University of Alberta

PROFESSIONAL ROLE TRANSITION INTO ACUTE-CARE BY NEWLY GRADUATED BACCALAUREATE FEMALE REGISTERED NURSES

by

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Special Mention

If I have been able to see further, it is only because I stood on the shoulders of giants.

Sir Isaac Newton

Victor Michael Boychuk

July 25th, 1929 - August 3rd, 2004

While I am so glad your life was long and your death brief, the pain of your passing and the space in my life left by your absence remains so very present for me. I have thought of you so often during the past 3 years Dad and, while my life will always be imbued with the essence of who you were and what you stood for, I am sorry that you are not here to share this special time with me. You have been my mentor in every way – by your life you modeled for me justice, courage, honor, discipline, determination and loyalty. By your death, you taught me the essential nature of caring and compassion in all that I do. And finally, through the course of watching you live with purpose and die with dignity I learned the most valuable lesson of all.... to surrender to, and rest peacefully within the restorative embrace of God's light. My greatest strength lies in the fact that I am of you – I was divinely blessed to have been your daughter.

Abstract

Newly graduated nurses are entering the workforce for the first time and finding that they have neither the practice expertise nor the confidence to navigate what has become a highly dynamic and intense clinical environment burdened by escalating levels of patient acuity and nursing workload. This research utilized qualitative methods to build upon and mature aspects of the new nurse's transition experience into acute care. The theory of transition shock and transition stages presented in this dissertation encompass a doctoral study period of 18 months. This dissertation is presented as the thesis for this study.

Dedication

Support the strong, give courage to the timid, remind the indifferent, warn the opposed.

- Whitney M. Young Jr.

This dissertation is dedicated to all the new nursing graduates whose courage and resilience, despite the challenges they face have inspired me for the past 10 years. In thanking you for passionately accepting the proverbial torch of competent caring, compassion and commitment that defines the nursing profession, I do so more in anticipation of what you may bravely do with it than in gratitude for having passed it. While we often recognize the rudimentary need for support, what we do not always see clearly is how those whom we support hold us up. My life is so much better because I have known you, my vision so much clearer because I have seen your spirit, and my heart so much warmer because it has felt the embrace of your hope and the fire of your passion.

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At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lit the flame within us.

Albert Schweitzer

To begin, I am eternally grateful to the new nursing graduates involved in this study, whose willingness to share their stories of vulnerability and triumph allowed me to find a voice with which to represent them.

I owe an incalculable debt to Dr. Joanne Profetto-McGrath and Dr. Olive Yonge for their endless faith and unwavering support of me as I often stumbled my way through the unknown territory of this program. They were patient, generous, kind, stern, grounding, loyal, and above all trustful of my vision. I lost count of the times Olive asked me "Judy, that's nice but what does it have to do with your doctoral program?" and I appreciated the nurturing Joanne so generously offered me during those frightening early days when my stumbling was most self-injurious. I will always marvel at how they seemed to know when to hold me back and when to let me go.

To my Leadership Team of *Nursing The Future*, I owe the height of my flame....

There are family members, close friends and colleagues who have stood by me throughout these years and whose patience with, and challenge of me permitted a much better version of myself to emerge (oh, that is SO Glaserian....). I want you to know that without you I would not be who I am today. Further to this, I doubt I would have had the courage to let go of who I was and become all I could be. I will be eternally grateful to you for your love and support of me through it all, particularly because I know that it may, at times, have been at great cost to yourself.

I would be remiss if I did not mention SIAST and the Nursing Division for the steadfast support of my scholarship over the past 10 years they have employed me. During the tenure of my doctoral program I received complete support to fully engage in my studies, often making me unavailable for course meetings, program development work and division meetings. I am incredibly grateful to all my faculty colleagues who have offered endless encouragement to me, stopping by my office to inquire about my program despite the grueling demands of their own teaching and scholarship schedules. To former Dean Diana Davidson Dyck and current Dean Netha Dyck, I owe a tremendous debt of gratitude. Their devoted support and encouragement of my work permitted me to move forward at a pace that would otherwise have been most difficult. It has been a privilege and an honor to work with all of you.

To my husband Eldon……words are so difficult to find. Basically, I owe you everything. You are the only thing in my life that has always made sense. I can't imagine you knew what Dad meant all those years ago when he said "She's all yours now…..", but you were obviously up to the task. I will spend the rest of my life thanking you for giving me back to myself.

And finally, to all that was gained and all that was lost, I am so grateful. I once heard that a path with no obstacles doesn't lead anywhere worth going. But it is not the obstacles that are worthy of mention – rather, it is what you do with what is set before you that is the most accurate measure of how far you have come and in what direction you are moving.

