THE ADJUSTMENT EXPERIENCE OF NEW GRADUATE NURSES TO ACUTE CARE ON PRINCE EDWARD ISLAND: AN INTERPRETIVE DESCRIPTIVE STUDY

by

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ABSTRACT

Many studies have been completed on the new graduate nurse transition experience but not specific to new graduates in acute care facilities on Prince Edward Island (PEI). The purpose of this study was to use an interpretive descriptive approach to examine this experience for ten new graduates in two acute care facilities on Prince Edward Island. Research interest was in trying to understand the underlying adjustments within the required transition and what could help or hinder these adjustments. All participants were interviewed within two years of graduation and the findings indicate that the adjustment experience for these new graduates is comparable to the experiences of registered nurses (RN's) elsewhere in Canada and abroad. New graduates on PEI experience four areas of adjustment which include social: taking on a new status; developmental: developing clinical expertise for area of practice; organizational: changing contractual relationships; and occupational: changing nature of work. Facilitators and barriers to adjustment are present with each particular area. Findings may provide a greater understanding of the main transitions that new graduates make as they move from the role of a student to an RN on PEI, as well as implications for nursing educators, administrators and researchers.

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Chapter 1

Introduction

The first several months of working as a newly registered nurse (RN) is a period of immense change during which the new graduate is required to make a transition from the role of nursing student to that of a practising nurse and to successfully adapt to that role change (Duchscher, 2009). Kramer (1974) introduced the theory of reality shock in her landmark research on new graduate nurses' experiences to capture the transition from nursing student to independent health care practitioner. Reality shock referred to "the startling discovery and reaction to the discovery that school-bred values conflict with work-world values" (Kramer, 1974, p. 4). Therefore Kramer developed a theory to explain the discrepancy between what nursing students thought nursing practice would be like versus their actual experience of being a nurse. The graduates in her study were consistently finding themselves unprepared for their new role because of the significant change from the role of nursing student to that of a graduate nurse. Partially in response to Kramer's research and that of others, changes in nursing education over time have been implemented to help students move more easily into the role of practising nurse and a number of successful orientation programs have been put in place to assist with the adaptation or transition of new graduates (Newhouse, Hoffman, Sulflita, & Hairston, 2007; Winfield, Melo, & Myrick, 2009). However, research from various countries, such as the United Kingdom, Australia, and the United States to name a few, provides evidence of a need to review the introduction of new graduates into the workplace and

their preparation for the responsibilities expected of them as practicing nurses (Horsborough & Ross, 2013; Parker, Lantry, & McMillan, 2014; Thomas, Bertram, & Allen, 2012). Research shows that many new graduates continue to experience some of the same difficulties and challenges that have been reported previously (Casey, Fink, Krugman, & Probst, 2004; Dyess & Sherman, 2009; Ellerton & Gregor, 2009; Gerrish, 2000; Kelly & Ahern, 2008).

Further research into the transition experience of the new nursing graduate have drawn comparisons between the graduates of Kramer's study in the early 1970s, to more recent Canadian nursing graduates (Duchscher, 2009). For example, Duchscher suggested that the transition from student to practising nurse is still felt as a shock and to retain new graduates it is essential to understand some of the adjustment challenges that they face when they are formally introduced to their professional community as new RNs. While there continues to be a number of research studies on the stages of transition that new graduates experience, there has been less focus on the types of adjustments that new graduates must make in this transition and what factors might facilitate or impede successful adjustment to the role of graduate nurse (Hoffart, Waddell, & Young, 2011). In Prince Edward Island (PEI), where this study was conducted, nursing administrators have tried to address how new nurses are introduced to their first clinical position in an effort to improve retention. Since the acute care environment is known as a stressful area because of the level of patient acuity I studied the transition experiences of new RNs, and in particular some of the adjustments they were required to make during that transition, in that particular care environment using interpretive description based on the research suggestions of Thorne (2008).

Background

Consistent in the literature are concerns about the current shortages of nurses, increased demands on nursing, and the difficulty in retaining clinically experienced nurses (Littlejohn, Campbell, Collins-McNeil, & Khaylie, 2012). The critical shortage of nurses has a tremendous impact on nurses and patients alike, in such areas as job satisfaction, nursing retention, patient outcomes, and surgical wait times (Mills & Mullins, 2008). Within Canada the nursing shortage is expected to increase by 2022 with the expected Registered Nurse (RN) shortfall modelled to be 60,000 full-time equivalents (Canadian Nurses Association, 2009). The impact of this anticipated shortage of nurses in Canada will be felt in the workplace if the trend of a growing number of RNs choosing early retirement continues (O'Brien-Pallas, 2003). In 2013, 15.4% of the Canadian nursing workforce who were 60 years and older did not renew their nursing licensure in the jurisdiction where they had previously been registered (Canadian Institute for Health Information, 2014). This continued trend in early retirement might continue because of opportunities for less stressful employment, leaving to care for aged parents, or simply to spend time with a spouse who has also retired (Blakeley & Ribeiro, 2008; Boumans, de Jong, & Vanderlinden 2008). Retirement of nurses in PEI is a nursing workforce issue because the average age of the regulated nurse workforce at 46.9 years in 2012 was the oldest in Canada (Canadian Institute for Health Information, 2013).

New nurses entering the workforce are an important human resource that is critical, not only to enhance, but to sustain the health care system in Canada and other countries (Health Resources and Services Administration, 2013). Nurses constitute the largest single professional group in health care, yet recent reports on this group suggest some

concerning trends (Canadian Federation of Nurses Unions, 2012). Some of these trends are: a) an aging of current nursing workforce with a high percentage of nurses nearing retirement; b) the number of nurses graduating each year is too low to sustain the profession and the number has actually decreased; c) regional disparities in meeting nursing workforce needs with rural and aboriginal communities most adversely affected; and d) challenges in retaining nurses in the profession and nursing practice. If sufficient attention is not given to address some of these trends it will be difficult to offset the predicted shortage of nurses in Canada (Canadian Nurses Association, 2009).

Devising realistic strategies to produce, recruit, and retain nurses within the Canadian health care system is critical to reduce the predicted shortfall of nurses. One of the strategies suggested in a report commissioned and published by the Canadian Nurses Association (2009) was to increase enrolment in entry-to-practice programs. The authors also realized that more needs to be done to retain these graduates in the profession once they enter. While accurate retention rates of new graduates within the profession are not well documented, research with new graduates in selected areas within Canada has found that slightly over 50% have considered leaving, or are definitely leaving their first nursing position (Rhéaume, Clément, & LeBel, 2011). A similar percentage of new nurses considering leaving was reported in a Scandinavian study (Rudman & Gustavsson, 2011). The quality of nursing leadership has the potential to have a positive effect on new graduate retention (Spence, Laschinger, Wong, & Grau, 2012). One of the main efforts suggested is to improve workplace environmental factors because the quality of the workplace environment is critical to retention of new graduates.

Efforts to ensure that the transition or adjustment experience of new graduates occurs in a supportive environment and that the early period as a practising nurse provides a positive foundation for continued nursing practice are instrumental in ensuring new graduate nurse recruitment and retention (Moran, 2012). New nursing graduates' first nursing position plays an important role in shaping perceptions of nursing, professional growth opportunities, and job satisfaction. Additionally, first job opportunities play a significant part in influencing the new RN's decision to remain in the profession (Duchscher, 2009).

Rationale

The overall process of transition or moving from nursing student to a well functioning graduate nurse has been the focus of a great deal of the research (Kramer, 1974; Benner, 2001, Duchscher, 2009). Some researchers have characterized this transition as a series of stages while for others it appears to be more of a developmental process. The transition is generally thought of as a role transition or an individual socialization (Duchscher, 2009) or an organizational socialization process (Phillips, Esterman, & Kenny, 2015). The length of time that a new graduate requires to successfully make this transition to his/her role or feel adequately socialized to the role varies widely. Despite the volume of research in this area and educational and initial practice changes made, many new graduates continue to experience challenges with their initial employment (Chernomas, Care, LaPointe-McKensie, Guse, & Currie, 2010; Clark & Springer, 2012; Lilja Andersson & Edberg, 2010a; Malouf &West, 2011). Too often the new graduate does not feel adequately prepared for practice and often experiences the clinical area as unwelcoming and even hostile (King-Jones, 2011). It is important to

continue with research on new nurses and at the same time look at their transition through a different lens in order to improve this experience.

The nature of a research study, whether qualitative, quantitative, or mixed methods, is shaped by the researcher's disciplinary interest, experience, and background (Thorne, 2008). As an acute care staffing consultant overseeing the hiring of nurses I have an interest in why some new nurses seem to quickly adjust to their first nursing position while others seem to have more of a struggle and some even leave the nursing profession early in their career. I also believe that much more can be done within a local context in order to improve new nurse transition and to facilitate that adjustment to their role as RN. In order to assist new graduates and to design strategies that will meet their needs it is important to first have a clearer understanding of their transition and some of the adjustment experiences they have within that transition. It was because of my interest in facilitating new nurse transition and the importance of the quality of this experience that I chose to study the adjustments these new nurses make within their transition and what could help or hinder them in the process.

Choice of Research Focus

Although related to grounded theory, Charmaz (2006) described how "sensitizing concepts" defined as "initial ideas to pursue and sensitize you to ask particular kinds of questions about your topic" (p. 16) help to shape the research. The use of a sensitizing concept is appropriate to interpretive description in that how you frame your research question is critical (Thorne, 2008). The concept or research idea you select can be influenced by the nursing literature, observations in the clinical area, or a combination of these factors. In a search for the concept I would pursue, my starting point was

"transition from nursing student to practicing nurse in an acute care environment", however I became aware that there were a number of adjustments that these individuals must make within that overall broad transition. To be successful in any transition an adjustment or adjustments need to occur. Adjustment is defined as adapting to something, like new environmental conditions or to a new climate or attitude (American Heritage Dictionary of the English Language, 2011). Therefore, for this research I chose adjustment as my main concept. By adjustment I mean the particular adaptations a new graduate is required to make to change from the student role to the role of an RN in order to have a successful transition to that of a practicing nurse. I believe that a series of adjustments are processes within the overall transition experience and I wanted to understand some of the adjustments that new graduates feel they need to make as they take on the role of an RN. From previous researchers (Duchscher, 2009; Kramer, 1974) we know about the various transitions the new graduate nurses make, but my research interest was in trying to understand the underlying adjustments within the required transition and what could help or hinder a successful transition.

Geographical and Social Context of the Study

Unlike the rest of Canada, where many capital cities report populations greater than 200,000, the entire population of PEI is only 146,000 (Prince Edward Island Population Report, 2012). The majority of Islanders are of Scottish and Irish descent, and evidence of this heritage is present in Islanders' work ethic and strong family connections. A predominately rural Island, there is an obvious appreciation among its inhabitants for the relaxed lifestyle offered by island living (PEI Department of Tourism, 2010). These would be factors encouraging new graduates to stay on the island and thus could

potentially contribute to a different transition than has been noted in mainly larger urban centres. In spite of the rural setting, nurses on PEI have the same opportunities for nursing education as those in more urban centers in Canada, with the evolution of the clinically based diploma program to the theory focused Baccalaureate degree currently offered through the University of Prince Edward Island (UPEI). These educational opportunities might make new graduates' experiences more similar to those found in previous research.

The Association of Registered Nurses of Prince Edward Island (ARNPEI) reports an annual average of 50 BScN graduates from UPEI (P. Boudreau, ARNPEI Registrar, personal communication, February 2015). Approximately 170 graduates applied for licensure from 2008 to 2011 and are currently still employed on PEI. The focus of this research will be on those new nurses who have been employed in acute care. At the Queen Elizabeth Hospital (QEH), the province's largest hospital, the environment in acute care is stressful (M. Harris, the Associate Director of Nursing, personal communication, February 2011). An increase in acuity of critically ill patients and the growing numbers of long term admissions of elderly patients in acute care are creating an increase in the acute care nursing workload, here as elsewhere in Canada. Some additional causes of stress may be attributed to existing nursing staff feeling the pressures of an increased workload, changes in practice with the recent implementation of a province wide Clinical Information System and a move towards a new Collaborative Model of Nursing Care. Given the current climate in acute care nursing on PEI, this research focused on some of the major patterns of adjustment new RNs face, what

challenges they experience, and what helped or hindered these individuals in their overall transition process.

Research Purpose and Questions

The overall purpose of this study was to identify some of the adjustments that new nurses make in their transition from student to RN and what may help or hinder them in making a successful transition. Three main questions guided my research: What are the main patterns of adjustment that new RNs make as they move from being a student to an RN? What are some of the adjustments challenges they experience? and What factors facilitate or impede these adjustments?

Chapter 2

Literature Review

A literature search on new nurse transition was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database with search terms entered singly and in combination to identify literature published between 2001 and 2014. This timeframe was selected because the Bachelor of Nursing (BN) requirement for entry to nursing practice in many jurisdictions in Canada started in 2000 and also because nursing education moved to educational institutions from healthcare institutions in other parts of the world around that timeframe (Pringle, Green, Johnson, & Downey, 2004). Consequently, nursing education was no longer a part of healthcare delivery and clinical experience for students changed from an apprenticeship model to a clinical education model. This change in how nursing education was delivered had implications for how nursing students were taught in the classroom and clinical settings as well as how the new graduate would be received in the clinical setting (Pijl-Zieber, Grypma, & Barton, 2014; Regan, Thorne, & Mildon, 2009).

The literature search was limited to English, peer reviewed journals. An initial search using key terms “new graduate,” “nurses,” “adjustment", "transition” and “acute care” was performed in various combinations. Truncation symbols “and” and “or” were also used in all searches. The search resulted in a large number of articles being identified. The transition of nursing student to qualified nurse or RN has been the focus of a number of research studies, qualitative, quantitative, and mixed methods research. Much of this research was on the transition experience while others were on the effects of

programs put in place to assist the new graduate to a successful transition. Some of the latter included evaluation of programs and strategies put in place to facilitate the transition and identified approaches to help new graduates to be successful and satisfied in their first position, such as nursing residency programs (Duclos-Miller, 2011; Tastan, Unver, & Hatipoglu, 2013). This chapter is a critical examination of the literature important to the current study on adjustment of new nurses in acute care. The literature review is not inclusive of all the literature on new nurse transition, but is a comprehensive sampling of literature that presented models of nurse transition, reviews of the literature, and quantitative, qualitative, and mixed method research on the topic. It consists of the following main sections: theories or models of transition and barriers and facilitators to new nurse transition.

Experience of Transition: Theories or Models of Transition

The experience of new nurse transition has often been captured by theories or models of this transition. As previously noted, one of the early and most influential researchers to study transition of nursing student to graduate nurse was Kramer (1974). In Kramer's early study of the adjustment of nursing students to nursing practice she theorized that a reality shock occurred when students left the security of the academic world and entered the nursing practice environment. The reality shock was the phenomenon that new graduate nurses experienced as they were confronted with the realities of the workplace. Kramer identified three main phases of transition. The first phase was described as the honeymoon phase where the new graduate identified some of the interesting aspects of the new role and could even experience a “buffering” effect during orientation and preceptorship against the reality that was to come. This initial

phase is experienced as rewarding because the person has achieved his or her goal of becoming a nurse. The next phase is the shock and rejection phase where the new nurse begins to experience some of the dissonance between what she or he was taught as part of the professional role of the nurse versus what is expected in the bureaucratic environment of a hospital setting. This phase is experienced as a conflict in that the new graduate must resolve the situation. The final phase is the recovery or resolution phase in which the new graduate either withdraws from the position or learns to adapt to the clinical setting.

A second model, while not developed to explain transition from student to nurse but is sometimes cited in studies on transition (Dyess & Sherman, 2009; Ellerton & Gregor, 2009; McNiesh, Benner, & Chesla, 2011; Pennbrant, Nilsson, Öhlén, & Rudman, 2013) is Benner's (1984) model of "From Novice to Expert". Benner was interested in clinical knowledge development in nurses. Benner interviewed 21 beginning and expert nurse pairs as part of her research to understand the differences in how these nurses used knowledge in clinical judgement. Benner developed a model which shows that nurses, while acquiring and developing skills, move or transition through five levels of proficiency 1) novice/beginner, 2) advanced beginner, 3) competent, 4) proficient, and 5) expert. Benner developed her novice to expert theory using the principles of Dreyfus' five levels of competency to describe skill development in the clinical setting. The five different levels are reflective of changes in skilled performance and transition through three distinct phases, which include a move from a reliance on nursing principles taught in school to the development of skills gained from experience, a change from viewing a situation as multiple fragments to seeing a more holistic picture with a few relevant

factors, and a movement from a detached observer to an active performer. The move from novice to expert is characterized by the transition from behaviour that is shaped by the rules of the institution to a more independent behaviour that is based on the individual's independent thought and belief. Although not every nurse will progress to the expert level, skilled pattern recognition is teachable and if acquired, will lead to advancement through the five stages.

A third model also frequently cited was developed by Duchscher (2008) and she identifies the model as the "Process of Becoming." Though similar to the work of Kramer (1974) and Benner (1984) in some aspects, Duchscher's model focused on the emotional component of adjustment as well as on the professional and intellectual personal development of the new graduate through each stage. In the Process of Becoming Model of Adjustment the new graduate moves through three stages of doing, being and knowing, usually over a 12 month period. The initial stage of adjustment, called the doing phase, is the period of time when the new graduate is going through the motions of doing what is expected of him/her in the role of registered nurse, with no question of rationale or alternatives to method of practice. This period, usually occurring during the first six months of practice, is a time of learning and settling into both the workplace and the new role when the new nurse is contented. She or he feels excited and pleased with the accomplishment of completing a nursing program and is enthusiastic to be working as a registered nurse. The new graduate will seldom question methods of practice in the working environment and will eagerly seek learning opportunities that may not have been presented during the educational program.

The second stage of Duchscher's (2008) model, identified as the being stage, is when the new graduate is becoming more aware of his/her surroundings and the dichotomies between what was learned in the academic setting and what actually occurs in the clinical setting. As the new graduate continues to adjust, he or she is more aware of some shortcomings of his or her academic preparation for some aspects of practice. During this stage there is a greater awareness of surroundings, a lack of professionalism of some senior nursing colleagues, time constraints for thorough preparation for complex procedures, and increased level of responsibility at which time the new nurse might begin to feel unqualified. As the new graduate adjusts during the stage of being, they will begin to question practices they observe and the rationale behind behaviours, policies, and procedures. Feelings of discontent may begin to surface during this stage and it can be a time of turmoil.

The third stage Duchscher's (2008) model is the knowing stage, in which the new graduate begins to come to terms with the reality of the work environment, the culture of nursing, and his or her own understanding of the meaning of nursing. This is when a new graduate is often faced with the responsibilities of a senior nurse, and the accompanying expectations of professional competence and independent practice. It is a reflective stage and may be a time when the new graduate has given thoughtful consideration to the decision to become a nurse. It may also be a time of choosing to leave a particular nursing unit, or, if too much personal conflict, to leave the profession of nursing. If a successful transition occurs, the new graduate comes to a resolution in this stage, which allows for a successful transition from a perception of themselves as a student and to an acceptance of themselves as an RN.

Duchscher (2009) further developed her work into a theoretical framework on initial role adaptation of newly graduated RNs that she called "The Transitional Stages Model of Adjustment." This model covered the initial 3-4 months of employment when the new RN experienced "transition shock." Duchscher acknowledged that this work built on the work of Kramer (1974), but also her own work and research on new nurse transition. In this theoretical work the focus was on the roles, responsibilities, knowledge, and relationships that can lead to some of the feelings of loss, doubt, confusion, and disorientation that new RNs experience during this early transition. As she indicated when new nurse enter practice they are confronted with many changes that may be physical, emotional, sociological, and developmental in character.

A fourth model based on grounded theory research used the metaphor of a sea journey to describe transition among a group of new nurses in Pakistan (Lalani & Dias, 2011). The core category was identified as "*sailing forward*" as the student transitioned to the role of a staff nurse in a tertiary hospital. The four themes that represented phases in the process were "*getting on board-stepping into the new role, sailing along the rough sea-initial adjustment, clinging to the life savers-support systems, and reaching the shore-resolution phase*" (p. E3). In stepping into the new role the graduate experiences beginning anxiety because of the level of independence and accountability, lack of familiarity with the unit and nursing assignments, and fear of making an error, but happiness as well for having completed the nursing program, gaining financial independence, and getting an orientation. The second phase of initial adjustment is likened to sailing on a rough sea because of difficulty with work organization, mismatch between ideal and reality, increased workload, and working double shifts. During this

phase personal life is disrupted and has to be juggled with patient care by missing out on personal life, having spiritual distress because religious activities were curtailed, being exhausted, and having no time for self-care. The third phase is a reaching out by obtaining support through relationships with senior staff, mentoring relationships, and support from the clinical teacher. The fourth and resolution phase is marked by an increase in competence, maturing in the role, and being able to speak up for their rights. The model is similar to others, however some of the effects on personal life appeared more prominent.

A fifth model was based on research with Swedish nurse graduates from 2004 and 2006 (Pennbrant et al., 2013). These researchers found that professional development of a nurse is an ongoing process which occurs over the course of the individual's career, beginning with nursing education and progressing throughout the person's career, hence the core process is identified as "*mastering the professional role*" (p.740). Mastering the professional role is a process which occurs once three interrelated sub-processes have been achieved: "*evaluating and re-evaluating educational experience, developing professional self-efficacy and developing clinical competence*" (p. 740). How well they master this role is dependent on a number of factors. If new graduates are placed in an environment that supports critical evaluation of their nursing education experience, they will be able to apply theory into practice in the nursing environment, resulting in professional independence and confidence which will lead to the core concept of mastering the professional role. This cyclical process requires time, support, encouragement and patience from their patients, co-workers, managers, family, and friends. Allowances of time and support are seldom present in the workplace, because of

a number of unavoidable influences, such as staff shortages, heavy workloads and budget cuts making mastering of the professional role more difficult for the new graduate. They are expected to begin work with the same level of competence as their co-workers and therefore are given the same level of responsibility, with little opportunity for reflection of their education or support as clinical competency develops.

