin to feel competent between six and twelve months after graduation.

In conclusion, the findings of this phenomenological study revealed that the successful transition to practice and the development of competence was dependent on a number of factors. This study suggested that further support from educational institutions; mentors and employers would be a benefit to new DHs. Furthermore,
RGDHs should consider self-reflection and SDL as essential for improving competence as a clinician.
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Appendix A

Research Ethics Approval

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms1/ethics-forms.html.
Appendix B

Participant Journal Reflection

Please take time to reflect on your experience on the first few months of work as a dental hygienist. Describe the experience of transition into private practice as you lived it. Write down any emotions, sensations, thoughts, or moods that emerged throughout that time. Please be as honest and descriptive as you can. It might be helpful for you to focus on an example that stands out. In order to aid you in your reflection, you may consider the following statements useful:

In the first few months of work, I felt like….

Being a new dental hygienist in private practice feels like…..

Thank you for your participation in the journal reflection.
Appendix C

Questions for Interviews

1. Demographic Information
   - Age
   - Gender
   - Location of practice

2. How would you describe yourself as a clinician?

3. What is it like to be a new dental hygienist in private practice?

4. Tell me about your first months in private practice, what was it like? How did you manage? (Describe your thoughts, and feelings that emerged about the experience).

5. What factors, if any, would have been helpful to have in the first few months in order to feel competent as a dental hygienist?

6. What factors, if any, made you feel less competent as a dental hygienist?

7. What experiences do you wish you could have had prior to graduating from the dental hygiene program in order to help prepare you more for private practice?

Thank you for your participation in this interview. You will be contacted for follow up if necessary.