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I would like to extend my profound gratitude to the organizations and agencies that have supported my doctoral research and study for the past 6 years:

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Introduction and Overview

This thesis represents the outcome of an extensive and comprehensive period of study and research spanning 6 years (2001-2007). It should be noted that the theoretical models of transition that result from this phase of study are inextricably linked to the author's 10-year history of study in the area of the new nurses' professional role transition. The intent of the doctoral phase of this program of research was to further examine, build upon and mature aspects of the new nursing graduate (NG) transition experience into acute care such that an accurate overall representation of this experience and the processes encompassed within could be confidently introduced into the scholarly community. The purpose of such an introduction is to advance the dialogue around the issues inherent in initial professional role adjustment. If we are to not only recruit and retain NGs, but motivate and inspire the future generations of our profession then we must come together in creating a strategic plan that can reflect, address and continually monitor the challenges NGs face when being formally introduced into their professional community. It is this collective effort that has the potential to yield transformative change within the discipline, for while the initial professional role transition of the graduate nurse (GN) is itself a unique stage in their professional journey it should also be considered a magnified reflection of the realities all nurses face on a daily basis. As such, the evolving transition experience of the NG has the potential to unite and advance the entire profession by making visible the contemporary challenges and triumphs of the whole nursing community.

Situating the New Graduate Transition Context

Providing quality health care depends upon understanding what constitutes a quality nursing work environment and then taking steps to provide for and support that environment. Numerous studies in North America have provided extensive evidence relating patient care outcomes to the availability of competent and qualified nursing care (Advisory Committee on Health Human Resources [ACHHR], 2002; Aiken, Clarke, Sloane & Sochalski, 2001; Aiken,

Clarke, Sloane, Sochalski & Silber, 2002; Antonazzo, Scott, Skatyn & Elliot, 2003; Buerhaus et al., 2007; Buerhaus, Donelan, Ulrich, Norman, DesRoches & Dittus, 2005; Canadian Institute for Health Information [CIHI], 2003). Despite further correlations between a shortage in quality nursing human resources and public health risk, demands for full-time nursing professionals continue to exceed the rate at which new nurses are graduating from educational institutions (Barney, 2002; Purnell, Horner, Gonzale & Westman, 2001; Shields, 2004). With current shortages of nurses straining an already taxed healthcare system, the stark projections of escalating attrition due to an aging workforce, and the premature exit of nurses out of the workplace because of physical and emotional exhaustion are rapidly becoming unacceptable consequences of a system out of control.

Experts claim that the current nursing shortage is unlike anything we have experienced to date (Cowin & Jacobsson, 2003; Mee & Robinson, 2003; Murray, 2002; Tanner, 2003). It is "the outcome of a long-term, complex composite of market, technological, and societal influences that have eroded the ability to respond to cyclical changes in the need for expert nurses" (Purnell et al., 2001, p. 179). A lack of respect, an unwelcoming hospital culture, inappropriate utilization of nursing knowledge, a focus on fiscal management rather than quality work environments, and attractive alternatives to hospital nursing are primary contributors to the current acute-care nursing workforce deficiencies (Barney, 2002; Bowles & Candela, 2005; Canadian Health Services Research Foundation, 2006; Lin & Liang, 2007; May, Bazzoll & Gerland, 2006). A recent report of nursing workforce trends in five countries (Canada, the United States [US], England, Scotland, and Germany) showed strikingly consistent symptoms of distress suggestive of: 1) fundamental problems in the design of nursing work, 2) inadequate staffing quotas available to cope with elevated acuity and census figures, 3) increases in worker absenteeism and subsequent escalating costs of nursing care provision, 4) qualitative evidence of healthcare administrations that are out of touch with the voices of struggling nurses, and 5) reports of "an

increased tendency for younger nurses to show greater willingness to leave their hospital jobs" (Aiken, Clarke, & Sloane, 2002, p. 261). Compounding this are reports claiming that more than 40% of NGs in the US are choosing not to practice nursing upon graduation (Ward & Berkowitz, 2002). The majority of those who begin practicing as professional nurses do so in a hospital setting and a concerning 33-61% of these graduates have been cited as changing their place of employment or leaving the nursing profession within the first two years (ACHHR, 2002; Baumann, Hunsberger, Blythe & Crea, 2006; Bowles & Candela, 2005; Cowin, 2002; Dearmun, 2000; Shields & Wilkins, 2006; Winter-Collins & McDaniel, 2000). Perhaps most troubling are statistics indicating that less than half of the current nursing workforce would recommend nursing as a career option (Baumann, Blythe, Kolotylo & Underwood, 2004; Commonwealth of Australia, 2002; Heinrich, 2001; Irwin, 2001), and a startling 25% would "actively discourage someone from going into nursing" (Baumann et al., 2004, p. 13). Renowned workforce analysts Buerhaus, Staiger and Auerbach (2003) have projected that a 40% annual increase is required in the enrollment of young people in undergraduate nursing education programs just to stem the impact of the workforce attrition expected by 2010. Others warn that the failure to understand and address the historical, sociopolitical and economic issues that underpin and subsequently perpetuate the stressful, oppressive and devaluing context of the acute-care practice environment may well eradicate any hope of sustaining a viable professional nursing workforce (Buchan & Calman, 2004; Burke & Greenglass, 2000; Callaghan, 2003).