The models above, while not inclusive of all research on models of transition, suggest that new graduates experience a number of overlapping or distinct phases or stages in their period of transition from nursing student to graduate nurse. These stages or phases are similar even when cross-cultural studies are included, suggesting that regardless of the context of country where the study has been carried out there are common challenges and difficulties that new nurses face.

Facilitators and Barriers To New Nurse Transition

A second category of research on new nurse transition important to the current research identifies some of the barriers or facilitators that might lead to successful transition for new RNs. These barriers could be classified as either individual or contextual barriers and often occur in combination. Usually no single factor is identified as either a barrier or facilitator to transition, rather it is a combination of several factors. This section of the literature review is a presentation and discussion of the findings on barriers and facilitators. The section includes literature reviews on new nurse transition as well as some of the quantitative, qualitative, and mixed methods research on new nurse transition.

Literature reviews on facilitators and barriers to new nurse transition

Five literature reviews were identified that summarized some of the facilitators and barriers that could have an impact on new nurse transition (see Table 2.1 in Appendix A). The finding of a review by Jewel (2013) on what affects new nurse transition supports the models presented above on new nurse transition in that it can be a difficult time in which the new graduate feels overwhelmed and stressed and often isolated. If these issues are not dealt with, the experience can have long term consequences, even to the point of the new graduate leaving nursing. A poor work environment and heavy workload are critical factors that contribute to these feelings but support and guidance from experienced nurses can do much to facilitate a good transition, as can acceptance by these nurses and by other healthcare team members.

Other reviewers have focused on the experiences of the new graduates and from those reviews barriers and facilitators have been identified (Higgins, Spencer, & Kane, 2009; Valdez, 2008) or a summary of best practices for new nurse orientation programs has been highlighted (Rush, Adamack, Gordon, Lilly, & Janke, 2013). Facilitating factors that were identified in these studies were such factors as having access to formal and social support in the work environment through orientation and preceptorship programs (Higgins et al., 2009; Valdez, 2008) and mentorship from experienced nurses in the unit (Jewell, 2013; Valdez, 2008). While preceptorship is important, the quality of that strategy is critical in that these preceptors need formal preparation (Rush et al., 2013).

Other best practices of transition programs stressed in the review were: 1) a focus on development of the practical skills of the new graduate; 2) connecting new graduates

with peers; and 3) being placed in a healthy workplace (Rush et al., 2013). These best practices address some of the barriers to successful transition that have been identified.

Barriers identified in these reviews are sometimes the opposite side of a facilitator in that feelings of stress, frustration, being overwhelmed by workload or responsibility, or being in an unsupportive environment have the potential to inhibit transition or at least make it more difficult (Jewell, 2013). The importance of a healthy workplace was illustrated in the review of how horizontal violence affects new nurses (King-Jones, 2011). Verbal abuse of the individuals in a number of forms is not uncommon and this behaviour coupled with feelings of being bullied has led to new nurses leaving or intending to leave nursing. Feelings of inadequate preparation to the level required of the new nursing position are also barriers (Valdez, 2008).

Quantitative research on facilitators and barriers to new nurse transition

There were a number of quantitative research studies (see Table 2.2 in Appendix B) that were located in the literature that addressed facilitators and barriers to transition to practice. While the express purpose of the research might not have been to identify these factors, the factors were evident in the findings. Many of these studies were about nurse retention and factors affecting new graduates' decisions to stay in nursing. Key factors for retention were work and job satisfaction, how nursing education prepared them for practice, and perceptions and experiences as new graduates (Cowin & Hengstberger-Sims, 2005; Craig, Moscato, & Moyce, 2012; Duclos-Miller, 2011; Halfer & Graf, 2006; Phillips, Esterman, Smith, & Kenny, 2012; Rydon, Rolleston, & Mackie, 2008; Scott, Keehehner, Engelke, & Swanson, 2008; Tastan et al., 2013). The findings from these

quantitative studies help identify some of the facilitators and barriers to a good transition experience.

Nurse retention. Efforts to ensure retention of new graduates were a common goal of the quantitative research conducted, with some identifying strategies that would assist in the prevention of nurse turnover. Nurse retention was found to be directly related to the new graduates' development of self concept, and barriers to this development were increased responsibility early into the profession, short staffing on off shifts such as weekends and nights, difficulty in communication with patients and families, and ineffective orientation policies, which caused the new graduate to feel overwhelmed, incompetent, and have poor self concept of themselves as a nurse, resulting in the decision to leave nursing (Cowin & Hengstberger-Sims, 2006; Duclos-Miller, 2011; Scott et al., 2008; Tastan et al., 2013). A positive transition experience in which a thorough orientation experience with supportive, experienced nurses was found to be a facilitator to new graduates intention to stay in nursing (Cowin & Hengstberger-Sims, 2006; Tastan et al., 2013).

Work and job satisfaction. Satisfaction with work affects the transition experience and is a factor in the adjustment experience of new graduates. A number of factors were found to influence dissatisfaction with work. Inconsistent schedules, working night shifts which had not been a part of their educational experience, and the increased workload for the new graduate were found to be barriers to job satisfaction and resulted in new graduates wanting to leave the profession (Halfer & Graf, 2006). In contrast, when professional respect was given to the new graduate by all members of the healthcare team, including senior nursing staff and physicians and greater autonomy

around scheduling was allowed or at least timely posting of these schedules, job satisfaction rates were higher (Halfer & Graf, 2006; Tastan et al., 2013).

Educational preparation of new graduate. Educational programs that the new graduates felt had adequately prepared them for work in nursing was found to be a facilitator to job satisfaction and intent to stay in nursing. A number of areas where educational preparation could be enhanced were identified. Some of these areas were knowledge related, such as pharmacology; others were more process oriented, for example conflict management, or professional development including how to develop portfolios and curriculum vitas (Rydon et al., 2008). Another area requiring improvement was organization and content of the nursing program with more clinical teaching delivered in a more concentrated manner (Rydon et al., 2008; Scott et al., 2008).

Perceptions and experiences as new graduates. The studies with a focus on comparisons of graduate nurse's perception of their transition experience to their actual experience identified that some barriers to a good transition were difficulty in communicating with patients' families, unexpected verbal abuse from patient, and limited exposure to the workplace as an employee prior to employment as a graduate nurse (Duclos-Miller, 2011). New graduates often feel unprepared for the realities of practice and in particular their level of preparedness for crisis situations continues to be a concern (Craig et al., 2012). Other factors such as good preparation by educators and facilitators for different types of conflict in the workplace and paid employment in healthcare as a student prior to work as an RN have been found to have a positive impact on the new graduates perception of work as an RN (Craig et al. 2012; Phillips et al., 2012). Phillips et al. found that senior nursing staff regarded new graduates differently if they had held

paid employment as students than those who had chosen not to seek employment during their nursing education. New graduates with no previous employment experience found this lack of experience to be a barrier to a successful transition, because they did not feel that senior staff gave them the level of support needed to function in the workplace.

Qualitative research on facilitators and barrier on new nurse transition

Most of the research that was located in the literature on new nurse transition was qualitative in nature and a few were mixed methods studies that focused on qualitative findings (see Table 2.3 in Appendix C). As with the quantitative research, the studies were not specific to identifying facilitators and barriers to transition, but could be examined for that purpose. These studies were generally on the experiences of new graduates or particular aspects of that experience, for example, learning to think like a new graduate (Etheridge, 2007).

Orientation. Orientation, mainly as a facilitator but sometimes as a barrier, was perhaps the most frequently identified factor in the literature. An orientation that included a tour of the hospital, written material that included information about the hospital and specific nursing unit, and availability of clinical educators and nurse managers were often cited as being most effective in making the new graduate feel comfortable and welcome during their early days as a new graduate (Chandler, 2012; Ostini & Bonner, 2012; Thomas et al., 2012; Wangensteen, Johansson, & Nordström, 2008). A positive orientation experience was also described as one that welcomed and allowed time for new graduates to ask questions when necessary, provided feedback during the initial orientation period, and provided structured orientation strategies, including classroom lectures and discussions. Orientation periods that were brief and

unorganized were found to be barriers to a positive transition experience, particularly when critical information with regards to such areas as human resources and collective agreements were lacking for the new graduate as a new employee of the facility (Chernomas et al., 2010; Thomas et al., 2012; Wangensteen et al., 2008). The importance of an introduction to some key nursing personnel, for example nursing educators, nurse managers and directors of nursing is frequently referred to in the literature as a significant barrier when a lack of availability to these individuals is apparent (Chandler, 2012; Cleary, Horsfall, Jackson, & Muthuakshmi, 2013; Dyess & Sherman, 2011; Feng & Tsai, 2012).

Preceptorship and mentoring. Much of the literature refers to the importance of preceptorship and mentoring in the new graduate's adjustment experience. The benefits of being "buddied" with a good preceptor and the availability of preceptors who set an example of excellent nursing practice was frequently cited as a facilitator (Chernomas et al., 2010; Guse & Currie, 2010; McKenna & Newton, 2007; Thomka, 2001). The duration of the preceptorship experience was significant in the new graduates' experience, and the opportunity for extended preceptorship was a definite facilitator to a positive experience (Johnstone, Kanitsaki, & Currie, 2008). New graduates who were able to seek out mentors for themselves, and had access to staff who modeled nursing excellence was frequently found to be a strong facilitator to a positive transition for new graduates by offering a sense of belonging, someone to look up to and someone to seek out if feeling uncertain in the clinical setting (Ellerton & Gregor, 2009; Evans, Boxer, & Sandbar, 2008; McKenna & Newton, 2007; Wangensteen et al., 2008). Zeller et al. (2011) found that support from senior, experienced nursing staff who made the new

graduate feel accepted and needed as part of the nursing team was a tremendous facilitator to a positive adjustment and decision to continue nursing.

Some barriers to the preceptorship experience were identified, such as disengaged or inexperienced preceptors or a lack of consistency in preceptors because of a limited number of staff who were available to preceptor the new graduates (Clark & Springer, 2011; Johnstone et al., 2008; Moore & Cagle, 2012; Thomas et al., 2012). Morales (2013) found that when new graduates did not have an assigned preceptor but rather were buddied on a daily basis with any available staff it resulted in a negative experience for the new graduate. Being assigned to preceptors who had unrealistic expectations of the new graduates or who had little commitment to the new graduates resulted in new graduates feeling unable to meet their own expectations of themselves (Parker et al., 2014).

Support. Throughout the literature, reference to the importance of support within the nursing environment is cited as a very necessary component of a good transition experience. Some noted areas of support were referred to by new graduates as times when they were made to feel welcome, when staff were found to be approachable and welcomed questions and when staff showed respect for the new graduates by giving recognition and praise for a job well done (Moore & Cagle, 2012; Ostini & Bonner, 2012; Parker et al., 2014)). Support from nursing colleagues, other new graduates and senior nursing staff was consistently referenced by new graduates as contributing factors to the development of competency as a beginning nurse (Clark & Holmes, 2007; Gerrish, 2000; Thomka, 2001; Zeller et al., 2011). When supports were available to enable the new graduate to meet the demands of the workload, and to provide a learning

environment in developing organizational skills to handle the workload, a positive transition could occur. When additional support from nursing administration was evident, the new graduates perceived themselves to have an easier transition to the nursing role, particularly when administration demonstrated an awareness and commitment to making necessary changes in the workplace which recognized the needs of the new graduate (Chernomas et al., 2010; Ellerton & Gregor, 2009; Johnstone et al., 2008; Mooney, 2007).

Dependency on the support from other nurses could be a barrier to nursing transition, when new graduates had difficulty letting go of the student role because they had a struggle trusting in their own abilities. New graduates reported an inability to achieve independence from other nursing staff, and found themselves worried about what supportive nursing colleagues would think of them when they were unable to complete their work (Lilja Andersson & Edberg 2010b; Duchscher, 2001). Lack of support from nursing colleagues, senior management, and other members of the healthcare team, particularly medical staff was frequently found to be a barrier to the new graduates' transition. Criticism from physicians and senior staff just for "being a new nurse" had a lasting effect on new graduates who recalled feeling disrespected and vulnerable (Chandler, 2012; Feng & Tsai, 2012; Lee et al., 2012).

Workload and increased responsibilities. Researchers consistently found that new graduates were overwhelmed with the increased workload they experienced during their transition from the role of a student to the new role as a graduate nurse, which appeared to be a barrier to their transition. These feelings came from either the new graduates' perceived knowledge gap, feelings of being "thrown in the fire", or from unexpected and

increased responsibilities (Clark & Holmes, 2007; Mooney, 2007; Thomka, 2001). Some researchers found that for a successful transfer of the knowledge acquired as a student to that of a practicing nurse, the increased workload created an environment that was not conducive to the necessary learning (Ellerton & Gregor, 2003; Johnstone et al., 2008). Other researchers reported that new graduates perceived the increased responsibilities in the workplace in some circumstances, such as independent medication administration, contributed to their perceived increased workload because they felt more anxious about these responsibilities which could take longer to perform (Lilja Andersson & Edberg, 2010b; Parker et al., 2014). Several articles reported new graduates finding themselves in unexpected roles, such as taking charge on evening, night, or weekend shifts, or assigned to supervise student nurses, which further intensified the workload responsibilities (Evans et al., 2008; O'Shea & Kelly, 2007). Often new graduates reported feeling unequipped to deal with new responsibilities such as paging physicians or delegating to other staff members (Ellerton & Gregor, 2009; Wangensteen et al., 2008).

However, if the new graduates felt prepared for the work and were confident in their own skill set and abilities, they more often perceived the workload to be reasonable and appropriate. New graduates who felt they had the necessary training, were well prepared in their academic programs for the expectations of the hospital environment and were able to transfer the clinical skills acquired in school found they had the ability to manage the workload (Clark & Holmes, 2007; Evans et al., 2008; McKenna & Newton, 2007; Wangensteen et al., 2008). Some new graduates considered the increased workload to be a "hands on" learning opportunity and welcomed the related training such as Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support

(PALS) certification for specialized areas of nursing, which gave them an increased level of confidence in their abilities to handle the workload (Feng & Tsai, 2012; Thomas et al., 2012; Zeller et al., 2011). In addition to feeling empowered by the trust received from senior nurses, new graduates recalled that their ability to handle the responsibilities of the increased workload allowed them to feel valued and appreciated by their patients, as well as feeling included and vital to the healthcare team. When new graduates reported confidence in their nursing abilities and felt capable of managing the increased responsibilities, the workload was found to be a facilitator to a successful transition (Clark & Springer, 2011; Johnstone et al., 2008).

The nursing environment. The overall nursing environment played a huge role in a successful transition experience for new graduates. When the environment was supportive as indicated above, and demonstrated a commitment to the individual, the new graduates felt welcomed and able to meet the requirements of the organization. Such approaches as recognition for a job well done, being treated with respect and courtesy and being valued as a new nurse were found to facilitate a positive transition (Lilja-Andersson & Edberg, 2010b; Cleary et al., 2013; Parker et al., 2014; Pennbrant et al., 2013; Zeller et al., 2011). Some barriers noted within the environment that could impede the successful transition experience of new graduates were a nursing unit that was competitive, where a culture of blame was evident, and where there were obvious power imbalances (Chandler, 2012; Cleary et al., 2013; Lee et al., 2012). Another barrier found within the environment that is known to have a detrimental effect on the transition for new graduates is the presence of horizontal violence from other nursing staff (Weaver, 2011). Sometimes cited as bullying, and frequently identified in more descriptive

language, such as inappropriate attitudes or behaviour toward new graduates, the effect of negative behaviours from nursing colleagues has been found to be a barrier in new graduates transition (Chandler, 2012; Dyess & Sherman, 2011; Evans et al., 2008; Johnstone et al., 2008; Kelly & Ahern, 2008).

Educational preparation of new graduate. As a facilitator, educational preparation was rarely mentioned, except the importance of a good knowledge base from their nursing program (Gerrish, 2000). In contrast, the educational preparation of the new graduate or a lack of preparation or knowledge in some areas is often identified as a barrier in their transition experiences. Generally feeling unprepared, not ready for independent practice, or lacking knowledge for this practice was not an uncommon feeling (Clark & Holmes, 2007; Duchscher, 2001; Ellerton & Gregor, 2009; Evans et al., 2008; Feng & Tsai, 2012). For some new graduates it was being unprepared for a particular speciality area and ability to think critically (Dyess & Sherman, 2011).

Choice of nursing as a career. A few of the studies mentioned career choice as either a facilitator or barrier to the transition experience. Two that possibly suggest that career choice may affect transition were identifying confidence in choice of nursing area (Dyess & Sherman, 2011) and feeling like nursing is "part of my identity" (Zeller et al., 2011). In at least two of the studies dissatisfaction with career choice was reported as a barrier to transition (Mckenna & Newton, 2007; Mooney, 2007), but others found that new graduate nurses were not prepared for the realities of the workplace or profession (Gerrish, 2000; Kelly & Ahern, 2008) or that nursing was a broader role than expected (Mooney, 2007), suggesting that the choice of nursing as a career may not have been fully explored.

Summary of the Literature

The transition experience of new graduates from the role of student to that of an RN has been of interest to researchers, educators, and health care administrators for over 40 years. The transition to a new work environment and adjusting to the new role within that work environment is a complex process, involving many factors that can influence the successful transition to both the environment and the role. New responsibilities and a new relationship with staff as well as a change in status within the facility have the potential of positively or negatively influencing the transition to the role of an RN in acute care. This chapter presented a review of the literature and discussion on the many factors that might influence the new graduates' transition to the role of an RN in acute care. A review of some of the factors to be considered in the new graduates' transition was presented, with particular consideration given to the facilitators and barriers in a number of specific areas, such as preceptorship, workload and the nursing environment and orientation practices for new graduates in acute care.

There are a number of similarities in the research findings in the literature on transition of new nurses in clinical practice. Consistently throughout the literature, is evidence of dissatisfaction among new graduates in their transition experience, when they feel the culture of the workplace is not supportive or there is a lack of perceived support from senior nursing staff and physicians. Employees may be more likely to have an easier transition experience when well established supports are present, with new graduates well prepared for the transition, both from their academic experience and their exposure to clinical practice, and when they are able to feel satisfaction in their work, specifically in being able to care effectively for their patients.

Limitations of previous research.

There are a number of limitations that need to be considered when critiquing the literature. Various time periods have been used to examine transition experiences and these varied from a few months to over two years. Facilitating and impeding factors would vary by the time that the new graduate had been in the clinical area. While no exact timeframe has been identified for how long a transition to a clinical area may take for a new graduate, there seems to be some agreement that the first 12 to 24 months is a critical time at least for deciding on nursing as a career and staying with an organization (Parker et al., 2014). Models of new nurse transition range from early adjustment, for example, the first 3-4 months (Duchscher, 2009), to the first year as an RN (Pennbrant et al., 2012), and even to two years post graduation (Hoffart et al., 2011).

A second limitation is that the area of nursing practice of the new graduate is not always identified in a study and this could have played a role in the new graduates' transition experience. Additionally, some studies combine a number of different areas of practice and this could produce some of the variability regarding facilitating and impeding factors. The transition experiences in highly specialized areas where new graduates are recruited directly (Reddish & Caplan, 2007; Winslow, Almarode, Cottingham, Lowery, & Walker, 2009) could vary greatly from acute care units and even acute care units might vary considerably in acuity and complexity. The nature of the practice has the potential to affect the transition experience. Those new graduates who began employment in their clinical area of choice, with familiar preceptors with whom they may have had positive interactions during their student placements may be more likely to report more positive experiences.

Additional factors such as culture or country of study could also have had an impact on research, particularly those conducted in European and Asian countries where nursing organizations might differ, and as such could be considered a limitation. A limited number of Canadian studies are available on the transition experience of new graduates, especially those conducted in Atlantic Canada. International research, particularly American and Australian, is abundant, but cannot be assumed to accurately reflect the experiences of Canadian new graduates, much less nurses in Atlantic Canada. Other factors that could have been examined were gender differences or age of new graduates, such as women versus men and mature graduates versus young graduates who entered nursing immediately following high school.

In conclusion, it is apparent that the transition experience of new graduate nurses continues to be of interest to nurse researchers. As a result, significant changes have been made in orientation practices, preceptorship selection, supervision of the new graduate during the initial period of employment within facilities, and a more thorough evaluation of the new graduates' experience from the new graduates' perspective. However, there remain barriers to successful transition for new graduate nurses from the role of the student to that of an independent practitioner. This area of interest is not restrictive to Canadian researchers as it appears to be of international concern, based on the exhaustive amount of available literature. Because of this apparent ongoing concern, and my own interest in the adjustment of new graduate nurses, particularly in a small island setting, it seems that a study of the adjustment experiences of new graduates in PEI is warranted, as the findings may identify unique experiences as well as opportunities for comparison with similar Canadian or international findings. Using adjustment as my

sensitizing or main concept would assist to more fully understand what occurs within the overall transition experience and might identify particular areas that could facilitate this experience.

Given the consistent concerns identified in literature regarding the transition experience of new graduate nurses coupled with my awareness of the current culture of nursing in Atlantic Canada, I was interested in studying the adjustment experiences in acute care among this group of relatively new graduate nurses on PEI and what might help or hinder that adjustment.

Chapter 3

Methodology

This research was conducted using interpretive description as outlined by Thorne (2008). Interpretive description is a method of qualitative research that has been evolving since 1991, as a result of an awareness of the need for alternate research methods which could specifically address the uniqueness of applied research. While qualitative research methodologies, such as ethnography, phenomenology and grounded theory, have been found to be quite applicable to applied health and specific professions, such as nursing, Thorne (2008) was interested in developing a research method which had the ability to guide the researcher through the examination of existing or new knowledge and offering a logical interpretation of that knowledge by considering not only what is heard by the researcher in their collection of data, but also by finding meaning in what is not heard. This methodology enables the researcher to break down what is known about a particular phenomenon and observe if from another angle, finding an alternative meaning than what had originally been considered.

Interpretive Description

Interpretive description is a research strategy for uncovering and promoting knowledge important in clinical practice where the main purpose is application (Thorne, 2008). Some of the foundational underpinnings of this research strategy are: 1) if feasible the research is situated within a naturalistic context, i.e., the participant's natural setting; 2) subjective and experiential knowledge are valued and both are used to provide insight into the research question; 3) commonalities and variations are important to the

understanding of the phenomena of interest; 4) time and context of the research provide insight but do not constrain the research findings; 5) human experience is largely shaped by social construction; 6) there is no single reality that defines an experience and often the realities can conflict or appear contradictory; and 6) there is interaction between the knower and what is known (p. 74). Interpretive description is not a single prescriptive set of methods but guides the researcher to develop a research design that is logical and defensible. While not prescriptive, interpretive description requires a systematic approach to research.

Originally, my intent with this research was to use grounded theory as outlined by Charmaz, (2006) as a methodological guide. As I progressed with conducting the research and in particular, the data collection and analysis phase, I found that my research was not in keeping with grounded theory. My research, although guided by the research question of adjustments that new graduates make in their transition from student to new graduate and what helps or hinders these adjustments, was aimed more at a practical understanding of the adjustments rather than identifying and theorizing the processes involved. Furthermore in my interviews my guided questions were more structured and focused than desirable for a grounded theory study and more in keeping with trying to describe and interpret what was occurring. As a staffing consultant in a large hospital one of my responsibilities is the hiring of new graduate nurses and over the years I have had an interest in the adjustment experiences of these new graduates. My rationale for conducting this research was more to understand these adjustments and look for a means of improving these experiences than identifying processes and theorizing what was occurring. Interpretative description was found to be a more suitable method, in that

much of my analysis of participants' responses was on the meaning and implications of information provided regarding their adjustment experience to the new role of a registered nurse (RN). Though other methods such as grounded theory can and have been used very effectively within nursing research, interpretive description was suggested by my thesis supervisor and found to be quite suitable for my particular field of interest due to the guidance it offered in the interpretation of the data collected. As well, the unique development of interpretive description from a nursing perspective made it an appealing and logical method to pursue.

Methods

Participants and Recruitment

The intention of my research was to explore the experience of new graduates in acute care, so my selection of participants was limited to three acute care facilities on PEI. I am currently employed at the largest facility on PEI and have worked in a number of capacities within the facility, which has led to a vast knowledge of the facilities and the staff within, including new graduate nurses. As I wanted this to be a learning experience with individuals with whom I had no previous exposure, I chose to recruit participants from the two rural facilities, where I would be less likely to have previous exposure to the participants, their working environment, nursing colleagues and administration, and policies and procedures of the facilities. The intention in my research was to interview participants and then review their experiences to find any similarities that could emerge by way of patterns or themes in analysis of the data (Thorne, 2008).

The sampling approach used was purposive. Purposive sampling is when "the settings and specific individuals within them are recruited by virtue of some angle of experience that they might help us better understand (Thorne, 2008, p.90). There is no recommended sample size for an interpretive description study. A small number of participants is justified "if the background literature and disciplinary wisdom suggests that a certain phenomenon occurs commonly within clinical populations and what is needed is a more in-depth exploration of its underlying nature (Thorne, 2008, p. 94). Based on that principle I aimed to recruit approximately 12 participants.

Since I wanted to target acute care in two particular institutions in rural PEI and new RNs in those institutions within two years of beginning practice, following ethical approval I recruited participants by means of poster advertisement that emphasized the purpose of my research and participants I would like to recruit (see Appendix E for the recruitment poster). All interested participants were invited to contact me by phone or email. Initially, 11 individuals contacted me about the research. All expressed interest in participating, but one potential participant chose to withdraw from the study prior to an interview being conducted. I spoke to each interested new graduate who responded to the call and provided information on the nature of the research. An opportunity was given to each potential participant to ask questions about the research. Each participant then received a letter explaining the study and ensuring confidentiality and anonymity . In addition to the letter of explanation, a consent form was sent, advising participants of the purpose of the study, the primary researcher's name and contact information, and the name and title of the two thesis supervisors (see Appendix F). Once consents were

returned to me by mail, participants were contacted and dates and times of interviews were scheduled.

Setting

The participants were given a choice for both place of interview and means of interview, that is, face to face or telephone. All ten participants chose to interview by phone and these interviews were conducted with participants at a pre arranged location, which allowed for privacy and comfort, as well as assurance that the interviews would be free from interruptions. All ten telephone interviews occurred with participants in their own home or place of residence. I conducted all the interviews from my office at my place of employment and all interviews were audio taped. Prior to audio taping I confirmed with each participant that they felt comfortable in their environment.

Data Collection

Although no particular data collection method is advocated in interpretive description I elected to use individual interviews for data collection because the individual experience of adjustment could be judged to be "known only to the person going through it" (Thorne, 2008, p. 126). All participants were interviewed within the first two years of employment as an RN in an acute care setting on PEI and the majority had been in the workforce almost two years. The purpose of the interview was to understand the adjustment process that new graduate nurses experience as they transition from the role of a student to that of a practicing RN in acute care on Prince Edward Island. Previous exposure to the facility, orientation practices, preceptor experience, and general feelings of acceptance within their assigned worksites during the first one to two

years of employment as an RN were explored as factors that might have an effect on that experience.

Data were collected by means of a structured open-ended interview conducted via telephone . All interviews were audio-taped, with a signed consent from all participants collected prior to data collection and with a thorough explanation of the research provided. Though questions were structured with a fairly scripted interview guideline, they were open-ended and probing questions were asked when necessary, to clarify participants meaning in their response. As a novice researcher I chose a more structured interview approach as I wanted to ensure a thorough and broad coverage of the transition experience. One of the limitations in an unstructured approach to research on new nurse transition that Thomas et al. (2012) reported was that their participants tended to focus on single incidents in great detail rather than talk about the broader phenomenon of transition. The structured approach avoided that from occurring and kept all interviews moving along, as questions provided a broader focus. The average length of time for each interview was approximately one hour.

Data Analysis

Interviews were audio tape recorded and I transcribed each one verbatim. Transcribing the taped interviews myself was beneficial to the process and gave me an opportunity to carefully review the conversations that had occurred, listening to tone of voice, pauses in responses and enthusiasm at particular points, which suggested an inference or additional meaning. This review of taped conversations is described by Thorne (2008) as an opportunity to hear what participants are really saying by "focusing on words and sounds and silent spaces rather than simply the storyline" (pg.144). Once

transcribed, the data were re-organized in a separate file, using a two column table, with the transcribed interviews in the left column and coding of the participants' comments in the right column. Thorne (2008) advises that the use of broad based coding in the initial phase is beneficial in creating data "bits" that can be more thoroughly analyzed and categorized into similar categories. This method of broad based coding allows for clearer description of common themes in the data. Caution was necessary in the coding of the data to avoid merely summarizing, but to focus more on an analytical consideration of what meaning was actually being divulged in the participants' statements, which is one of the benefits of interpretive descriptive research (Thorne, 2008).

The underlying principle of the comparison of data is to establish analytic distinctions (Thorne, 2008). Comparison of the data was performed and was initially followed by the comparison of margin notes that I had made in the transcribpts of the interviews. This method of comparing data from one participant's experience with another's, allowed me to identify the similarities as well as variation in the data. Though supportive of coding techniques in data analysis, Thorne advises to use coding cautiously, as the true meaning behind participants' statements is often not found in the words used, but in how they are interpreting their experiences as they describe them. Following Thorne's direction in reviewing notes I wrote during my research, allowed me to pay closer attention to the meaning of statements and responses, including silence before responses, and tone of voice used. Clearer identification of themes, or patterns as I identified them, became evident through this interpretive descriptive approach.

The interview data were collected and compared to identify common patterns among the experiences of the participants. Data were compared which resulted in a more

complete pattern being developed. The gathering and comparing of memos written during analysis of the interviews allowed for organization of thoughts and interpretation during the analytic process. Persistent phrases were identified in the data and reflected the central patterns. From my data analysis, four areas of adjustment for the new graduate RN in the acute care setting on PEI were identified.

Rigour: Building in Credibility Indicators

As with any type of research it is important to address the quality or rigour of the research and in particular how the integrity of the research findings are ensured. Thorne (2008) refers to this process as "building in credibility indicators" and advises that every researcher has an obligation to ensure their work is unbiased, honest, and shows evidence of an un-opinionated phenomenon. Every effort has been made to ensure that the information provided here is from a purely objective perspective with the intent to inform readers of the experiences of the new graduates involved in this research. As well, all information provided by participants has been as accurately transcribed as possible, all collected data have been provided to my thesis supervisors, and all questions asked of participants were consistent to ensure no leading or prompting of expected or anticipated responses. When necessary, I repeated and/or reworded questions to provide clarity to the information I was seeking. In analyzing data Thorne (2008) offers sound advice on some of the hazards frequently experienced by researchers, and these have been considered in the assessment of my findings. Thorne suggests that premature closure, misinterpretation of the frequency of key points being mentioned by participants, and over inscription of self are common barriers to accurate interpretation of data. To prevent this from happening I had frequent discussions with my thesis supervisor.

Credibility indicators that I included in my research were epistemological integrity, representative credibility, analytical logic, and interpretive authority (Thorne, 2008, pp. 223-226). For research to be credible there needs to be a fit between how we understand and develop a research problem, including the assumptions made throughout, and the findings that are reported. The congruence among these knowledge assumptions is the key to epistemological integrity. The change from a grounded theory approach to interpretive description allowed me to achieve epistemological integrity and have a better knowledge fit throughout the research process.

Representative credibility is the link between any research findings and especially theoretical claims inherent in those findings and how sampling regarding those findings took place. To achieve this indicator I worked closely with a thesis supervisor to ensure that no particular finding was based on a single participant's view and that participants were carefully screened to ensure they met the research criteria set for the study so that the data reflected my phenomenon of interest. The third credibility indicator that I demonstrated was analytical logic in that I have made explicit my research process throughout the project including my decision-making on data generation and analysis. Finally, the last indicator used was interpretive authority, which addresses the trustworthiness of my interpretations. Frequent debriefings with my supervisor over data analysis assisted me to ensure that the findings were firmly rooted in the data and not overly influenced by my experiences or beliefs about new graduates in the system. For a finding to be credible I needed to demonstrate how and why I considered it important and how it was supported in the data.

Ethical Considerations

This research was conducted in compliance with the Human Research Ethics Board of the Health Research Ethics Authority (HREA) requirements at my educational institution for research with human participants. HREA consideration and approval is guided by the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans 2* (TCPS2)(Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). Prior to the start of this research, permission to conduct the research was obtained from HREA. Written informed consent, including consent to be audio taped, was obtained from each participant before I began any data collection. Consent forms were mailed to interested participants, who all returned the signed consent forms by mail prior to any data collection taking place. It was after consent had been obtained that a time was arranged, at each participant's convenience, for the telephone interviews to take place.

Before beginning each interview, I reviewed the purpose of the research and confirmed with the participants their agreement to participate in the research. All participants were reminded that confidentiality would be maintained, and all transcribed interviews would be numerically coded, with only myself as the researcher and my thesis supervisors having access to the content of the interviews. The identification numbers of each interview corresponded to consent forms.

Data security. Part of the ethics of the research was to ensure that the data were secure and that confidentiality was maintained. All original taped interviews with participants, the transcribed interviews from these tapes, memos and consent forms have

been secured in a safe place at my residence. All electronic copies of transcribed interviews are encrypted on my home computer, individual files are password protected with only myself and my thesis supervisors being privy to the required passwords for access. Printed copies of the transcribed interviews have been saved in a secure, concealed location at my home. As well, I have used a personal journal to organize memos gathered during data analysis, and this journal has been securely stored with the printed copies of the transcribed interviews.

Protection of the participants. The research was considered to be of low risk to the participants. First, it was the participant's choice whether he or she responded to the recruitment poster. However, I was aware that if the new graduate was not making a good adjustment or had experienced a critical incident, taking part in the research could be emotionally upsetting, and I had put in place mechanisms for counselling as specified in my research consent. Although I monitored participant response, none of the participants expressed any distress. To my knowledge, this research did not pose any physical risks to participants.

Chapter 4

Findings

The purpose of this study was to identify some of the adjustments new graduate nurses on PEI are required to make in the transition from being a nursing student to becoming an RN in an acute care environment, identify some of the challenges within these adjustments, and to explore factors that helped to facilitate or impede these areas of adjustment. This research is based on the findings of interviews with 10 new graduate nurses from classes of 2009 to 2012, who entered nursing practice in one of two rural acute care facilities on PEI immediately upon completion of their respective nursing programs. Of the 10 participants, one was male and the others female[1]. All participants graduated from nursing programs in Eastern Canada with the majority from the university in the province where the study was conducted.

In this chapter I present the patterns or type of adjustment that new graduate nurses in acute care on PEI are required to make, identify the adjustment challenges within the type of adjustment, and present some of the facilitating and impeding factors to this adjustment that helped them make a successful adjustment as explained to me by these 10 new graduate nurses. At the time of the interview all of the new graduates had been nursing for 2 years or less, and all were currently employed as Registered Nurses in acute care facilities on PEI. The participants were able to identify particular types or areas of adjustment required and what helped or hindered them in this adjustment. The

[1] In order to maintain confidentiality the pronoun "she" will be used if a pronoun is necessary because there was only one male in the group of participants.

participants were adjusting to performing as a nurse in a different and an expanded way from that previously experienced as a student. The working context for these new graduates had changed in that they were no longer students in the clinical area, but were now RNs and as such, were independent practitioners and employees of the institution where they worked.

The findings in this study are presented by the four main patterns that captured the areas of adjustment, as well as some challenges experienced, and conditions that had an impact on the adjustments required (See summary of findings in Table 4.1 in Appendix H). The four main patterns of adjustment are: (1) Social: Taking on a new status, (2) Developmental: Developing clinical expertise for area of practice; (3) Organizational: Changing contractual relationships, and 4) Occupational: Changing nature of work. While all the participants were required to make adjustments in the four areas identified, some participants experienced greater challenges than others, while some settled into the new role with minimal difficulty. Although the patterns or areas of adjustment and adjustment challenges are interrelated and share some of the facilitating and impeding factors, I have presented them separately in order to have a thorough exploration of these various factors. The facilitating and impeding factors are based on the participants' perceptions of what might have helped or hindered the particular area of adjustment.

Social: Taking on a New Status

The transition from student nurse to an RN is social in nature. Becoming a new RN confers a new status and requires the individual to make the necessary adjustments that would accompany this change in status. In essence the students were engaged in a change of roles as they left the role of student to take on that of an RN in an acute care unit.

They were acutely aware of the difference in status from that of a nursing student to that of an RN. This change in status was evident in how others in the clinical area treated them and how they were expected to respond. The main adjustment challenges that participants experienced in taking on the new status of RN were: 1) Developing a new self-image; 2) Forming collegial relationships; and 3) Communicating with a wider network.

Developing a new self-image.

The first adjustment challenge was that of developing a new self-image; that of being an RN. New nurses are required to take on this new self-image as they enter the clinical area and begin to no longer think of themselves as student nurses. All of the new graduates described some form of a realization that, although they had successfully completed their nursing program, were successful in their registration examination, and achieved RN status, there was still an adjustment in their development of their own image of themselves as an RN. Some only recognized themselves as an RN when they received their first pay check at an RN rate of pay. For others this occurred when they were able to introduce themselves to patients and families as "*I'm your RN today*". One described her awareness of herself as an RN when she heard herself referred to as an RN by senior nursing staff and received positive feedback from them in performing nursing tasks.

> *I have a lot of support if something goes wrong, like, they'll* [other RN's] *tell me they wouldn't have done anything different and I did everything I could do as an RN.*

There were a number of instances when their image of being an RN seemed threatened. It could be overwhelming when faced with something new especially a

procedure they had not done as a student and that required supervision. Such a situation led to the feeling of *"I felt like a student again, just because school does help in terms of skill set and everything, but it's different when you get in the real world."* Another challenge voiced by one participant was that the role of the nurse is not always understood by those outside the profession and this lack of clarity about what a nurse does can be internalized by new nurses. Colleagues as well as the wider society are important in developing this new self image. How the new nurse feels the public views nursing has the potential to reinforce not valuing what nurses contribute to society:

> *Well I just don't think the general public really appreciate what it is that my job entails. Sometimes you just kinda feel like, you come home from work and I'm just "you just don't have any idea what my day was like, what happened in my day." And some days you just feel underappreciated too. You don't make enough money for what you do. Most people don't have any idea what you do.*

Seeing oneself as a nurse, and having this image of self reinforced in a positive way by colleagues, patients, families and society as a whole has the potential to assist new nurses make that social adjustment to the role of RN. It could also give the new graduate a sense of confidence in his or her abilities and pride in any achievements, thus assisting with the overall transition to being a professional nurse.

Forming collegial relationships.

A second adjustment challenge was that with their new status as an RN they were now required to be in a collegial relationship in the clinical area rather than in a teacher-student relationship. For some of the participants this was a greater adjustment challenge

than for others. Many of the participants believed they lacked the experience to develop these relationships because as students they felt they often missed out on the opportunity to interact with all the members of the healthcare team. These individuals believed how their clinical experiences were structured worked against a more collegial approach to care when they were students. Even being paired with a nurse on the unit during their clinical experiences as students did not always help with collegiality because in those situations "*it's only you and your co-assigned."*

When I asked one new graduate what were some of the challenges she found in her new role as an RN, she quickly replied "*Physicians! Just creating those new relationships."* Physicians or incidents with a particular physician were often mentioned as a challenge and some participants were not sure how to approach physicians. There were even some members of the staff that they felt they had not interacted with as students and initially as a new graduate they were not quite sure what role that person had in the health care setting. As well as physicians and other members of the interdisciplinary team, the new RNs had to form working collegial relationships with the nurses on the unit. For the most part, the relationship between the new graduates and senior staff, prior to the introduction of the new graduate to the workplace as an RN, had not been well established. The student would have had more interaction with her clinical instructor than with the nursing staff on the unit and aside from passing along patient information as advised by her clinical instructor, conversation between themselves and the nursing staff about patient care on the unit had been somewhat limited. One of the participants described the difference between being a student and a new RN and the importance of collegial relationships and how reactions of patients made a difference:

Well. I find its just belonging to a team, I find that, even though we have, like, we don't work, we don't have team nursing on our unit but we work as a team. You're never alone if you have questions or a critically ill [patient], *you always have your team backing you, including the nurses, the doctors, the pharmacists, even the families of the patients. And I feel I make more of a difference. I find that people listen to you more. . . . Whereas as a student they're a little more apprehensive, they'll ask you questions but they'll also ask the nurse.*

Communicating with a wider network.

A third adjustment challenge, that is closely related to forming collegial relationships, was the requirement of communicating with a wider network, in particular physicians, patients and their families. As students they did have somewhat limited communication with these groups but the nature of the communication had changed. As new RNs they were required to communicate directly with physicians around patient assessments and updates rather than communicating this information to an RN who would then communicate with the physician. Some of the participants in this study described the difficulty they had in earning credibility with physicians so that good communication was possible:

I find the working relationship between doctors and nurses different, compared to when I was a student or a graduate awaiting registration (GAR) and then becoming a new grad, in different complex situations. If I did have a critical patient, the doctor would want to know my assessment but then would want to know who I was working with and what their assessment was. Just having conversations with the physicians, basically

they're more comfortable with the nurses that are already there. They just have to learn what our assessment skills are and if we're correct and that kind of stuff.

As I analyzed the above response, it was apparent that the student did not feel that the doctor was particularly interested in who she was working with, but rather, was concerned with the credibility of her assessment skills. She felt the doctor's question of "*who the new graduate was working with*" was more to determine if competent, experienced nurses, who were also on staff, concurred with the new graduate's assessments. This example illustrates how complex communication is and what message it conveys to the new graduate.

In these particular acute care clinical settings student nurses do not have the experience of taking orders from doctors or communicating with doctors as their patient's primary care givers so learning new communication patterns and being comfortable with these were necessary in learning to communicate within a wider network. Although opportunities to communicate with doctors, patients, and families were certainly a part of their student experience, the extent of communication that was now required as an RN was different. This change put new demands on the RN for the type of detailed observations that were required. One new graduate voiced frustration with this:

You learn to have everything written down, because you know he's [the doctor] *gonna ask questions, and he doesn't care if you're busy or forgot to look it up, he'll just get mad. Like, you don't get taught that in nursing school.*

Challenges with communicating with doctors predominated the new RNs initial descriptions, but a number acknowledged that the expectations that they communicate with others, such as other health care workers or family members, could present challenges. These instances created "*a lot of responsibilities that you learn as you go, for example speaking to family members, taking calls*" and could be anxiety producing. Whether or not these responsibilities are part of the nurse's defined role is not the point, they were in contrast to being a student:

> *You end up doing so much more than just scope of practice. As a student you're able to say 'no', but whenever you're an actual nurse, if you say no patients are suffering, there's no one to deal with it* [responsibilities seen outside of nursing].

Facilitating and Impeding Factors to Taking on a New Status

There were a number of factors that could be identified as either facilitating or impeding factors in taking on a new social status. Some of the adjustment experiences associated with that change varied for individual participants. Some of the participants did not feel they had to make as big an adjustment as others in meeting some of the challenges. Collegial relationships were easier in some units than others and thus in a number of instances were not a big adjustment. The main facilitating factors for taking on a new status seemed to be satisfaction with career choice or working in clinical area of choice, realizing they were not so different from experienced RNs, and acceptance by the staff and feeling part of the team.

Satisfaction with career choice or working in clinical area of choice.

Satisfaction with career choice or working in a clinical area of choice was important to how the new nurse saw her new status as an RN. Some individuals enter a nursing program because they had "*always wanted to be a nurse*" and most of the experiences in their nursing program confirmed their choice. Others enter with more ambivalent thoughts about nursing as a career choice and student experiences can either confirm that was a good career choice or not. One of the questions I explored with participants was around nursing as a career choice. At the point of the interview, not all participants felt that nursing was the best career choice for them, some waivered about their career choice, and others confirmed that they were quite satisfied and could not imagine having another career. A contrast in the description of initial impressions of working as a new RN was noted:

> *Um awful. I didn't love it* [working as a nurse]. *I thought oh my God, what was I thinking. . . . I just thought it would be different, I don't know how to describe it.*

with the more common type of response to this particular question:

> *Oh, I loved it! I mean there was still lots to learn, and new experiences. Maybe some new grads had other experiences, but I enjoyed it, I still enjoy it. . . . Good! So far so good. A lot of patients ask me, "So how do you like being a nurse?" I'm like "So far, so good." I haven't had any days when I've regretted going into nursing, yet, and hopefully there won't be any.*

The group who viewed career choice as negative or were more ambivalent would not find adjustment as easy because they were still grappling with the question of career

choice. The more positive group not only affirmed their choice but saw future possibilities for their careers. Their adjustment to the new status was easier.

> *I enjoy* [being a nurse]. *I'd like to go a little further with my education, but yeah, I do enjoy my job and I'm definitely happy with my career choice.*

Overall the new graduates were pleased with their career choice. Several participants mentioned continuing their nursing education, and looked forward to opportunities away from the acute care setting, and into more community based opportunities. Though some voiced frustration with their current position at the "*bottom of the totem pole*", these participants recognized the need to start somewhere and saw the benefits of building a good foundation in a hospital setting. When asked how she felt about her career choice now, this new graduate summed it up nicely.

> *Um, good I feel good. I feel like there are always going to be challenges in nursing but I feel good. Sometimes I've got to remind myself why I went into it, and it was bedside nursing, but not to get too involved in the politics and that sort of stuff, and just go and be an advocate, and be the nurse as much as I can.*

Particular clinical areas have appeal for some graduates and not for others as a career option. Some participants went into nursing because they wanted to work with a particular population, such as, children or older adults. Others wanted to work in a particular area or setting, i.e., community or acute care. For others a particular clinical experience as a student suggested a good fit with a particular clinical area or group of patients. A number of the participants had taken a position in an area where they had completed a student preceptorship and had enjoyed working in that unit or others had

worked as float nurses until they found a position that was a good fit. Not all the new RNs interviewed were in a nursing position or clinical area that they wanted and that contrasted with expectations they had for their nursing career. In nursing programs, as the participant quoted below illustrated, students are told they are prepared to work in a variety of settings and that they have a choice in where they will work. The reality is that the desired nursing position is not always available and the new graduate's options may be more limited if they wish to work as an RN in a specialty area or in the community. There seemed to be more job openings in acute care. One participant, when asked about her career choice explained:

> *Well, I think it's just more like, I'm not sure if I'm in the right area? And its kinda like, when I first started it was like, "Oh you know, you can go anywhere, you can have any job you want" that kind of thing. And now, it's like, that's not really the case.*

Most of those interviewed were satisfied with the clinical area where they worked and a few had moved from one clinical area to another within acute care. They saw acute care as an opportunity to develop their clinical expertise and nursing knowledge. It was an important part of development in their nursing role. While some had aspirations to continue with further education in the future and perhaps move into different positions, that was not the case for all new graduates as one indicated when I asked at the end of the interview what her next step would be:

> *The next step is to stay right where I am. Just to continue to educate myself and be the best bedside nurse I can be. . . . I mean I very much enjoyed school*

when I was there but I love bedside nursing and I'm quite content with where I am right now.

Realizing they were not so different from experienced nurses.

Working side by side in a more collegial relationship, rather than in a teacher-student relationship or even a preceptor-preceptee relationship, with a more experienced RN, seeing how the senior nurses performed, and what these nurses experienced was helpful in taking on the new status of RN. This working relationship allowed for a comparison between themselves and their more experienced colleagues. This mode of working let the new graduate know that even experienced nurses had challenging days, heavy workloads, and stressful situations. It was the realization that they were not so different from experienced nurses that facilitated taking on their new status as an RN. When I asked one participant if she felt her feelings about her work and the "*burden*" of the work as she described it was related to being a new graduate she responded:

No, I don't really think so. I used to but now I realize that all the nursing staff are feeling the same thing. It's not just the new grads. I feel I am as able to carry the burden as [well as] *the other staff, it's just really, really busy.*

The senior staff nurses were appropriately considered by new graduates to be the nursing experts, and were described as such throughout the conversations I had with them. Once the new RNs entered the workforce and had developed a more collegial relationship with senior staff, they realized the nature of the senior staffs' feelings regarding the work site and workload. Senior staff nurses were frequently described by younger, recent graduates as overwhelmed by changes occurring at the workplace, the increased acuity of inpatients, and the increased nursing workload. One of the

participants spoke of having to form her own opinion regarding the acuity of her workload, when a senior staff suggested that the workload was too heavy. The new graduate did not consider herself to be overworked, and described feeling confused by the senior staff member's assessment of her workload.

> *It was sometimes the older staff who were, or could get sometimes, like, were starting to get overwhelmed or burnt out or something. So they would come into the room and see that there were six people and they would automatically assume, like "Oh my God, you must be so busy!", and so on, and so on, but personally, I felt myself, like, I don't feel that busy?*

These new RNs had not previously considered that senior staff, whom the new graduates considered to be experts in their field, could be experiencing the same frustrations in the workplace or with the workload as the new graduates were experiencing. This realization helped normalize how they were feeling and served to confirm that it was a workplace issue rather than their feelings being related solely to being a new RN.

Acceptance by staff and feeling part of the team.

One of the most important facilitating or impeding factors by far in taking on the role of an RN was how well accepted the new RN was by the staff on the unit and how much they felt part of the team. All the participants mentioned this factor to some extent in their interview. Generally the participants felt that they were in a supportive environment for new graduates. It was something they had been concerned about because they had heard stories where in institutions this was not always the case and that new RNs did not always feel welcomed and even made to feel unwelcome or made to think that the

new graduates were not contributing. The new graduates' acceptance was evident in the support they felt they had from others in becoming part of the team. The acceptance could be felt in being comfortable asking questions in the clinical area, having encouraging words from the staff, or just being included in whatever was taking place. One graduate, in response to whether she had support from other nurses on her unit explained:

> *I did actually* [feel supported]. *Especially, I thought I would be . . . I don't know, like "oh, no, she's not a real nurse" but they were like, really supportive of the new grads. They were like "we're willing to help." If there was anything going on that they thought we'd like to see, like "we're putting in a PICC over here" or "we're doing a cardioversion" they were really good to come and get us. And they were very supportive of if you kinda forgot something or just missed asking a question. They would prompt you with "oh you should ask" . . . they were very supportive, very helpful.*

The understanding and positive comments from senior nurses to the new RNs was very important to the new graduates who did not want to appear "*stupid*" or "*not pulling their weight*" and at the same time having a need to learn and further develop their clinical knowledge. Often particular experienced nurses were cited as so important in developing a level of comfort in the clinical area. These nurses were identified as good role models and often the new graduates sought them out. At the unit level, support was most readily felt, "*they* [staff nurses] *were all supportive, you never felt like you were bothering them.*" Some felt support could be perceived from the managerial level or at the organizational level. In describing her manager, a new RN said:

> *I felt the manager was quite supportive of me . . . She was very supportive in trying to educate me to take additional education so I could provide the best possible care in* [name of unit where new RN worked]

Thus some felt the managers took a more direct interest in them and how they were doing, while for others the managers were more distant. Similarly, at the organizational level most of the new RNs felt that the organization as a whole was supportive of new RNs and others had a more negative view of support at the organizational level. The unit level support and feeling part of the team on that unit though did appear to have the more lasting effect. New RNs needed and desired this support and understood that those at a higher organizational level had more concerns than new nurses or did not "*seem to understand what we're dealing with*."

Developmental: Developing Clinical Expertise for Area of Practice

The transition from student nurse to RN is also a developmental process in that the new nurse is expected to develop the clinical expertise to perform at the expected level of a beginning practitioner in an acute care environment and in a particular clinical area. New graduates enter the workplace with beginning competencies and they need to develop these competencies further to provide safe and effective care within a defined clinical area. Several of the participants in this study were well aware of their limitations and lack of knowledge that they attributed to limited exposure to or limited experience with many aspects of nursing care. Though nursing education prepares the new graduates with the basic competencies of a nurse, most of the participants identified some gaps that they felt were evident in their education or their practice as a student nurse in the clinical

setting, which resulted in feeling unprepared for independent nursing practice. For example, one new graduate found herself placed in charge very early after completing her orientation, and was surprised at the level of responsibility that was given to her. She challenged her colleague, when told that she would be responsible for anything and everything that walked through the door in the emergency department "*because she was an RN*." The individual went on to suggest "*An RN is an RN*." This particular new graduate had enough confidence in her own knowledge and awareness of her limited experience with acutely ill patients to challenge her colleague's response. The new graduate recounted this experience:

> *One of the comments that was made to me one day, I was in charge of the emergency department for a shift, and I was the most senior nurse down there, and the comment was made, "you`re an RN, you`re an RN, you can work anywhere". And I said, "you bring your wife in here, in full resuscitative mode, and then you tell me an RN is an RN." You know, you want someone that knows, and you need someone that knows.*

During their developmental period and as they gained additional knowledge and experience, they could feel quite overwhelmed. One new graduate talked about her experience caring for a patient with an unfamiliar diagnosis. Though she may have had all the necessary teaching of the pathophysiology of this particular condition, no opportunities to actually put into practice her learned knowledge of the disease had been presented to her as a student.

> *It's just the fact that you can be a little overwhelmed, I did anyway, just at the beginning, because you read about all these diagnoses that people are*

> *going to have and all the things that could happen, but you don't always have that experience as a student, that you've even cared for a person that has had* [that particular diagnosis].

Another new graduate described more severe episodes of being overwhelmed, to the point of questioning her decision to become a nurse. She described feelings of being overwhelmed with "*everything that involved nursing*." She also felt alone in her frustration and that no one else could understand how she felt about what it meant to be a nurse. There were some differences among participants in how overwhelmed they felt when they first started practice and some of this depended on the clinical area where they worked. One new graduate's comments illustrated the importance of the clinical area.

> *It was overwhelming at times because, like in the emergency department, I know you've got to be flexible everywhere but it's so much more there because you never know what's coming through the door, and at times it was like, so busy and so overwhelming, and you were left in our Observation Room and that's where I started off. You would have 6 patients in there for a lot of the time and you would be responsible for all those six patients. Lots of time you were often on your own, and I just found it very overwhelming, having to care for these 6 people that you don't know what's wrong with them.*

The main adjustment challenges in developing clinical expertise for area of practice were developing a systematic approach to care and making your own decisions.

Developing a systematic approach to care.

A developmental challenge was the ability to develop a systematic approach to care that was a good fit for the new RN in completing her assigned nursing work. Even though as students they were expected to have a systematic approach in their patient assignments now they had to incorporate other responsibilities into that care, as well as having a greater number of patients under their care, and other staff to supervise. The development of clinical and management expertise and using these in a systematic manner was a necessary part of the adjustment experience. They had to find their own rhythm. Some struggled with identifying themselves as any sort of clinical experts, but found that as their confidence grew in their approach to patient care, a systemic approach to care began to develop. Finding their own way of nursing within the established rules of the facility seemed to be a process that each new graduate developed independently. With this individualized approach to nursing care, a sense of confidence began to emerge.

> *I just kinda tell everybody, like, you've just got to kinda figure out your own way, like what works for you. Like, I was with a preceptor and I just kinda followed her routine, and after a while, then, I graduated and I still kinda followed her routine, but then, it was like, this isn't my way. I needed to come up with my way of doing things and organizing my time. Planning my chart checks, and stuff. I just go, like, when I graduated this* [was] *what I did, this is how I do it now.*

It took time for the new RN to develop some of the skills required for having a systematic approach to care. Some of the skills identified were organizational and management skills that would facilitate meeting the responsibilities of the nursing role.

While the new RNs realized the importance of organizational and management skills they also acknowledged that these skills took time to develop. In exploring challenges to the transition of being a nurse, a participant talked about the many competing responsibilities she experienced in her clinical role from deciding on priority of care to patients to making sure she did not miss doctors' orders and summed it up as:

> *It's just that organizational thing and being on your feet enough to check on everything and remember to check the charts and keep on top of everything. Yes, it's all about time management and staying well organized, but it's kind of hard when you're learning and you feel you have to ask so many questions.*

Making your own decisions.

A second adjustment in their development as clinically competent nurses was feeling comfortable with decision making when it came to patient care. Although critical thinking skills and decision-making are taught in nursing programs applying these abstract skills may not be fully realized as a student. Additionally as students, clinical nursing instructors or a nurse preceptor was usually readily available to test decisions. In the student role while they learn what constitutes good patient care decisions, but they are not the decision maker. Now as the RN they must assume that responsibility:

> *As a student at the most you have four patients. As a student they prepare you for critical thinking but they don't actually put you in the situation where you are actually on top of the totem pole. And the doctors are only there for a short span and the head nurse is just there from 7:30 to 3:30 so there are lots of times when you actually are at the top of the totem pole and*

have to, like, really make decisions. And I mean I knew that there would be that, but I wasn't prepared for exactly what that involved.

Being able to make decisions about care was challenging for a number of reasons. Going from the situation, as a student, where you always had someone to consult with to the situation where "*now you are the go to person*" is a huge step and could be a source of anxiety. It required the new RN to assert herself in a team situation and be able to defend her position when challenged by co-workers:

You know I am the team leader and this is the way it has to be today. I apologize but this is my practice and this is my best practice.

Facilitating and Impeding Factors for Developing Clinical Expertise for Area of Practice

In their development of the clinical skills required in the acute care unit where they were working some of the facilitating and impeding factors were preceptorship and support from other nurses and familiarity with the system of nursing care delivery.

Preceptorship and support from other nurses.

One of the most important factors mentioned by all the participants was just how critical preceptorship was during orientation to the unit and to help them adjust to the work of an RN and meet their clinical responsibilities. Preceptorship stood out for these new RNs and the preceptors assigned to new grads played a significant role in the new graduates' adjustment. Most participants described their preceptors positively and as "*amazing*" or "*awesome"* as were other nurses and staff on the unit who provided help during orientation and beyond. Preceptors assisted the new RN through nursing procedures that they had learned about or observed, such as taking doctor's orders,

hanging blood, or administering certain medications that they were not permitted to do as students and "*even though you see it, it's totally different than doing it*." When I asked about best experiences of the initial work experience I often had a response similar to this:

> *I would definitely say the preceptorship, yeah, it was just, like, if you felt there was anything wrong or if you wondered anything it was great to have that preceptorship experience in there and maybe we need to go a little longer in the future. Like, I know you're an RN, but if we go a little bit longer* [being preceptored], *then I'll know you're a little bit more comfortable.*

However, preceptorship experiences varied for the participants and not all had what they would describe as ideal. This less than ideal experience could be because of length of time they were preceptored or the system of preceptorship. Those who had a single preceptor for the entire period felt this system had merit in helping them adjust. That situation was in direct contrast with those who could be paired with a different nurse every day during orientation and felt they "*would have benefitted more if I had one consistent go to person.*" Having a consistent person was so important that one participant who was not able to have this experience and complete her preceptorship with that person felt she missed out to the point that "*there wasn't any closure to my experience*."

It was not only the support they received from their assigned preceptor but support from other nurses and often physicians on the unit that helped them in developing their clinical expertise. On units where support was widespread and the new graduate felt this support adjustment in developing clinical expertise was definitely facilitated. In

responding to the question of what was an enabling factor in their transition experience one new RN quickly replied:

> *The staff I work with. They are amazing people. . . . It's like everybody just, like the communication, it's just amazing communication with everybody, even with the doctors. Like we have really good doctors. If they're doing a procedure they don't mind if you go in and watch and ask questions and it's like you're always learning. They've been really good to help out and kinda set you on your way.*

Familiarity with System of Nursing Care Delivery

Nursing care delivery systems help to organize nursing work especially the use of nursing personnel in giving care and the type of system defines responsibilities for that care. These systems of care vary somewhat in terms of who is responsible for what aspect of care that is given. Generally students are exposed to different nursing care delivery systems throughout their nursing education but that is not always the case, especially if clinical experience has been gained in one institution. Most of the new RNs had had experiences in the institution, if not the particular unit, where they were now working. These experiences gave the participants familiarity with the predominant system of nursing care employed in these institutions and was often cited as a reason why transition to their new role was not so difficult. This familiarity with many of the routines and staff members meant there was compatibility with how they were expected to deliver care and how they had been taught to organize and deliver that care. When this familiarity was missing it made it more difficult for the new RN:

> *Well right out of school I did primary care nursing, so you were assigned to your patients. You did everything for your patients, meds, cares, assessments, everything like that, and you dealt with the doctor that was covering your patient, so that's what I was used to. Well here the head nurse, and we didn't have a head nurse in* [province where did education], *here the head nurse mostly calls the doctors, and looks things up in the drug book, so I didn't really like that much. I felt like I was removed from the patient. . . . It was really an adjustment period.*

The importance of the system of care being familiar to the new nurses and their adjustment experience was illustrated by a change in the system of care in the settings. A new Collaborative Model of Care (CMOC) has been implemented at all levels of health care across PEI over the last three years, which happened to coincide with the initial work experience of all the new graduates involved in this research. The CMOC was implemented in efforts to allocate health care professionals to the area where they would be working to their fullest potential, based on their education and skill set. Some of the participants had previous exposure to the new CMOC, depending on their clinical placements as students. Regardless of their previous awareness or exposure to the new CMOC, it did have an impact on their adjustment experience, based on the change that was happening in health care across PEI. During the implementation of the CMOC, new RN's were often finding themselves in an environment of uncertainty, with no clear role description established for themselves as new graduates, or for their nursing colleagues, either the RN's or Licensed Practical Nurses (LPN's).

> *The year I graduated was when the new Model of Care had come into play and the unit I was on was the trial unit, so it was just like a lot of chaos,*

and a lot of drama all at once. It was trial and error, like, how the floor should be run and the responsibilities of the RN. Everybody knew the responsibilities and roles of the LPN, but nobody really knew what the RN should be doing. As a new grad you were still trying to get your boundaries, but you were coming out and we weren't doing assessments and we weren't doing medications, and we were doing the baths and vitals! And that was not...like...that was one of the things we were taught that I thought, "Oh I hate this!" and that's what I was doing!! So it just didn't have a very positive start.

Organizational: Changing Contractual Relationships

New nursing graduates might find themselves in a new work environment, or might be in a familiar setting in which a clinical component of his or her education had occurred, but the difference for both of these individuals is that she or he is now in a new role with different expectations. The new graduate is now an employee of the institution governed by the goals, visions, and policies of that institution rather than that of the nursing program and educational institution where they were studying. As a consequence of this change they are no longer governed by the contractual relationship between the educational and health care institutions that previously allowed this individual to be a student in an institution, but rather by the contractual relationship that exists between the institution and them as an employee. This change in contractual relationships and the rights and responsibilities associated with the change is something new graduates face as they begin work as a nurse. It is the period of time in which the graduate nurse settles into the reality of the work place and makes the adjustment from performing as a student

nurse to that of a practicing nurse. Some of the adjustment challenges experienced by the new RNs were being unsure of performance, expanding responsibilities, and dealing with workplace conflict.

Being unsure of performance.

Student clinical evaluation is an important and formal part of clinical learning and students are frequently evaluated to ensure they are meeting the clinical objectives of each course and that they are becoming safe practitioners. This clinical evaluation is an integral part of each student's experience and serves as an indicator to the student how well he or she is doing. Clinical faculty or faculty with a preceptor, depending on the model of clinical teaching employed, have the responsibility for the evaluation. Even though students are encouraged and in some instances required to engage in self-evaluation, they always have an external assessor to gauge their clinical performance. This evaluation gives them some reassurance that they are performing at a reasonable level. As a new graduate an adjustment is required because they no longer have these regular clinical evaluations. Regular evaluations did not seem to be part of their new contractual relationships. One new RN felt that a checklist to provide feedback during this period would be beneficial:

> *Yeah, like a check list sort of thing. I mean, I've been practicing for over a year, and I'm still not 100% sure, and I mean, the checklist, I know at* [nursing program] *. . . I mean its very difficult with a checklist just because nursing is so broad and that sort of thing, but just to discuss . . .like "People seem happy with your work" or "these are things that you've done well" or "we're pleased to have you here." That sort of thing.*

Some of the participants voiced frustration in the lack of feedback that they received from the organization as a new RN, and this left them uncertain of their own progress as an RN. Although most of the participants received positive reinforcement and suggestions for exposure to new tasks and skill development, a few suggested that they were uncertain of how they were performing. Several indicated that they had no feedback from their nurse managers and were not certain that the nurse managers were even aware of their performance in the workplace.

> *I felt like* [the nurse manager] *wasn't even there. She was never really on the unit to see how [I] was doing, or how things were going. I'm not really sure what our manager thinks because [I'm not familiar with her].*

Another new graduate was frustrated in that because she did not get feedback in the workplace, she never really knew if she was measuring up to the standards of her nursing colleagues or the facility itself. She would have been more comfortable during her first few months of nursing if a performance appraisal had been offered, similar to the structured feedback she had received on a regular basis as a student. When an opportunity to meet with the new nurse manager was offered, the new graduate expected this to be a chance to discuss her progress. The new graduate was caught off guard when the meeting turned out to be for an entirely different purpose and did not give her the feedback she desired.

> [the nurse manager] *did do* [a performance appraisal], *but I mean, she was like, she had nothing to say, because she didn't really know how I was doing. It was more an introduction to her.*

When feedback on performance did it occur it was particularly helpful to the new graduate and they appreciated receiving this information. It let them know how they measured up to expectations regarding clinical competencies and how other staff perceived their performance. These evaluations and any feedback were found to be "*really helpful and supportive.*"

Expanding responsibilities.

The role of student and the contractual agreements under which students operate in the clinical environment meant that the student had more limited responsibilities than an RN would have. When the student becomes a nurse in the organization, responsibilities shift and the new nurse finds a number of new or different responsibilities added to the expectations of the nurse, or as on participant put it "*you have a lot of other responsibilities that you had to learn as you go.*" These responsibilities can encompass arrangements for patients or communication with families and others. Often this realization comes when confronted with a new situation as one new RN described when she found out she was responsible for helping with funeral arrangements:

> *Like a nurse is more than a nurse. I find in nursing there's so many little things that you always do just because you're the nurse. You basically do things that nobody else would do. It's like everything that everybody else doesn't do. . . . I just find that as a nurse you're supposed to do everything.*

Often it is the new responsibilities that nurses are required to take on that presents adjustment challenges because they do not feel prepared for these responsibilities. Even such changes as having night shifts or working weekends was something the participant was not prepared to do. Having to take on the responsibilities can be anxiety producing

for the new graduate as well as making them question their level of preparation. Students may learn about these responsibilities but that is not the same as being required to perform certain procedures as a new nurse as a participant recounted:

> *So now* [until experience as an RN]*, you can't take Doctor's orders, or you can't hang blood, there's just a lot of things you can't do until you have RN after your name. So, even though you see it, it's totally different than doing it. So to go through a few things, like, not hang blood, and then you're in the middle of an emergency, and all of a sudden you're giving blood to a patient, and you're like, "Oh, I've never done this before!" We give a lot of pain medications too, and as an RN we can give them push, but as a new grad we can't, so we need to have an RN that's done it before. Just little things, that you don't really think of until you're out there and it's your first time to do something, and it's like, "I don't exactly know what I'm doing here!"*

All described being overwhelmed with the expanding responsibilities at some point during their adjustment experience, although the degree at which they felt overwhelmed varied. Some, such as the new graduate quoted below, attributed her feelings of being overwhelmed to her awareness of her responsibilities. When I asked one graduate about some of the challenges she experience as a new nurse, she replied:

> *I think again, some of those responsibilities, that you didn't really realized existed. What sheets do you fill out when someone's being transferred? How do you do a medication reconciliation? Everything like that. It's one thing to*

know your medications and how to do an assessment, but it's another thing to know how to assist someone.

The feelings of being overwhelmed were directly related to the expanding responsibilities because being employed as an RN, in contrast to being a student, meant that more responsibilities were attached to the new status of the individual. While direct nursing care responsibilities might not have been so different than experienced as a student, there are many other organizational responsibilities that need to be fulfilled.

Dealing with workplace conflict.

Students may not always experience the workplace as a welcoming environment and some research has even demonstrated that students may be the target of horizontal violence in the workplace. However, in general they are shielded from workplace politics and much of the conflict that occurs in the unit. As a new RN an adjustment challenge is that they are confronted with the reality of the workplace and what is happening there because they are more directly affected. They are part of the unit and the team so will be part of what is taking place on the unit as they try and negotiate their place on that unit.

As part of the adjustment experience, the new graduates found themselves to be dealing with workplace conflict to varying degrees. Part of the conflict appears to be related to the degree of change happening within Health PEI and the introduction of the new CMOC described above. The uncertainty surrounding the roles of the RN versus LPNs led to conflict among the nursing staff and the new graduate was often caught in this situation. In asking about some of the challenges experienced with the transition to the role of an RN one participant described the conflict she felt:

Um, the challenges, um I guess for me it was a different year, because of the Model of Care. That was a huge challenge because there were some dynamics between RNs and LPNs, who were, and as a new grad, um I don't know, you just felt like you were trying to please everyone. And it was just, yeah it was really hard.

Other areas of conflict that some, but not all experienced, was in interactions with other healthcare providers. For some this was with physicians who were "*rude or hangs up on me.*" When faced with these situations at first it is difficult not to internalize the blame for the conflict and wonder if and how you contributed to the situation. One participant in describing an interaction with a physician who she later learned does not communicate with nurses regarding orders for patients said: "*I'm used to it now, but at first I was just like "Oh my God! Did I make him mad*?"

Facilitating and Impeding Factors for Changing Contractual Relationships

A number of factors were instrumental in how well the new RNs were able to adjust to the organizational change that confronted them in their new relationship to the institution where they worked. Chief among these factors was knowledge gained from previous experience on the unit, feedback from peers, patients, and families, and orientation to hospital policies.

Previous experience in the unit.

Many of the students had experience as a student, completed a preceptorship, or worked in another capacity in the unit where they now worked as a new RN. Generally for these individuals this past experience was definitely a facilitating factor in adjusting to the new contractual relationship and they may not have the same adjustment challenges

that others not familiar with the unit would have experienced. This previous experience afforded a degree of familiarity with the working of the unit than that of those without the experience and that those new to the unit had to learn. Additionally they knew unit personnel or "*personalities*" of the staff on the unit and in turn the staff had some knowledge of them and their performance. They also knew the routines and how things were done on the unit. A new RN talked about her initial introduction to her workplace as an RN and felt her familiarity with the workplace from her previous exposure was extremely beneficial, providing her with a level of comfort in the surroundings in which to begin her practice as an RN.

> *I spent so much time on that unit, I knew the routine, I knew their way of charting, I just found that being there for so many weeks before graduation really gave me a boost. I don't know that I would have felt as comfortable if I hadn't been there as a student. I wouldn't have known the routine and I would have been a lot more intimidated.*

One exception to previous experience on the unit as a facilitating factor was for an individual who had completed her RN but had worked in the unit in a previous healthcare worker role. Although she still had the advantage of being familiar with staff and policies of the unit initially she had a challenge with co-workers that later resolved, and were not present when she transferred to another unit:

> *The acceptance* [by previous peers] *that I went on to school was probably the biggest issue. . . .I don't think they undermined my education or my abilities, I think it was more on their own terms of having issues with the fact that now I had a*

degree. And you know my response was that everyone has a choice to go back to school and I chose to so that just means I'm in a new role.

Those unfamiliar with the unit and the institution felt they had a steeper learning curve in order to fit in and adjust to the working of the unit. This was particularly the case for those who studied nursing in another province and slightly different health system. They dealt with a greater degree of lack of familiarity and had a steeper learning curve just to know policies and procedures, contacts within the hospital, and unit routines.

Feedback from peers, patients, and families.

Positive feedback served a number of functions and among others suggested to the participant that she was meeting expectations of the organization. Being a new employee it was critical to the new graduate to know how well she was measuring up to others' expectations. Peer comments about decisions or being able to ask questions was described as particularly helpful. Getting positive feedback from peers was identified throughout the interviews as a facilitating factor in the new graduates' expanding responsibilities because it reassured the new RN that she or he was performing well as a nurse.

They were always there if you had a question. Like, if I had a patient whose blood sugar was 6 and he didn't eat breakfast, and now it was lunch time and he didn't eat any lunch, I wouldn't give him his insulin, and I could check with another nurse to see what they would do, and they would all take time and tell me, "no, that's what I would do too." They were all supportive, you never felt like you were bothering them. It's like we are all the same nurses for that patient, like, we all were concerned about what was best for him, because we all took care of him.

Feedback from patients and their families was definitely a positive reinforcement that they were performing at a satisfactory level. This could be from feedback that patients and families made to others or could be the result of what they observed. The feelings of satisfaction in seeing patients progress well throughout their hospitalization experience the realization of the role played in that experience was a powerful experience:

> *Especially with a new Mom and a new Dad, and they are so nervous when they first come in, in labour, and then the baby is born, and they ask you everything about how to take care of the baby, and you help them with breastfeeding and bathing the baby and then, the day comes for discharge and you see this little family going home. You just feel like, yeah, I was a part of that, and you're so happy*

It was difficult for some to judge how well they were doing in their new clinical practice. Comparison with the performance of other new RNs helped in self-evaluation because this comparison allowed them to judge how well they were able to meet their practice expectations and some sought this feedback:

> *It was almost more scary after you got your results* [for RN exam], *because you were on your own. I mean you could still fall back on people, but it's almost like you were let loose. You need to do stuff on your own. And even other new grads, like they would collaborate with me on something and they would ask what I thought, I mean, and it was like, "what do you think"? We were all out the same amount of time, so that also helped, so we would always talk things over and discuss situations, and* [ask each other] *"what would you have done"? So that was really helpful. We could kinda, you know, work together and talk together.*

This feedback helped the new RNs gradually learn to judge her own progress and how well she was doing as a nurse. The positive feedback helped to make them more comfortable in their new position and validated their abilities and competence as a registered nurse. Self evaluation was also crucial. Self evaluation is something they will develop as they engage in continuing competency programs that are part of registration as a nurse. A new graduate describes how she developed or used certain outcomes to help her gauge how she was doing in the clinical area:

> *I think I'm finally making a difference and that what I'm observing and what I'm doing is making a difference in the person's health. And that I'm doing what is acceptable and that I'm doing the right thing, which is what I was taught to do. It makes me feel that I am competent to be working as an RN, and that I am a nurse just as much as the other nurses here.*

Orientation to hospital policies.

When I asked directly about what helped with their transition experience a number of participants identified orientation as one of the most important factors. Even if during orientation they thought "*at times it felt too long"* in retrospect they learned many things that were not covered elsewhere, but which they needed to know in the role of a nurse. The amount and type of orientation that the new RN received was definitely a facilitating factor in meeting the adjustment challenges associated with the change in contractual relationships and how well they fit into their new organizational structure. It was during this period of time that they not only discovered new responsibilities but what were some

of the resources to help them with these responsibilities. Orientation, was cited by a number of the new RNs as a factor that helped ensure their needs were met:

> *I had three days of orientation and they went over everything, like, one for filling out paper work for time off, and going over payroll, like going over the policies and procedures. General ones for the hospital and then once I got to (the nursing unit) and then they were a little more in depth.* [They covered] *What I was allowed to do without doctor's orders, and what I needed an order for. I had a really good orientation that really set the bases. Some of the little simple things that I never thought of that were really important, and they told you how to get all that done. They* [the orientation days] *were really helpful.*

However, not all the graduates had positive experiences with their orientation to the unit and the institution. Some of the participants felt that they did not receive the necessary information to function in their new role as RN. Because not all the new RNs had previous experience in the institution a deficit in their orientation could be as simple as not having a tour of the facility. For others it was not knowing what to do in certain situations involving patient transfers or making arrangements with outside agencies for a transfer or referral. However, the ability to ask questions of a receptive staff during orientation definitely helped with adjustment to the policies of the institution.

Occupational: Changing Nature of Work

Together with a change in contractual relationships the nature of work changes for the new RN. As a student she or he would have a clinical assignment that would consist of from one to perhaps four patients and this assignment would be for the purposes of learning to care for a patient or a group of patients. This contrasts with an RN assuming

responsibilities for care of patients on a unit and having particular responsibilities for those patients or care of a group of patients depending on the system of care in place. In making this adjustment there were a number of adjustment challenges, with the main ones being greater exposure to a wider variety of patient situations, higher patient workload, and readiness for whatever comes your way.

Greater exposure to a wider variety of patient situations.

Several participants reported a greater exposure to a wider variety of patient situations as an unexpected adjustment and spoke of varying experiences, including increased independence in patient responsibilities and decision making. They could appreciate too that they might be comfortable in one speciality or unit because of past experience, but that did not mean they were comfortable with all the specialities covered in that unit. In smaller rural hospitals a number of specialities are covered in a unit, such as obstetrics and paediatrics and this requires the new graduate to prepare for and respond to a greater variety of patients and their conditions in the clinical area. A few also were required to float to various units. For the new RN responding to each situation could be stressful as they learned to engage in decision-making about actual patient situations. As a participant explained:

> *I guess really it's just the fact that you can be a little overwhelmed. I did anyway just at the beginning because you read about all these diagnoses that people are going to have and all the things that could happen, but you don't always have that experience as a student, that you even cared for a person that has had one* [particular diagnosis].

This quote illustrates that learning about patient situations in nursing education programs and dealing with these situations in practice are quite different phenomena. This greater exposure to varied patient situations had implications for the skills required to deal with these situations and this was illustrated by a participant talking about her initial impressions of working as a nurse:

> *It* [being a new RN] *was very different. I felt like I was a student again, just because school does help in terms of skill sets and everything, but it's very different once you get into the real world and I just found that school didn't adequately prepare us for that.*

Higher patient workload.

A second occupational challenge was that of workload. One of the questions that I asked the participants was their impression of their workload as a new RN. All reported an increase in their patient workload and they needed time to adjust to this change to be able to respond appropriately. They felt somewhat lacking in the organizational skills required to move from a few patients to a larger patient load. For some a greater workload was an expectation for which they felt somewhat prepared. Others felt totally unprepared:

> *That it* [workload] *was quite unexpected. No, not at all* [prepared]. *I went from primary care, where I was responsible for 3 or 4 patients to team nursing of 15 patients.*

This change could be complicated by not being comfortable delegating part of the care to others because that was not something they were necessarily exposed to as a student, "*That learning to delegate, that was huge. Even now, sometimes you still*

struggle with it. You just feel like, "Oh, I'll do it myself later." In addition to the heavier patient workload and the need to delegate the new RN could also be responsible for supervision of other staff and that added to her workload as well. While some accepted this as a inevitable part of their adjustment to their nursing role, others questioned the necessity of some of the expectations placed on the nursing team in general and some of the implications this had for the kind of care they could give patients. This individual wondered if the workplace expectations were realistic:

> *It was heavy, unnecessarily heavy at times. Sometimes the acuity was heavy, too heavy for the staff that we had working. There's kind of, I don't want to say this, but kind of like an old way of thinking. Some things have just never changed (on this nursing unit). I mean, some patients get up and get freshened up and sit up in the chair, and then get back to bed for a while and then back up to the chair, which is great for them. There'd be a lot of long term care patients that we'd be charting on once a week. You need to be really careful with that, having so many nonacute patients may have cluttered the care of the acutely sick patient. You might be really focused on changing one patient or helping to get a patient out of bed and you might miss the fact that a patient down the hall was really sick. I didn't really enjoy that, having 15 patients to look after.*

Readiness for whatever comes your way.

A third occupational challenge was being ready for the variety of patients and clinical situations that nurses are faced with in an acute care area. The new graduate nurses are adapting to the role of RN in acute care and spoke throughout all of the interviews of an awareness that nursing is an unpredictable profession and for these

particular participants, occurring in unpredictable environments. Though not all of the participants voiced total confidence in their abilities as an RN or in their choice to remain within the profession, all of them seemed to have achieved an awareness of this unpredictability. With this awareness many were able to demonstrate through conversation an attitude of readiness or acceptance of whatever happens throughout the course of their shift.

> *There's always something different going on and you're never bored! I mean, there's been days when you're feeling overwhelmed and stuff like that but you come back the next day and it's 100% better.*

Facilitating and Impeding Factors for the Changing Nature of Work

Just as with the other areas or patterns of adjustment there were some key facilitating or impeding factors that could be identified that assisted the new RNs with their new work situations. These were realistic expectations and knowing what is important and adequate staffing on the unit.

Realistic expectations and knowing what is important.

An important factor in the changing nature of work was the ability to have realistic expectations of what is possible in a particular time frame given the level of acuity of the patients receiving care and the resources available. New RNs sometimes have difficulty with the skills needed to meet standards of care and workload expectations and have to reconcile how they have been taught to deliver nursing care versus external demands of a clinical unit while maintaining patient safety. As a new RN described when talking about some of the transition experiences and challenges she encountered:

> *And just trying to, not really prioritize, but like, just kinda realizing, okay, this isn't really important right now and this is, like you knew in the back of your head, but you still felt like you had to be superwoman and get everything done. That was a big one. It needs to be done, but you can eliminate some things. Like, you got all day, it doesn't need to be done right now, that was a big one.*

It is when new RNs learn the skills of knowing what is important and needs to get done versus what can wait until later that they are able to set priorities. This is not always easy because of the pressure to get routine care completed at a certain time of day. Additionally feeling a degree of comfort and confidence in delegating certain responsibilities to other healthcare workers under your supervision and that you do not have to do everything yourself also facilitates adjustment to their new occupational role. In developing the ability to determine what's really important in the run of the day patient and other staff reactions played a role in how the nurse judged this situation:

> *If the patients are happy. You always hear horror stories of* [demanding] *families and that sort of thing, any negative, and then like staff look at you differently. And I mean, whenever you're a new grad, you've gotta figure out your own rhythm and then you're stuck trying to work among a team, and have to be successful, among other different personalities. So if I have a good crew working with me, and then like, if you have good staff then the patients are happy.*

Adequate staffing on unit.

A final facilitating or impeding factor for new graduates was the staffing compliment on the unit in the workplace. As a student, most participants had responsibilities for 4 to 6 patients, with a preceptor or buddy working alongside, to ensure that nothing was missed in the patients' treatment, medication or tasks. As a new graduate, full responsibility for every aspect of patient care was now expected, and often the staffing on the unit would not have been sufficient to help the new graduate successfully adapt. As a consequence often the new graduate felt "*run off my feet.*" In describing her impression of her workload as a new nurse, one participant replied:

> *Well, when I initially started with my degree here on the inpatient unit on the medical floor I found the workload extremely heavy. I was responsible for 15 patients and out of those 15, nine of them were mine to medicate. I found that they also expected, and I mean expected, you to do 'cares.' . . . It's not a reality to medicate 9 people in a 2-hour span especially where you have older people where it takes a little longer.*

The discomfort with the patient-staff ratio and expectations was the cause of anxiety in the workplace for some new graduates, and caused them to question their ability to handle the increased workload. One participant described the workload as worrisome and a burden, in considering the tasks she was responsible for as an RN:

> *Sometimes I worry, I don't know if it's just because I'm new, or because we're so busy, but I worry that I can't follow things through exactly 100%. I found over the summer especially, there were a lot of casual workers, so we were working short. Which really puts a burden on you as*

a team leader, things need to get done, and they have to be done well, which is hard if you're working short.

Statements such as these suggest that the increased workload coupled with the high patient to nurse ratio could indirectly be contributors to feelings of low self-esteem, low morale, and decreased confidence among some new graduates. The staffing shortage could also be contributors to new graduates questioning their nursing knowledge or ability to appropriately manage the work load, which could cause new graduates to consider themselves to be incompetent.

Summary

In the transition from nursing student to RN there are a number of interrelated areas where adjustments might be required. In this research I identified four main interrelated areas: social, developmental, organizational, and occupational, where new nurses encountered particular challenges as well as identified some of the impeding or facilitating factors. The facilitating and impeding factors and the degree to which particular ones were relevant to a new RN also helped to understand some of the variation seen in the new graduates' overall transition and these will be discussed in the following chapter.

Chapter 5

Discussion

Research using interpretive descriptive methodology strives to help understand the meaning found in words spoken, as well as the tone of voice, the silence gaps used in communication, and inferences used by participants. This understanding comes from an interpretation of the descriptions given by participants in an effort to produce findings that describe an experience of interest to a researcher (Thorne, 2008). In this study I used interpretive description to explore the experiences of 10 new graduate nurses to better understand what it was like to be a new RN practicing in acute care in PEI, what adjustments they were expected to make in their transition from student to RN, what shaped these adjustment experiences, and how my findings compared with other new graduate nurse experiences that have previously been reported in the literature. In the research I was able to identify four main areas or patterns of adjustment as nurses transition to being an RN. Although there may be other areas where adjustment might be required for new nurses, the main adjustment areas for the participants in my study were: (1) social and taking on a new status (2) developmental and developing clinical expertise for area of practice (3) organizational and changing contractual relationships, and (4) occupational and the changing nature of work. These areas of adjustment are interrelated. The findings from my research suggest that new nurses beginning work in acute care in PEI continue to experience many of the transition challenges that their counterparts in other parts of the world experience despite efforts to make this transition as smooth as possible.

Similarities to previous studies were found in the research on new nurse transition, but a few differences were noted as well. What is promising is that the majority of the new RNs in this study no longer seem to suffer from the "reality shock" that Kramer (1974) identified over 40 years ago. However, some of the new graduates reported greater challenges and difficulties with the transition than others and some areas of adjustment appear to be more challenging than others. Variation in experiences is not unexpected and can be explained by a combination of individual and environmental or contextual factors. The following is a discussion of the study findings and comparison with the literature of these areas of adjustment, some of the challenges experienced, as well as the facilitating and impeding factors that account for some of the differences in new nurse transition. A more thorough understanding of these adjustments and influencing factors could lead to further improvements in the overall transition experience.

Social and taking on a new status.

Comparable to findings in the literature, the participants experienced a social adjustment to their new role as an RN. They experienced some of the social changes that accompanies moving from a student role to a professional role and the necessity of letting go of the former role and assuming the latter (Duchscher, 2001). Taking on a new status is a socialization process in which the required knowledge, behaviours, skills, and values are incorporated into the person's life and this process requires that the new nurse develop a professional identity that incorporates these attributes (MacIntosh, 2003). This socialization process is heavily influenced by how that socialization occurs and can be influential in whether the new nurse will choose nursing as a career or abandon the

profession (Feng & Tsai, 2012; Price et al, 2013). Furthermore, socialization of new graduates is largely facilitated by the nursing environment in which the new graduate finds her or himself and whether that environment is welcoming or not (Higgins et al., 2005; King-Jones, 2011; Valdez, 2008; Wagensteen et al., 2008). Senior nurses on the unit and their interactions with new nurses are particularly important. When there is little or no interaction with the senior level of nursing colleagues and validation of their new status, new graduates struggle with feeling recognized or valued as nurses (Evans & Boxer, 2008). Likewise involvement of nursing administration and positive actions by this group are necessary for the new graduate to feel supported (Halfer & Graf, 2006; Johnstone et al., 2008; Mooney, 2007).

For most of the participants in the study social adjustment was not a major challenge because they felt that the nursing environment was supportive in that new graduates were welcomed, treated with respect, nurtured, and accepted as part of the team; all factors that are known assist the social transition to a professional nurse (Chandler, 2012; Jewell, 2013; Lilja Andersson & Edberg, 2010a; Moore & Cagle, 2012; O'Shea & Kelly, 2007; Zeller et al., 2011). A few of the participants questioned if they had made the best career choice or were in the best clinical area for them. Although not identified by many of the qualitative researchers, questioning career choice or feeling less than satisfied with this choice, such as some of the participants reported, can make this social adjustment more problematic, can lead to having a feeling they do not belong, and even lead to attrition from the profession (McKenna & Newton, 2007; Mooney, 2007; Price et al., 2013; Scott et al., 2008; Tastan et al., 2013). In contrast when new nurses are able to internalize the image of a nurse into their identity and feel a sense of pride in this

identity the social adjustment is facilitated (Zeller et al., 2011; Zinsmeister, & Schafer, 2009).

One of the areas of adjustment, communicating with a wider network, continues to be an adjustment challenge for new nurses. Communication between nursing and physicians has been well documented as an area where conflict can occur, in spite of repeated attempts for improvement by educators, administrators and members of both disciplines. New graduates' negative socialization with physicians has been found to cause stress and anxiety, resulting in the new graduate being unable to trust their own abilities, or to see themselves as a nurse (Craig et al., 2012; Duchscher, 2001; O'Shea & Kelly, 2007). The importance of good communication between nurses and doctors is well documented in the literature and cited as critical to the collaboration between these professions for safe and effective patient care (Cleary et al., 2013; Craig et al., 2012; Duchscher, 2001; 2007). The extent to which good nurse-physician relationships occur has not been found to be at a desirable level (Nelson, King, & Brodine, 2008). Despite increased efforts to improve inter-professional working relationships through inter-professional education (Cranford & Bates, 2015; Hudson, Sanders, & Pepper, 2013) it might take some time for these effects to be felt throughout practice and needs to be monitored. Negative interactions with physicians were mentioned as an impeding factor for adjusting to the role of a nurse, but many participants were learning to overcome this by becoming more assertive. It is often a function of time, experience, and gaining confidence for the new nurse to feel comfortable challenging negative behaviours (Lalani & Dias, 2011). New nurses might attribute a lack of good working relationships with physicians to their status as new nurse but it is more widespread than that. In a survey on

this topic with nurses working in medical-surgical units for varying periods of time, only 30% of the nurses said they had a collegial relationship with physicians, 50% said physicians understood what nurses do, and 62% of the nurses felt they were subordinate to physicians (Johnson & Kring, 2012). The research by Johnson and Kring illustrates it is not only new nurses who have communication gaps and challenges with physicians.

One of the facilitating factors to the social adjustment of developing a new self-image that was identified in this research and that did not appear to be in the literature is the observation by the participants that they had come to the realization that their experiences and reactions were not so different from those of more experienced nurses. As colleagues they saw more experienced nurses in a different way and that they too were often overwhelmed with various work situations. This observation helped to normalize some of what they were experiencing and not to individualize it and attribute solely to being new. Research on professional identity with experienced nurses has shown that this identity is a "career-long" iterative process" that is reworked throughout the profession and not just upon entry to the profession (MacIntosh, 2003). Furthermore, role transitions occurs when nurses move to different clinical areas especially if these areas or location differ greatly from the previous area (Banner, Macleod, & Johnstone, 2010; Holt, 2008; Zurmehly, 2007).

Developmental and developing clinical expertise for area of practice.

New graduates complete their programs of study with beginning competencies that have been designed so that the new nurse is prepared to give patient care that is safe, competent, and ethical and that can be delivered in a variety of clinical settings (Association of Registered Nurses of Prince Edward Island, 2011). While new graduates

have these beginning competencies the PEI Professional Association acknowledges in the document on entry-level competencies that time is needed "to consolidate professional relationships; learn practice norms in that practice setting; and gain depth in their nursing practice knowledge and judgment (p. 2). However, there is often a dissonance between actual preparation and perceived preparation especially related to clinical skills or performance. Some new graduates attribute their difficulties in developing their clinical expertise as quickly as they desire to a lack of knowledge, inability to apply knowledge to practice or inadequate clinical experience in their nursing program (Clark & Holmes, 2007; Craig et al., 2012; Duchscher, 2001; Ellerton & Gregor, 2009; Feng & Tsai, 2012; Gerrish, 2000; Lalani & Dias, 2011; Pennbrant, et al., 2013; Rydon et al., 2008). Often the new graduate believes that the source of clinical difficulties lies in their educational preparation, rather than being a function of having to develop clinical area specific skills (Horsburgh & Ross, 2013; Lilja Andersson & Edberg, 2010b). Although I did not investigate perceived adequacy of educational preparation, some thought their program could benefit from more clinical time.

One area that the participants in the research identified as a major adjustment for developing their clinical expertise was developing a systematic approach to care. A particular difficulty that they identified was with work organization and in particular management and prioritizing their work. New nurses have previously identified a lack of preparation in these areas (Gerrish, 2000; Higgins et al., 2009; Rydon et al., 2008). This felt lack of preparation leaves the new graduates feeling that they are unable to meet their own professional expectations and those of administrators and co-workers in the hospital setting (Clark & Holmes, 2007; Evans et al., 2008; Higgins et al., 2009). These feelings

have been found, in other research, to be detrimental to the new graduates' development, as they are quickly replaced with feelings of failure and incompetence (Andersson et al., 2010; Feng & Tsai, 2012; Phillips et al., 2014).

The ability to make independent decisions that is required in nursing care was another developmental adjustment challenge that the new nurses in the research identified and this is an area where previously new graduates have been found to have difficulty (Gerrish, 2000; Kelly & Ahern, 2008). Some researchers have attributed this to a lack of clinical knowledge, poor or underdeveloped critical thinking skills, or a combination of both (Casey et al., 2004; Dyess & Sherman, 2011). Others suggest the trouble with decision making is more related to a lack of confidence in or comfort with their level of knowledge and abilities (Wangensteen et al., 2008; Zinsmeister & Schafer, 2009). The participants in this research were reaching the point of being comfortable in their decision making ability at the time of our interviews, some with more confidence than others, and several still questioning their ability to do the job thoroughly and appropriately. Through the duration of the interviews, it became apparent that the doubting and questioning led to a revelation for the new graduates that they do have the capability of making their own decisions.

The importance of a good preceptorship experience for the new nurse to practice in a safe and more independent manner cannot be overestimated. This was reinforced by the participants as they responded to what helped them most with their transition to nursing. Those who described what they considered a good or optimal preceptorship felt that they could not make the transition as well as they did if this support had been missing and those with less than ideal experiences felt it took them somewhat longer to

adjust. Preceptorship has been identified as important to successful nurse transition (Clark & Holmes, 2007; Evans et al., 2008; Higgins et al., 2009). An optimal preceptor experience contributes to assisting the new nurse to gain confidence in a supportive relationship, gives permission to ask questions, and provides opportunities for supervised skill development and these factors are critical to developing clinical expertise (Casey et al., 2013; Phillips et al., 2012). Less than optimal preceptorship could occur for a number of reasons and some the participants reported were inconsistent preceptor availability, lack of staff to preceptor, and a shortened preceptorship; factors reported in the literature (Johnstone et al., 2008; Moore & Cagle, 2012; Thomas et al., 2012).

Nurses and other colleagues play a major part in new nurse development of clinical skills and the participants in the research certainly acknowledged this was a major facilitating factor. Support from nursing colleagues in their supervision of new procedures was frequently mentioned as a facilitator to the new graduates' clinical expertise development and decision making ability, which is consistent with the literature (Goodwin-Esola, 2009; Mooney, 2007; Scott et al., 2006). Mentoring by experienced nurses is particularly important (Valdez, 2008) as is having strong professional role models in the workplace (Ellerton & Gregor, 2009).

One factor that has not been identified as a facilitating factor for developing clinical expertise but one that I identified in the research was familiarity with the system of nursing care in the employing unit because the new nurse might not have been exposed to that model of care in their nursing educational program. This finding became more evident when I had participants educated in different provinces that tended to have different systems of nursing in place in the main clinical institutions used for clinical

education. New nurses who had primarily practiced as students using a primary care model found it more difficult when expected to take a team approach to care. More felt they were affected when a new model of care was introduced because of the nursing role ambiguity and the change that ensued. A similar finding was also reported in research by Ostini and Bonner (2012) and their new nurses also felt the change created role ambiguity. In Ostini and Bonner's research, team nursing was being introduced on units where some of their participants worked. These participants identified senior nurses' role ambiguity and lack of what delegation or supervision skills were needed for less senior nurses as two issues that affected their transition.

Organizational and changing contractual relationships.

As the new nurse settles into the work environment, another area of adjustment that was found in this research is moving to a new organizational structure and being governed by changed contractual relationships. For this adjustment to occur the new graduate requires a working knowledge of the institution where they are employed and the policies and procedures that govern their work in the organization. This area of adjustment has not been extensively discussed in the literature, although in research on nurse transition nurses have identified that getting information on policies was helpful for a successful transition (Craig et al., 2012; Thomas et al., 2012).

An area of adjustment for the participants was not getting the same level of feedback they were used to as students. This situation made them unsure of how they were performing. A lack of feedback on performance as a new nurse has been cited as problematic (Johnstone et al., 2008; Moore & Cagle, 2012; Wangensteen et al., 2008). Without this feedback self doubt can surface and it is difficult to develop confidence in

performance (Casey et al., 2004; Duchscher, 2001; Etheridge, 2007; Morales, 2013). Current literature supports the need for consistent feedback from nurse managers that the new graduates in the research desired in order to achieve appropriate development and growth of independence as an RN (Duclos-Miller, 2011; Dyess & Sherman, 2009; Goodwin-Esola et al., 2009).

One of the adjustment challenges that the participants frequently reported was the number of new responsibilities that was expected of them in their role as a nurse. Often these were responsibilities that they had not been aware of as a student because they might not be directly to their clinical development. Expanded or increased and unexpected responsibilities has frequently been cited as one of the major challenges that new nurses face (Mooney, 2007). The complexity and scope of the nursing role is often not well understood by the new graduate because of a lack of exposure to these as students (Thomka, 2001). Often students are not familiar with the practices that governed by collective agreements and human resource departments to the same extent that is required of them as nurses (Chernomas et al., 2010).

Another area of adjustment was dealing with workplace conflict. Workplace conflict or lack of harmony could have a detrimental effect on a new nurse's ability to successfully integrate into a new workplace and organization (Cleary et al., 2013; Parker et al., 2014). This conflict often leads to feelings of stress, inadequacy, or lack of confidence in the new graduate (Lavoie-Tremblay, 2008). This conflict can take a number of forms such as bullying, verbal abuse, or belittlement of the new nurse (Craig et al., 2011; Evans et al., 2008; King-Jones, 2011; Thomka, 2001). While generally the participants in the study experienced a lack of conflict in their new environment, a few

felt caught between the conflict in nursing roles that arose because of the introduction of a new nursing model. These findings could be because new graduates are more sensitive to major changes and uncertainty in the workplace as they attempt to fit into the unit and as a consequence they experience greater chaos than the nurses already on the unit who were prepared for the change through in-service education (Jewell, 2013). Workplace politics that arises from these changes, no matter the source, would affect new nurses as they experience these for the first time (Chernomas et al., 2010).

A number of factors that were instrumental in how well the new RNs were able to adjust to the organizational change were similar to those reported in the literature. The depth and quality of the orientation to the institution that the new nurse receives can do much to foster being able to handle issues that arise because of organizational change (Cleary et al., 2013; Ostini & Bonner, 2012; Scott et al., 2008; Thomka, 2001; Wagensteen et al., 2008; Zinsmeister, & Schafer, 2009). Orientation was cited by the participants as critical to their learning and getting the information they required to perform adequately in their role. Payroll information and employee assistance go beyond what students need to know but is required for the new nurse, who is now an employee. This acknowledgement of employee status as part of the transition of new nurses, particularly paid employment, was also identified in other research that helped transition (Lalani & Dias, 2011; Morales, 2013; O'Shea & Kelly, 2007). However, employee status also required shift work (Casey et al., 2002); something that some of the participants felt they were not prepared to do.

The feedback that the participants received on any aspect of performance was helpful to them as well as they adjusted to being a nurse. They valued this feedback from

preceptors, nursing staff, and patients and families as well. It is recognized that new nurses require positive feedback on their performance as a gauge to how well they are performing (Jackson, 2005; Pennebrant et al., 2013; Thomka, 2001; Wagensteen et al., 2008). They also value having positive relationships with their patients and families (Jackson, 2005; Zeller et al., 2011). This helps build their confidence and indicates they are meeting the needs of their patients.

One of the factors that many of the participants said helped ease their transition and helped them with adjusting to their new organizational change was having previous experience on the unit. This has not been very frequently mentioned in the literature as being a factor, except for in a study by Horsburgh and Ross (2013) who found that having had an experience as a student in the unit helped with transition because it gave them some familiarity with the working of the unit. This might have been prominent in the study findings because so many new graduates had returned to a unit for employment where they completed a preceptorship while a student. These were units where they had enjoyed their time as a student and felt positive about returning to work.

Occupational: Changing Nature of Work.

The final area of adjustment that was identified in this research was occupational in nature and related to the changing nature of work as they moved from student clinical assignments to a nursing workload. One of the outcomes of this change was that they had a higher workload than they did as students. The ability to manage a higher patient workload was as aspect of the new graduates' adjustment experience, though not necessarily unexpected. They were aware that there would be a change in workload and that they would be responsible for more patients than they had as a student. At first this

increased workload could be experienced as overwhelming. This is not an unexpected reaction of new nurses when faced with increased workload and greater responsibilities (Ellerton & Gregor, 2009; Thomka, 2001). This increased workload could also be experienced as exhausting or chaotic or even "nerve-wracking" (Clark & Springer, 2012; Feng & Tsai, 2012; Zinsmeister, & Schafer, 2009). Many of the participants described their initial introduction to a higher workload as overwhelming. The higher workload often comes into conflict with values that new nurses bring into the clinical setting, such as engaging in patient centered care and having time with patients (Duchscher, 2001; Feng & Tsai, 2012; Mooney, 2007).

In addition to the higher workload, i.e., more patients under their care, the new graduates were also exposed to a wider variety of patients and conditions. These patients and conditions were often unpredictable so they had to feel ready for whatever situation they faced in the clinical area. Other reports of new graduates being overwhelmed with the greater exposure of a wider variety of patient situations are found throughout the literature, with varying levels of support reported in assisting the new graduate in their responsibilities as an RN in dealing with those situations (Halfer & Graf, 2006; Kelly, 2008; Mooney, 2007). New graduates often voice concern over making errors or how they will perform when faced with a new situation (Evan et al., 2008; O'Shea & Kelly, 2007; Ostini & Bonner, 2012) and these concerns were voiced by some of the participants.

Just as with the other areas or patterns of adjustment there were some key facilitating or impeding factors. The two main factors were realistic expectations and knowing what is important and adequate staffing on the unit. High and unreasonable

expectations of new nurses is cited as one of the occupational challenges that they face in transition (Mooney, 2007). Additionally staff shortages affect their transition often because these shortages mean there is more dependence on them at a time when they are learning to handle a higher workload (Lalani & Dias, 2011; Chernomas et al., 2010; Feng & Tsai, 2012; Horsburgh & Ross, 2013). Both of these areas affected the participants to some extent.

In trying to make the change to a new occupational role the participants struggled with the ability to manage time and fulfil their responsibilities in a timely manner. Time constraint is a major concern of new graduates because often they take longer to complete their work because they are new to a speciality or to a procedure (Feng & Tsai, 2012). However, the participants also questioned the need to meet some of the demands of routines that were entrenched in particular units.

Summary

New RNs on PEI have similar adjustment challenges to those of new nurses in other parts of the world. These challenges are mainly social, developmental, organizational, and occupational in nature. For the most part the new graduates are meeting these adjustment challenges and transitioning well to the nursing profession. However, there are both individual and contextual factors that affect their transition and these factors account for the variation in ease of transition. Career choice and choice of the clinical area where they work are some of the individual factors and those who were less satisfied with these choices or were ambivalent about the choices appeared to have greater adjustment challenges. The contextual factor that made the most difference to adjustment was the nursing environment. Most of the new nurses felt that they were in a

welcoming environment for new nurses and that preceptorship and a thorough orientation together with the support that goes with these programs were particularly helpful. One challenge that many of the new graduates mentioned was the uncertainty of knowing if they were performing as expected or not because of the lack of formal feedback. Positive feedback from colleagues and patients and their families were reassuring, but they would have appreciated some form of structured feedback. Some of the contextual factors that presented the new nurses with challenges were not necessarily related to the fact that they were new graduates. The change associated with the introduction of a new model of care and the high patient workload in particular units could be two such factors. The participants did stress that when they realized more experienced nurses had some of the same sources of stress that they had, they felt reassured that contextual rather than individual factors were responsible for some of the difficulties with transition.

Chapter 6

Limitations, Implications, and Conclusion

The final chapter of this thesis outlines the limitations as well as the implications for nursing educators and administrators in their preparation and support of new graduate nurses in their adjustment to the role of RN, especially in an acute care setting. Further implications for nursing research are also identified.

Limitations

There are limitations to the current research. One of the limitations was that the participants were interviewed once and all the interviews were conducted over the phone. Further conversations could have offered an opportunity to delve deeper into the factors that either contributed to or inhibited a successful adjustment experience. Recruitment ran over a longer period than expected so too much time had passed from the first interview to going back for a second interview. Additionally, less structured interviews could have allowed the participants to tell me more of their experience as it occurred without the discussion being led by the script of questions. As a novice researcher I felt the structure would make sure that I covered the various aspects of transition.

A second limitation could have been the timing of this research because this research was conducted during the implementation of a new Collaborative Model of Care in the province. As well as creating a change in the culture of nursing in these institutions the change in the way nursing is practiced could have created some increase in the level of stress felt by the new graduates within the workplace. Some of the

findings of this research could also have been more about the change in care delivery and less about the new graduate experience.

Implications for Nursing Education and Administration

There are a number of implications for nursing education and nursing administration that arise from the research findings in this study. Nursing education and administration have not been separated out because as the document *Entry-level competencies 2011-2015* by the PEI Professional association states "Creating a quality practice environment is the shared responsibility of governments, employers, nurses, nursing organizations and postsecondary educational institutions" (p. 19). Therefore it is important to share the research findings with both nurse educators and administrators and others to determine what if any changes might be needed to be made to prepare nurses for the nursing environment they might encounter. It is also important to examine the quality of a nursing environment so that the transition experience is enhanced. While I recognize that responsibility is shared between nurse administrators and educators, their roles differ so under the main areas where I have implications, I highlight differences for administrators and educators.

Improved communication among healthcare workers. One implication for nursing educators and administrators from this research is the continued need for education at all levels of healthcare provision regarding the importance of collaborative and respectful communication among all staff members. The cost to healthcare facilities because of verbal abuse within a multidisciplinary team is detrimental, both in dollars spent in replacing staff who frequently miss shifts to avoid conflict, and also in patient outcomes when quality of care is affected by staff who hesitate to seek advice or

assistance from non supportive nurses and physicians (Rowe & Sherlock, 2005). Though efforts have been made to improve communication with physicians the need for improvement in inter-professional communication is evident.

Although few instances of verbal hostility or belittling from doctors was mentioned, it is something that leaders in organizations and institutions cannot continue to tolerate. Tolerance of these unacceptable behaviours can have a negative effect on the new graduates' adjustment, as indicated in the experiences of participants in this study. Nurses, as well as physicians, need to understand the importance of appropriate and effective communication at all levels of the inter-professional team. Bullying among nurses is addressed in the nursing curriculum, but nursing educators and administrators may need to look at a wider audience for education and consider the implications of bullying on a larger scale such as happens in the clinical area. Education about bullying in healthcare has to occur at an inter-professional level and include nurses, physicians, and other health care professionals,

Even though inter-professional education on respectful communication and treating all team members with respect is needed, nurse managers and administrators need to be clear in their communication with all nurses, not just new graduates, that abuse of any sort is not to be tolerated, and any evidence of abuse or misconduct from any individual within the workplace is to be reported and dealt with effectively. New graduates need to feel confident that they are just as entitled to respect from their colleagues. Harassment policies are in place in all areas of government across PEI, (K. Fraser, Director of Human Resources, personal communication, 2015) though the level of enforcement or compliance with these policies has not been explored in this research.

Regarding their interactions with physicians, new graduates must feel confident that they are capable of providing care to their patients, and this capability has been deemed, not at the discretion of physicians, but through their nursing education and their professional associations or registration bodies.

Nursing workload and responsibilities. A second implication that comes from this research is the number of participants who described their workload as very heavy and that this produced feelings of being overwhelmed. Additionally they felt that the expanded responsibilities that came with the nursing role added to an already heavy workload. Their observations that even experienced nurses who worked in the institutions experienced some of the same feelings of being overwhelmed suggests that this is an issue for nursing administrators as well as nursing educators. Nursing administrators and managers need to examine the nursing workload and effects it is having on the nurses in a clinical area and see what can be done with the resources they have to improve this situation. If the resources are not available nursing administrators need to advocate on behalf of the nursing staff to obtain the resources.

For new nurses in particular they need to ensure that these individuals have a workload that allows the new nurse to meet some of their transition needs, such as debriefing regarding clinical decision-making, asking any questions they have about patient care, accessing procedure and policy manuals, and learning to delegate. Because priority setting and work organization were areas where the new nurses experienced some difficulties, initially they might need some assistance with this. Nurse educators could also look at preparation of new graduates in these particular areas and determine how to improve learning experiences regarding these skills. Although teaching with clinical

simulation does not replace actual clinical experience with real patients, clinical simulation has the potential to enhance student's learning regarding these skills.

New nurse support structures. Some schools of nursing have invited recent graduates to come back and speak to students about their experiences in the workplace as new RNs and this practice could be more consistently established. No one has a better appreciation for the realities of the new RN experience than the new RN themselves, and hearing first hand from those that have gone before them may offer a better appreciation of what to expect. Within the institution, as well identifying recent graduates from the past 2- 5 years at the workplace that would be willing to be available to talk with and offer support to new RNs, special assistance could be introduced as well. Most facilities have employee assistance programs available through human resource departments and could consider developing a specific new graduate assistance program that could address the stress and uncertainty among new graduates for those that might need that program. Having and promoting such a program would signal to new graduates an awareness of the potential stress and anxiety associated with transition and a safe and confidential place for the new graduate to get specific help.

Orientation and preceptorship. These programs were identified in this research as two of the most important facilitators for successful transition and meeting the adjustment challenges of the new graduate. Although the orientation programs in the institutions were well organized and had a thorough explanation of the expectations of the new graduates, coverage of the policies and procedures governing the nursing units and specialty areas, and an explanation of human resource practices such as scheduling, leave requests, and payroll, the extent to which the new nurses completed these programs

varied. One implication would be to continue with existing practices, which appear to be effective but to monitor these programs to ensure that all new nurses complete these as designed.

What seemed to be missing in the current orientation experience was an opportunity for nurse managers to spend time with the new nurses for an evaluation of their orientation experience. Most of the participants in the research had very limited exposure to nursing administration, and no opportunity to speak with nurse managers about their individual orientation experience. Follow up with new graduates regarding their transition needs could be conducted in regular intervals, perhaps at the 2 month and 6 month period following their introduction to the new workplace. This follow-up could serve to identify any weaknesses in the preceptor and orientation programs as well as identify individual needs of a particular new nurse.

Current nursing preceptorship and orientation practices on PEI seem to have supports in place that are nurturing to the new graduates' development as a practicing RN and orientation policies for new nurses seem to be well established on PEI, or at least, in the two facilities involved in this research. However it is imperative that these supports are regularly monitored and evaluated for effectiveness. Consistent provincial orientation practices in all acute care facilities as well as comparisons to other facilities across the country could also be conducted among senior nursing administrators, including provincial chief nursing officers to ensure orientation practices are well developed and maintained according to evidence of best practice.

Evaluation and feedback to new nurses. From this research it is apparent that new nurses desire and need feedback on their performance to ensure that they are meeting the

standards of nursing care expected of them. Feedback on their performance on a regular basis could do much to allay some of the anxiety and uncertainty they experience regarding their performance as a nurse. The development and institution of a good evaluation procedure that is specific to new nurse transition could help improve performance of these individuals by identifying areas where they do well and areas for improvement. In addition it could help identify areas where a number of new nurses experience difficulty and suggest areas to strengthen in preceptorship and orientation programs. Where appropriate, feedback could be given to nursing education for areas that might need to be strengthened in their nursing curricula.

Implications for Nursing Research

From my research there are some implications for further research. One of the questions that arises is does the transition experience of new nurses differ from other health care professionals, such as physicians, physiotherapists, nutritionists, or social workers? Further research could be conducted to explore and compare the transition experiences of new nurses with these other health professionals to determine what differences exist if any and how other health professions address this transition. A beginning step could be a comprehensive review of the literature on transition for health professionals to determine what is known in this area. This could be an area of inter-professional study and discussion.

From my findings and the nursing literature it was apparent that individual or personal factors and environmental or contextual factors contributed to how well the new nurses were able to adjust to their initial nursing position. However, my research was not inclusive of the many factors that could be important. For example, I was not able to

determine show such factors as gender or a previous position as a different health care provider might influence this adjustment and both of these factors could be studied further. A larger scale quantitative research study that was able to be inclusive of a greater number of factors could be helpful in identifying the importance of these factors and studying them in greater depth.

A longitudinal study could be another approach to research on new nurse transition. Most of the research, including this study, uses data collection methods at one point in time and is usually retrospective. A suggestion for further research into the adjustment experience of the new nurse could be to follow a cohort of nurses prospectively at different time intervals. This would allow for a study of new nurses who are at similar stages of adjustment and allow for examining progression over time. Ideally a mixed method research design would be employed to capture subjective and objective data. This approach could be beneficial in identifying either an increase or decrease in the level of satisfaction found by new graduates with the role of RN in acute care over time.

The participant's observation that their experience is not so different from other experienced nurses raises the importance of separating out those factors that affect new nurses versus those that affect all nurses is an important finding; too often we make the assumption that a nurse is having difficulty because of being new, rather than what they experience being related to a more systematic effect. Comparative research between new nurses and nurses of varying experience that examines some of the factors that are stressful for new nurses could help in this regard.

Conclusion

This research has identified that the main patterns of adjustment that new nurses make when they transition from the role of nursing student to that of an RN are social, developmental, organizational, and occupational in nature. In making these adjustments there are a number of challenges that these new nurses frequently face. Additionally there are a number of factors that serve to help or hinder them in the adjustment. Findings indicate that new graduates are adjusting fairly well on PEI and overall have a good transition experience to the role of an RN. The adjustment experience of these participants is similar to those found in international and other Canadian studies, however, there are some aspects of their experience that have not been well explored in the literature.

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Appendix A: Table 2.1: Summary of Literature Reviews on Experiences of New Graduate Nurses (GN's)

Author(s)/(Year)	Purpose	Methods/Databases and years covered	**Number of articles identified/**number used in review	Findings: Barriers/Facilitators
1. Valdez/ (2008).	Examine and interpret role of transition from novice to competent practitioner/emergency setting.	Systematic review/Medline, CINAHL, SCOPUS and ProQuest Dissertation 1980 – 2007	**63 articles**/ 21 articles: • 6 qualitative • 12 quantitative • 3 Non-research	**Barriers:** 1. Unsupportive work environment; 2. Stress and frustration; and 3. Inadequate preparation. **Facilitators:** 1. Mentoring by experienced nurses; 2. Social support in clinical area; and 3. Good orientation to clinical area.
2. Higgins, Spencer, & Kane/ (2009).	Review experiences and perceptions of newly qualified nurses in the UK during the transition from student to staff nurse.	Systematic review/CINAHL and MEDLINE 1996 – 2009	**48 articles/** 17 articles: • 13 qualitative • 1 quantitative • 3 discussion papers	**Barriers:** 1. Stress because of increased responsibility and accountability; 2. Lack of management and organizational skills; 3. Unrealistic and conflicting expectations of nursing and the nursing role; and 4. Inadequate pre-registration preparation. **Facilitators:** 1. Preceptorship programs and 2. Supportive environments.

3. King-Jones/ (2011)	Explore the prevalence of horizontal violence in the workplace and its impact on the socialization experience of nursing students and new GNs.	Methods used to conduct this research were not provided in the published article	**32 articles/** 12 articles: • 8 quantitative • 1 qualitative • 2 papers • 1 published text	**Negative impact on GNs:** 1. Poor and unwelcoming work environment; and 2. A number of new nurses considered leaving because of verbal abuse and feeling bullied.
4. Jewell, (2013)	Identify what can affect new nurse transition and how to support these new nurses.	Literature review/CINAHL Plus, ProQuest Nursing, Science Direct, and Academic Outline	**Not identified/** • 23 peer reviewed articles	**Main findings:** 1.Transitions difficult and stressful; 2. Workload and amount of responsibility overwhelming; 3. Work environment experienced as chaotic; 4. Feelings of isolation; 5. Long term effects when transition negative; 6. Need to be accepted by nursing peers and team; and 7. Need support and guidance from experienced nurses.
5. Rush, Adamack, Gordon, Lilly, & Janke/ (2013).	Identify best practices of formal transition programs for new graduate nurses.	Integrative literature review using Cooper's five-stage approach/PubMed, CINAHL, and Embase	**159 papers/** • 47 articles: All quantitative studies were used	**Better Practices:** 1. Practical skill development; 2. Formal education for preceptors; 3. Formal support available; 4. Connection with peers; and 5. Placement in a healthy work environment.

Appendix B: Table 2.2 Summary of Quantitative Research Relating to New Nurse Transition

Author/ (date)/ Country	Purpose/Participants/ Setting	Methodology/ Data collection/ Data analysis	Barriers/ Challenges	Facilitators
1. Cowin & Hengstberger-Sims/ (2005)/ Australia	Development of graduate nurse self-concept and intention to stay /New nurses (n=187 at baseline or pre workplace measure, n=83 at time two or six months, and n=71 at time three or twelve months after graduation)/ Variety of health care areas	Descriptive correlational study with repeated measures/ Mailed surveys including the nurse general self concept questionnaire (NSCQ) and Nurse Retention Index (NRI)/ Descriptive statistics, factor analysis, and analysis of variance using SPSS	1. Decrease in nurse self-concept from time two to time three; and 2. Did not have a significant decrease in the intention to leave plans over time	1. Areas of self-concept that increased from baseline to time three were care, communication, knowledge, and leadership; and 2. As nursing self concept increased intent to stay increased.
2. Halfer & Graf/ (2006)/ United States	Explore changes in job satisfaction or dissatisfaction, perceptions of work environment/ New graduate nurses (n=84)/ 265 bed tertiary care children's hospital	Nursing satisfaction survey tool /Likert scale and four open-ended questions	1. Inconsistency of schedules; 2. Night shifts; and 3.Workload	1. Professional respect among all members of the healthcare team; 2. Career development opportunities; 3. Timely description of work schedules during orientation to new nursing unit; and 4. Self-scheduling or team scheduling.

3. Rydon, Rolleston, & Mackie/ (2008)/ New Zealand	Examination of educational issues affecting new graduates/Response rate of 24.5% of 278 graduates/ Most in a nursing role in a variety of positions	Descriptive and correlational using mixed methods design/Mailed out survey/Descriptive and correlational study using SPSS	Areas of educational deficiency: 1. Time management, pharmacology, and preparing a curriculum vitae; 2. Need greater inclusion of assertiveness training and conflict management to deal with bullying and violence in the workplace; 3. Need greater time in clinical blocks to obtain more hands on experience; 4. Clinical teachers who do not possess current knowledge and skills; and 5. Lecturers not fostering strong relationships with local health boards to facilitate employment of new graduates.	1. Most graduates (84%) rated their educational preparation satisfactorily in preparing them for the role of a registered nurse; and 2. The program helped prepare confident and self aware individuals and nurses
4. Scott, Engelke, & Swanson/ (2008)/ United States	Explore influences of personal and work factors on intention to leave and career choice during transitioning period/New nurses (n=329) working between 6 months to two years/Variety of nursing workplaces	Descriptive and correlational/Secondary data analysis of survey data/ Descriptive and correlational statistics	Significant associations with intent to leave current job: 1. Frequency of short staffing; 2. Low career satisfaction; 3. Higher educational preparation; and 4. Low job satisfaction	1. Longer orientation that met all the needs of the new graduate was a predictor of job satisfaction

5. Duclos-Miller/ (2011)/ United States	Compare graduate nurse's perceptions of their transition to the professional role to actual experiences and challenges/(n=46) at 7 months after graduation/ acute care settings	Correlational/Survey using Likert scales	1. Difficulty in communication with patients' families; and 2. Unexpected verbal abuse from patients.	1. Strategies identified that assist in the prevention of nurse turnover rates; and 2. Nursing internship and residency programs.
6. Craig, Moscato, & Moyce, (2012)/ United States	New graduates expectations and concerns about practice/ new graduates 6 months after graduation (n=43)/Not identified	Descriptive study /Mail survey	*Greatest concerns*: 1. Ability to handle unexpected crisis; 2. Missing something critical; 3. Inabilty to provide safe care; 4. Lack of nursing knowledge; 5. Making mistakes; 6. Time management; 7. Not being viewed as competent; 8. Being yelled at; and 9. Being able to fit in.	*Most helpful*: 1. Nurses who model best practices; 2. Information on unit's "nuts and bolts; 3. Having a single preceptor; 4. Having multiple preceptors; 5. Lighter caseload while learning; and 6. Time to debrief with preceptor.
7. Phillips, Esterman, Smith, & Kenny/ (2012)/ Australia	Explore impact of pre-registration employment on successful transition to nursing practice/ (n=392)/Variety of clinical areas with majority in acute care	Cross sectional study/On-line Survey questionnaire. Data collected over a four month period/ Descriptive statistics	1. Higher expectations in the workplace for graduate nurses who had previous paid employment as a student.	1. Previous work experience; 2. Opportunities for skill development; 3 Communication; 4. Team work; 5. Time management; and 6. Ability to deal with conflict.

8. Tastan, Unver, & Hatipoglu/ (2013)/ Turkey	Identify factors affecting new graduate nurses transition and how these factors affect their intent to stay in nursing/new graduates (n=263)/working in military and university	Descriptive and cross-sectional study /survey questionnaire	1. Ineffective orientation; 2. Non-supportive nursing staff; 3. Challenging transition; 4. Strong desire to leave the profession; 5. Shortage of nurses; 6. Long shifts (12-16 hrs); 7. Fatigue; 8. Fear of making mistakes; and 9. Disappointing career choice	1. Working in a supervised environment with an experienced, capable senior nurse; 2. Professional socialization; and 3. Strong relationships with other new graduate nurses; and 4. Clarity about expectations of their job.
9. Parker, Giles, Lantry, & McMillan/(2014)/ Australia	New nurses experiences of entering the nursing workforce/ New graduates (n=282)/Variety of clinical areas	Mixed methods cross sectional design/Online survey/Descriptive and correlational analysis using SPSS	1. As many as 21% relied mainly on other new graduates, enrolled nurses, nursing assistants or medical officers for support; 2. Up to 26% felt they did not have the information needed to do their job; 3. A relatively high percentage were unsure of whether or not they would remain in nursing and 10% were looking for a career outside of nursing.	1. Ninety-one percent had designated new graduate program coordinators and 63% had a designated preceptor or mentor; 2. Other RNs (85%) and clinical nurse educators (71%) were identified as support that could be relied on; and 3. Eighty-five percent intended to pursue further education with a number looking at specialty courses in nursing.

Appendix C: Table 2. 3: Summary of Qualitative Research on New Nurse Transition

Author/ (Year)/ Country	Purpose/ Participants/ Setting	Methodology/ Data collection/Data Analysis	Negative findings: Barriers, challenges, concerns or sources of stress	Positive findings: Facilitators or conditions that helped with transition
1. Gerrish/ (2000)/ England	Transition to practice perceptions of new graduate nurses / Nurses working from 4 to 10 months as graduate nurses (n=25)/	Grounded theory/Indepth interviews/ Constant comparative method of analysis	Stressful transition because of: 1. Anxiety over responsibility for managing patients; 2. Having inadequate clinical skills; 3. Stress over level of accountability; 4. Fear of litigation and losing nursing license; 5. Lack of management skills for self and others; 6. Inability to delegate care; 7. Difficulty with prioritizing care and clinical decision-making; and 8. Staff shortages that disrupted preceptor experience.	1. Having qualified nurses on unit for help and support and as role models to learn their professional nursing role; 2. Had a good knowledge base from their nursing program; 3. Ability and confidence to identify their limitations and seek guidance; 4. Internalized that learning was a lifelong process; 5. Having a preceptor; 6. Being supplementary during preceptorship; and 7. Getting feedback on performance.

2. Duchscher/ (2001)/ Canada	Perceptions of nursing practice for newly graduated nurses/ New nurses in first 6 months of practice (n=5) (all women)/Acute care	Qualitative phenomenological approach/two indepth interviews and reflective journaling/ Constant comparative thematic analysis	1. Lack of knowledge; 2. Lack of focus in their work; 3. Lack of time and energy to deliver quality patient care; 4. Being dependent on nursing peers for assistance in completion of basic tasks; 5. Anxiety over interactions with physicians; 6. Traumatic because sometimes subject to verbal abuse by senior physicians; 7. Traumatic because of difficulty applying knowledge to practice; 8. Overwhelming because of degree of responsibility; 9. Exhausting emotionally, spiritually, and physically; 10. Being egocentric and self focused rather than patient focused; 11. Fearful that they would be perceived negatively by nursing staff ; 12 Concern that they would not be accepted by others on the unit; and 13. A lack of self-confidence in knowledge and abilities.	1. Abilities to come to terms with realities of work environment; 2. Accepting their inadequacies and a degree of uncertainty; 3. Letting go of the student role and taking on a professional nursing role; 4. Becoming more self- aware and developing ability to trust themselves; 5. Ability to engage in patient-centered care; 6. Comfortable raising questions in the clinical area; 7. Being more critical of what being told; 8. Mastering unit routine, practice standards, and performance of tasks; and 9. Developing more interdependent relationships with senior staff and physicians.

3. Thomka/ (2001)/ United States	Experiences and perceptions of RNs during transition from graduation through first year of practice/Nurse in practice of l< 15 years (n=16 with 13 women and 3 men)/Diverse areas of practice for initial employment~5 acute care	Descriptive qualitative/ Questionnaire with open-ended questions/ Thematic analysis	1. Transition stressful and not as they thought it would be; 2. Expectations for mentoring, support, and orientation not always met; 3. Often felt overwhelmed, nervous, or exhausted; 4. Having nursing colleagues who lacked patience, were critical, or approached them with a "sink or swim' attitude; 5. Being criticized in front of patient; and 6. Being treated with resentment and hostility	1. Orientation period that was positive ('very helpful, concise, intense etc.); 2. Treated with respect and as an equal; 3. Given autonomy to do their work; 4. Receiving praise for work done well; and 5. Being given assistance or encouraged to ask questions.
4. Casey, Fink, Krugman, & Propst/ (2004)/ United States	Experiences of changes with time in transitioning to a professional role/New nurses over a 12 month period, n=270/Six acute care hospitals	Descriptive comparative design using mixed methods/Survey with qualitative section on difficulties with transitioning/ Thematic analysis using key words	1. Lack of confidence in skill performance; 2. Deficits in critical thinking and clinical knowledge; 3. Anxiety and fear over making an error; 4. Lack of acceptance and respect from experienced nurses; 5. Degree of responsibility and feeling overwhelmed; 6. Not prepared for shift work; 7. Being asked to preceptor; 8. Lack of organizational skills and setting priorities; 9. Communication with physicians; and10. Feelings of insecurity.	1. Positive experiences with preceptors.

5. Jackson/ (2005)/ England	What a good day was like for a new nurse and the impact that good day had on the new graduates' feelings about nursing/(n=8) who had qualified for <1 year/Surgical wards	Phenomenology descriptive /2 individual interviews and informal group interview to clarify themes/ Thematic analysis using Giorgi's framework	1. Emotional reactions to patients' sad circumstances; and 2. Inappropriate use of humour in the workplace	1. When felt performed well; 2. Good relationship with patients; 3. Feeling that they had achieved something; 4. Getting the work done; and 5. Team work
6. Etheridge/ (2007)/ United States	How new graduates learn to think like nurses/N=6 new graduates/Working in acute care institutions	Longitudinal using descriptive phenomenology/ Identification of themes	1. Lack of confidence in knowledge and abilities; and 2. Unprepared for level of responsibilities, especially decision-making.	1. Having varied experiences with patients; 2. Greater exposure with and interactions with members of the healthcare team; and 3. Repeated clinical experiences.
7. Clark & Holmes/ (2007)/ England	Competence of newly qualified nurses and what influencing these/Newly qualified nurses, and others/There were n=50 new nurses out of 105 participants/ Clinical areas not identified	Qualitative exploratory study/Focus groups and individual interviews for ward managers/ Content analysis	1. Lack of readiness for independent practice because of knowledge gaps; and 2. Overly concerned with completing specific tasks	1. Confidence from other staff in the new graduate; 2. Time to consolidate practice; 3. Support from other staff; 4. Having a formal program of development; 5. Ability to transfer skills; 6. Having a preceptor; 7. Opportunities to learn under pressure; and 8. Acceptance into the workforce.

8. McKenna & Newton/ (2007)/ Australia	Knowledge and skill development over the first 18 months /New nurse graduates (n= 25 initially with 21 women and 4 men but only n=9 completed all focus groups)/Four general hospitals from a variety of settings	Qualitative approach using Phenomenology/ Focus group interviews at 3 different points in time over 18 months/ Data analysis using Colaizzi's framework	1. Early dissatisfaction with career choice; 2. Unable to achieve a sense of belonging; and 3. Multiple rotations through nursing units inhibiting effective socialization with a multidisciplinary team.	1. Early job satisfaction; 2. A sense of belonging; 3. Developing independence in practice; 4. Moving on and able to help others with practice; 5. Feeling like an equal with other members of the team; 6. Respect for senior nursing staff; and 7. Relevance of knowledge acquired in early nursing practice.
9. Mooney, (2007)/ Ireland	Perceptions of transition/New nurses in first 12 months (n=12) /Acute general hospital	Grounded theory/ Indepth interviews/ Coding of data at various levels, i.e., in vivo and axial coding	1. High and unreasonable expectations; 2. Broader role than expected with higher workload; 3. Unexpected and increased responsibilities; 4. No time for nursing; and 5. Disappointment with career choice.	1. Support of ward manager
10. O'Shea & Kelly/ (2007)/ Ireland	Experience and meaning of being on a clinical placement/ New nurses with 6 and 7 months experience (n=12) /Medical. surgical nursing wards	Heideggerian hermeneutic phenomenology/ In-depth Interviews /Colaizzi's framework for analysis	1. Feeling nervous and scared; 2. Physical stress; 3. Lack of managerial and organizational skills; 4. Lack of clinical skills; 5. Responsibility for students; 6. New situations; 7. Administrations of medications without supervision; and 8. Interactions with physicians.	1. Getting respect from others; 2. Feeling appreciated by patients; and 3. Being paid (employment and security).

11. Evans, Boxer, & Sanber/ (2008)/ Australia	Evaluation of Transition Support Program for newly registered nurses (NGN) and experienced nurses (EXN)/ NGN (n=9) (EXN) (n=13)/Seven large and small, private and public hospitals	Qualitative descriptive /Individual interviews /Extraction of themes	1. Bullying; 2. Unfair work schedules; 3. Inadequate staffing; 4. Lack of support available on weekends, evenings and nights; 5. Lack of acknowledgement from unit managers; 6. Feeling unsafe in practice; 7. Program courses not relevant to workplace requirements; and 8. Increased responsibilities such as charge nurse .	1. Having a preceptor; 2. Length of transition support program; and 3. Confidence attained during clinical practice.
12. Johnstone, Kanitsaki & Currie/ (2008)/ Australia	Level of support for nurse graduates in Australia, best provider of support, and time needed/ New graduates (n=14) and key stakeholders (n=21)	Exploratory descriptive case study/qualitative and quantitative data from individuals and focus groups/ Content and thematic analysis	1. Lack of consistent positive feedback; 2. Disengaged or inexperienced preceptors; 3. Lack of staff to preceptor new graduates; 4. Lack of consistency in preceptors; and 5. Inappropriate attitudes or behaviour towards new graduates.	1. Duration of preceptor support and timeliness of support; and 2. Nursing administration awareness and commitment to making necessary changes in the workplace to support new graduates.

13. Kelly & Ahern/ (2008)/ Australia	Understand the subjective personal experience of new graduates prior to employment and 1 & 6 months post-employment/ New graduates 6 months after graduation/ (n=13) 11 women and 2 men/Variety of clinical areas	Phenomenology based on Husserl/ Semi-structured interviews/ Thematic analysis using Nvivo software	1. Unprepared for/limited awareness of what profession entailed; 2. Disparities in workload and rosters; 3. Cliques and "language" associated with nursing; 4. Power games, hierarchy and meanness of other nurses; 5. Unprepared for decision making, nursing role, reality of new role; and 6. Not enough time for patients.	No facilitators identified.
14.Wangensteen, Johnsson, & Nordstrom/ (2008)/ Norway	How new graduates experience first year as a nurse/New nurses (n=12 with 10 women and 2 men/Medical. Surgical area (8) Home Care (4)	Qualitative design/ individual semi-structured interviews/ Content analysis	1. Experiences of chaos and uncertainty; 2. No orientation or period interrupted; 3. Lack of feedback on performance; and 4. New responsibilities and not having the overview to inform physicians and to delegate.	1. Having an orientation program; 2. Having a supportive environment (being welcome and comfortable asking questions); 3. Getting feedback on performance; 4. Having positive experiences; 5. Gaining confidence; and 6. Ability to manage challenging situations.

15. Ellerton & Gregor/ (2009)/ Canada	New graduates readiness to practice/ New nurses who completed a four year baccalaureate program and were working 3 months (n=11 with 10 women and 1 man)/ Acute care facility	Qualitative descriptive study within an interpretive social science approach/Semi-structured interview/ Thematic analysis	1. Taking longer time to complete procedures; 2. Focused of self and completion of tasks and not on patients; 3. Dependency on other nursing staff; 4. Lack of expertise in communicating at a meaningful, therapeutic level with patients and families; 5. Feeling overwhelmed with the acuity and volume of workload; 6. Lack of knowledge and skill necessary for safe, independent practice; and 7. Felt nursing program was deficient in clinical practice opportunities.	1. Having accessible and competent preceptors for a period of time; 2.Confidence in knowledge and skills of preceptor and other nursing staff; 3. Aware of resources available in nursing environment to support continued learning and skill development (e.g., drug manuals, procedure manuals, and learning packets prepared by the institution); and 4. Presence of professional role models in the workplace.
16. Zinsmeister, & Schafer (2009)/ United States	Lived experiences of graduate nurses during the first 6. 12 months of clinical nursing practice/ New nurses (n=9)/Clinical nursing	Qualitative phenomenology approach/ Standardized open-ended question using individual interviews/ Thematic analysis using Miles and Huberman	1. Initially expectations of new graduates were nerve-wracking; and 2. Lack of self-confidence to handle certain patient situations.	1. Preceptorship especially relationships made and support obtained; 2. Comprehensive and detailed orientation; 3. Sense of professionalism and feeling pride in nursing role; 4. Clarity of role expectations; and 5. Self-confidence and comfort.

17. Lilja Andersson, & Edberg/ (2010a)/ Sweden	Experiences of nurses in the first year after graduation in their new professional role/New nurses (n=8 with six women and 2 men)/Hospital environment	Qualitative/ Unstructured interviews/ Content analysis	1. Inability to be independent; 2. Not able to prioritize tasks; 3. Spill over effect to home and social life; and 4. Worried what others thought when unable to complete work.	1. Being respected in the workplace; 2. Accepted socially and as part of the staff; 3. Being listened to in the clinical area; 4. Becoming familiar with routine; and 5. Breaking down of professional boundaries.
18. Lilja Andersson, & Edberg/ (2010b)/ Sweden	How nursing education prepared new nurses for practice/New nurses (n=8 with six women and 2 men) one year after practice /Hospital environment	Qualitative/ Unstructured interviews/ Content analysis	1. Amount and depth of knowledge in pharmacology was not sufficient and needed more on administration of drugs, drug metabolism, and dosage and side effects; and 2. Continued to have difficulty seeing the relevance of nursing theories to practice.	1. Applied clinical courses; 2. Sound knowledge of scientific method helped with finding and evaluating information, ability to question information, and think critically; 3. Confident they had sound knowledge in medical sciences; and 4. Importance of nursing science to making a difference to patient care.
19. Chernomas, Care, Lapointe McKenzie, Guse, & Currie/ (2010)/ Canada	New graduate nurses perception of their experience of transition from the role of student to the role of independent RN/ New nurses (n=9)	Part of a larger study/Focus group methodology/ Individual and group discussions/ Thematic analysis	1. Unfamiliarity with Human Resources and collective agreements; 2. Staff shortages; 3. Workplace politics; 4. Being placed in unfamiliar settings as a float nurse; and 5. Limited nursing educator availability.	1. Supportive nurse managers; and 2. Guidance and support from experienced nurses.

20. Dyess & Sherman/ (2011)/ United States	Evaluation of the Novice Nurse Leadership Institutes one year transition program /New graduate nurses (n=81)/ Acute care community facilities	Qualitative research study design/pre and post program focus group interviews/ Hermeneutic analysis	1. Fear of independence in new role; 2. Poor communication within the multidisciplinary team; 3. Horizontal violence; 4. Professional isolation; 5. Underdeveloped critical thinking skills required for specialty areas; and 6. Getting contradictory information.	1. Confident in choice of practice area; 2. Determined to make good use of transition program; 3. Support/validation from other new graduates in dealing with horizontal violence; 4. Direct contact with nurse leaders when needed; and 5. Consistent preceptor experiences with only one preceptor.
21. Lalani & Dias/ (2011)/ Pakistan	Description of transitional processes from student to staff nurse and identify influencing factors/ New nurses in first year of practice, number not identified/Hospital. based	Grounded theory/ Unstructured interview/ Constant comparative data analysis	1. Had anxiety beginning to practice as a nurse; 2. Difficulty organizing work; 3. Communication; 4. Gap between ideal or what learned and reality of practice situation; 5. Increased workload; and 6. Missing personal life and religious practices.	1. Financial independence; 2. Individual characteristics (e. g., hard working, self-confident, taking initiative); 3. Cooperation from senior staff nurses and team leaders; 4. Support from clinical nurse instructors; and 5. Learning to speak up for their rights.
22. Malouf & West/ (2011)/ Australia	Experience of transition to acute care nursing/ Beginning practitioner in first 12 months of practice, n=9, 8 women and 1 man/ Variety of acute care tertiary care hospitals	Principles of grounded theory/Series of three indepth interviews/ Focused selective and theoretical coding	1. Anxiety about communication with staff and being able to fit into the clinical unit and be part of the social group; 2. Fear of appearing stupid to other staff members through lack of knowledge.	1. Being able to let others know of any lack of knowledge.

23. Zeller, Doutrich, Guido, & Hoeksel/ (2011)/ United States	The lived experiences and decision to continue nursing/New nurse graduates (n=6), two years or more following graduation	Hermeneutic phenomenology /Individual taped interviews/ Thematic analysis	1. Emotionally draining aspects of nursing; 2. Unprepared for clinical nursing; 3. Fear of not being a good nurse; and 4. Feeling overwhelmed.	1. Satisfaction being able to help patients; 2. Feeling like nursing is "part of my identity"; 3. Receiving thanks and recognition from patients and families; 4. Support from senior, experienced nursing staff; 5. Feeling accepted and needed as a part of the team; and 6. Educational opportunities to assist with knowledge deficit.
24. Chandler/ (2012)/ United States	New nurses experience of transition during first year/New nurses/(n=36)/ Working in a variety of clinical areas	Qualitative descriptive using appreciative inquiry/ Semi- structured interviews/ Content analysis	1. Not feeling welcomed; 2. Fragmented and shortened orientation; 3. Criticized just for being new nurses; 4. Felt no one to consult with or available to answer questions; 5. Minimal support; and 6. Competitive environment.	1. Being supported and welcomed; 2. Assistance and monitoring by preceptors; 3. Having other new nurses on the unit; 4. Being in a culture of inquiry; and 5. Feeling nurtured.
25. Clark & Springer/ (2012)/ United States	Lived experience and satisfaction during first year of nursing practice/New graduate nurses (n=37) with 32 women and 5 men/ A public 600 bed acute care facility	Descriptive qualitative study using Krueger's Systematic Process/One hour focus group interviews /Thematic analysis	1. Chaotic workload; 2. Stress of not knowing or having no one to turn to in times of uncertainty; 3. Disinterested preceptors; 4. Redundant and unnecessary paperwork; and 5. Difficulty accessing policies and procedures on computerized system.	1. Feeling valued and appreciated by the patients; 2. Feeling included by the team; and 3. Feeling like a vital and valued team member.

26. Feng & Tsai/ (2012)/ China (Taiwan)	Socialization experiences of newly graduated nurses/Baccalaureate nurses (n=7)/ Working in four medical centers	Qualitative descriptive study/semi-structured open ended questions/ Content analysis	1. Perceived lack of knowledge and experience; 2. Staff shortages; 3. Lack of support from senior staff; 4. Time constraints; 5. Exhaustion due to heavy workload; and 6. Dependence on staff who are critical of the new graduate.	1. Opportunities for hands on learning.
27. Lee, Hsu, Li, & Sloan/ (2012)/ China (Taiwan)	Understand the transition processes of new nurses in Taiwan/ New nurses with less than 4 months experience (n=16)/Working in a teaching hospital	Phenomenolog design/Eight weekly group interviews/ Thematic analysis	1. Cultural norms, e.g., compliance with authority, self-control and acquiescing to the group; 2. Less professional competency resulting in a power imbalance; 3. Unfamiliarity with environment and specialty; 4. Vulnerability and open to criticism; and 5. Internalization of vulnerable position.	1. Working to become an insider; and 2. Trying to transform self to fit in the unit.
28. Moore & Cagle/ (2012)/ United States	Lived experiences of new nurses during an internship program/New GN enrolled in a 12. 18 month internship program (n=10)/ICU and ER	Heideggerian phenomenology/ Individual and Unstructured interview/ Hermeneutic analysis	1. Lack of evaluation of the experience; 2. Disrespect from staff; 3. Preceptor absent either emotionally or physically; and 4. Not being trusted to give care; and 5. Not believing in oneself.	1. Good relationship and fit with preceptor; 2. Being challenged and assessed by preceptor; 3. Staff acceptance of new nurses and showing respect; and 4. Preceptor present but not "hovering".

29. Ostini & Bonner/ (2012)/ Australia	Experiences of new graduate transition to RN role / New graduate nurses (n=5) three female and 12 male/Rural regional acute care setting	Qualitative study/ semi-structured individual interviews/ Content analysis	1. Facing new tasks for the first time; 2. Fear, anxiety, and panic when faced with a new skill; 3. New model of care introduced; and 4. Having to change rotations.	1. Being supported; 2. Orientation to facility; 3. Having questions answered; 4. Having debriefing; 5. Availability of staff educators; and 6. Support by all on the team.
30. Thomas, Bertram, & Allen/ (2012)/ United States	The lived experience of the first year of practice /New graduates within their first year of practice (n=11)/Acute care hospitals	Qualitative phenomenological design/one to two hour interviews/ Micro analysis and triangulation of texts	1. Orientation that did not include a clinical unit experience; 2. Inconsistent preceptor availability; and 3. Inconsistent orientation among hospitals.	1. Orientation strategies with classroom lectures and discussions; 2. Additional training such as ACLS and PALS; and 3. Written material about the hospital and specific nursing unit
31. Cleary, Horsfall, Jackson, Muthulakshmi, & Hunt/ (2013)/ Singapore	Views of preparation, workplace transition, and support /New nursing graduates from degree program (n=17)/Hospital employees	Qualitative/ Individual interviews using a list of 23 questions/ Thematic analysis	1. Meetings where blame placed on new nurse; 2. Units where nurses divided; 3. A "blaming culture"; 4. Insufficient resources for peer support; and 5. Insufficient time for breaks.	1. Good support through an orientation program; 2. Experienced nurses in unit willing to assist; 3. Being preceptored; 4. Strong leadership on the unit; 5. Good role models; and 6. Good communication.
32. Horsburgh, & Ross/ (2013)/ Scotland	Experiences of newly qualified staff nurses/New nurses in first year of practice (n=42)/Hospital employees	Qualitative/ Focus group discussion/ Thematic analysis	1. Not prepared for reality of nursing; 2. Felt thrown into the deep; 3. Poor staffing levels; 4. Support "the luck of the draw"; and 5. Negative staff - entrenched views and resistance to change.	1. Orientation; 2. Being supplementary on unit during orientation; 3. Supports in place; 4. Skills part of undergraduate program; 5. Completion of a module in the area now working; 6. Buddy system; and 7. Having clinical supervision.

33. Morales/ (2013)/ United States	Lived experience of new graduate nurses/ Hispanic new graduate nurses (n=7); Females=5 and males=2/ Acute care (n=4) and outpatient clinic (n=3)	Qualitative phenomenological methodology/ In-depth semi-structured interviews/ Coding using Nvivo	1. Not having an assigned preceptor; 2. Negative experience with a preceptor; 3. Self doubt; and 4. Not acknowledging differences, e.g., being Hispanic.	1. Being an employee; 2. Being bilingual; 3. Having an assigned preceptor; 4. Contact with professional association; 5. Help from a nurse practitioner; and 6. Asking and having questions answered.
34. Pennebrant, Nillson, Öhlén, Rudman/ (2013)/ Sweden	Professional development of nurses in the first year/ New nurse (n=330 with 310 women and 20 men/ A variety of health care organizations	Mixed methods/ One open-ended question on professional development in a self-reported Mailed questionnaire/ Constant comparative method	1. Lack of adequate preparation for practice; 2. Unsupportive team or climate critical of new nurses' skills; 3. Lack of public understanding and valuing of nurses; 4. Staff shortages and high workloads; 5. Complexity and lack of clarity of nurse's roles; 6. Insufficient manager support; 7. Negative encounters with patients and families; 8. Fatigue and having limited resources to deal with parenting, finances etc.; and 10. Low pay and shift work.	1. Clinical experience as student; 2. Supportive work teams and a positive ward atmosphere; 4. Support and encouragement from managers; 5. Realistic expectations of new graduates; 6. Positive and non-judgmental attitudes of co-workers; 7. Positive feedback; 8 Positive encounters with patients and their families and supports; and 8. Stable relationships with families and friends.
35. Parker, Giles, Lantry, & McMillan/ (2014)/ Australia	Experiences of new graduates in the first year of practice/N=55 new nurses in seven focus groups/ Variety of clinical settings	Mixed methods/ Survey and focus groups for qualitative data/ Thematic analysis	1. Managing routines and workloads, anxiety about medication administration; 2. Having to deal with disharmony in the workplace.	1. Being in a positive workplace culture that had a commitment to helping new staff and would treat them with respect and courtesy.

Appendix D: Table 4.1 Summary of Patterns of Adjustment, Adjustment Challenges, and Facilitating or Inhibiting factors

Pattern of Adjustment	**Main Adjustment Challenge**	**Facilitating and Impeding Factors**
1. Social: Taking on a new status	1. Developing a new self-image; 2. Forming collegial relationships; and 3. Communicating with a wider network.	1. Satisfaction with career choice or working in clinical area of choice; and 2. Familiarity with system of nursing care delivery; 3. Acceptance by the staff and feeling part of the team.
2. Developmental: Developing clinical expertise for area of practice	1. Developing a systematic approach to care; and 2. Making your own decisions.	1. Preceptorship and support from other nurses; and 2. Compatibility of practice with how they were educated.
3. Organizational: Changing contractual relationships	1. Being unsure of performance; 2. Expanding responsibilities; and 3. Dealing with workplace conflict.	1. Previous experience on the unit; 2. Feedback from peers, and patients and families; and 3. Orientation to hospital policies.
4. Occupational: Changing nature of work	1. Greater exposure to a wider variety of patient situations; 2. Higher patient workload; and 3. Readiness for whatever comes your way.	1. Realistic expectations and knowing what is important; and 2. Adequate staffing on the unit.

Appendix E

ARE YOU A BN?

ARE YOU CURRENTLY WORKING IN ACUTE CARE?

Would you like to take part in a research study?

I am looking for BN GRADUATES who:

- currently work at either Prince County Hospital or Kings County Memorial Hospital
- are graduates of 2009, 2010 or 2011
- began work as an RN in an acute care facility on Prince Edward Island

To take part in a study of the adjustment of new graduate nurses to the acute care environment in Prince Edward Island. For more information about the study or to ask if you can take part, please contact: Doris Taylor at 902-894-2393 or e-mail at drtaylor@gov.pe.ca

Appendix F

Consent to Take Part in Research

TITLE: Adjustment of new graduate nurses to the acute care environment in Prince Edward Island.

INVESTIGATOR: Doris Taylor

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

Introduction/Background:

Adjustment from a student to a professional role is often a difficult transition process and this has been shown to be the case in nursing. This may be especially the case for new nurses in acute care because of the nature of that practice. It is important to understand the process that new graduates go through in their adjustment so that efforts can be made to provide adequate support for the new graduates in the workplace. This support may then help to increase work satisfaction and greater retention of nurses in acute care.

1. **Purpose of study:**
   The purpose of this study is to examine the new graduate nurses' experience of their adjustment to the role of a Registered Nurse in an acute care facility on Prince Edward Island and some of the factors that may help or hinder that adjustment.

2. **Description of the study procedures:**
   If you are willing to participate in this research, I will talk with you either in person or over the phone, explain the study in detail and you will be asked to take part in an interview with me about your experience as you adjusted to your new role as a Registered Nurse in an acute care facility on Prince Edward Island. The interview will take about one hour, and I will have some questions for you about your

experience, which will get our conversation started. You can share as much or as little about your experience as you are comfortable sharing. I will be doing similar interviews with other graduate nurses on P.E.I. Our conversation will be audio taped. The information I will collect will help to better understand this experience.

3. **Length of time:**
If you agree to be a participant in my research you will be expected to meet with me for one interview sometime over the next two months at a place and time of your convenience. This interview can be conducted over the phone if that is more convenient for you. The interview will last approximately one hour.

4. **Possible risks and discomforts:**
There are no anticipated risks related to participation in this study. However, if you have not had a positive experience, with your permission I will refer you for consultation to the Manager of the Human Resources department at the facility at which you are currently employed, or to an employee health professional through the Employee Assistance program of the Department of Health.

5. **Benefits:**
It is not known whether this study will benefit you.

6. **Liability statement:**
Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

7. **What about my privacy and confidentiality?**
Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

When you sign this consent form you give us permission to

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records
The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This **might** include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information
The research team will collect and use only the information they need for this research study.

This information will include your information from interviews.

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will kept for five years.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored at 90 Cameron Road, RR. #, Cornwall, P.E.I. Doris Taylor is the person responsible for keeping it secure.

Your access to records
You may ask Doris Taylor to see the information that has been collected about you.

8. Questions or problems:
If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

Doris Taylor, (902) 675-4569

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:
Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

Signature Page

Study title: Adjustment of new graduate nurses to the acute care environment in Prince Edward Island.

Name of principal investigator:
DorisTaylor

To be filled out and signed by the participant:

	Please check as appropriate:
I have read the consent.	Yes { } No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { } No { }
I have received satisfactory answers to all of my questions.	Yes { } No { }
I have received enough information about the study.	Yes { }No { }
I have spoken to Doris Taylor and he/she has answered my questions	Yes { } No { }
I understand that I am free to withdraw from the study • at any time • without having to give a reason	Yes { } No { }
I understand that it is my choice to be in the study and that I may not benefit.	Yes { } No { }
I understand how my privacy is protected and my records kept confidential	Yes { } No { }
I agree to be audio taped	Yes { } No { }
I agree to take part in this study.	Yes { } No { }

_____ _____ _____

Signature of participant Name printed Year
Month Day

_____	_____	_____
Signature of person authorized as Substitute decision maker, if applicable	*Name printed*	*Year Month Day*
_____	_____	_____
Signature of witness (if applicable)	*Name printed*	*Year Month Day*

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____	_____	_____
Signature of investigator	Name printed	Year Month Day

Telephone number: _____