We know that the movement of NGs between institutions, or out of the profession altogether can be primarily attributed to five factors: 1) emotional exhaustion secondary to competing professional demands, excessive workloads, and a sense of powerless to effect change (Cho, Laschinger & Wong 2006; Sadovich, 2005), 2) horizontal violence and abuse from seasoned RN colleagues (Cox, 2001; Farrell, 2001; McKenna, Smith, Poole & Coverdale, 2003; Rowe & Sherlock, 2005), 3) a plummeting professional self-concept and self-confidence within

NGs without sufficient consideration for the impact of this change on their professional motivations and inspirations (Cowin, 2001; Randle, 2001), 4) hospitals that are severely understaffed, with RNs subsisting within a culture that is resistive to new ideas and burdened by negative attitudes about nursing and health care (Askildsen, Baltagi & Holmes, 2003; Chiha & Link, 2003; Duchscher, 2001; Duchscher, 2003a; Gerrish, 2000; Oermann & Garvin, 2002), and 5) undergraduate educational and employment institutions that do not consistently or comprehensively provide formal knowledge transfer or professional integration programs of support such as undergraduate curricula on transition preparation, seasoned-novice nursing mentorship and preceptorship programs, NG internships or residencies, transition facilitator or NG advocacy initiatives or extended workplace orientations (Duchscher, 2003a; Gerrish; McKenna et al., 2003; Oermann & Garvin).

While the most overt cost to employers may be seen as the replacement of exiting nurses, an even greater cost may be a threat to the health of the public as a whole. Increased patient morbidity and mortality rates are a natural consequence of new and experienced nurse burnout that is secondary to inadequate staffing, job dissatisfaction and the moral dissonance of the practicing nurse (Jackson, Clare & Mannix, 2002; Randle, 2003; Rogers, Hwang, Scott, Aiken & Dinges, 2004). Near-miss research clearly warns of the dangers of expecting GNs to practice without access to experienced colleagues for clinical collaboration and leadership (Ebright, Urden, Patterson & Chalko, 2004; Hall, Doran & Pink, 2004). Finally, limited human resources dictate the immediacy of implementing creative programs that support role appropriation of various nursing professionals for the purposes of optimizing performance throughout all scopes of nursing practice (Aiken et al., 2002; Askildsen et al., 2003; Clarke, 2001; Clarke & Aiken, 2003; Shields, 2004). As a result of deficits in quality nursing-care provision that may be inaccurately represented as primarily commodity-based, the newest inductees into the profession are being recruited and hired into practice areas where decision-making and clinical judgment

expectations exceed the graduates' developmental capabilities (Duchscher 2003b). Graduates are at risk of buckling under the strain of workload expectations that are unprecedented and work environment stressors that have reached unacceptable levels (Duchscher, 2001; Jasper, 1996; Kelly, 1998; Keuter, Byrne, Voell & Larson, 2000).

Purpose and Significance of the Study

The purpose of this study was to explore both the process and substance of the initial 12 month journey taken by NGs making the role transition to professional practice in acute care. The importance of exploring an understanding of the longitudinal process of role transition in nursing relates to the above mentioned challenges for institutions of healthcare, schools of higher learning and policy makers in this country to both understand and respond to issues inherent in the socialization process of NGs to the contemporary professional practice environment. Concurrently, it is the enormous frustration inherent in being unable to practice as fully-functioning professionals within the hospital system that is underlying the current job dissatisfaction of NGs and driving these energetic and motivated young nurses out of acute care and out of the nursing profession altogether (ACHHR, 2002; Baumann et al., 2004; Cowin, 2002; Dearmun, 2000; Winter-Collins & McDaniel, 2000). While it is clear that NGs experience role performance stress, moral distress, discouragement and disillusionment during the initial months of their introduction to professional nursing practice in acute care, it remains unclear what relationships exist between these experiences and the passage of time. As important to the objective of this research are the connections that can be drawn between the challenges faced by NGs practicing in acute care and the broader professional issues being cultivated within the current context of nursing practice.

Reflected in the foundational literature review for this study is limited research that identifies and explicates the stages through which NGs advance during their initial professional

socialization journey. Of the background literature reviewed prior to initiating this research, 54 research studies were found that explored the transition experience to professional practice for NGs. Of those studies, 45% originate from the United States, 20% from Australia and New Zealand, 16% from the United Kingdom, 10% from Canada, and 8% from Europe. Of the 10% of Canadian studies related to this topic, 40% (2 studies) originate with this author. Eighty-two percent of the total number of studies reviewed used a qualitative approach to inquiry. The majority of those studies targeted specific points in time (3, 6, or 12 months postregistration) or accessed retrospective participant reflections to explicate an experiential perspective of the transition experience. Of the 82% of qualitative studies on this topic, only four (10%) focused specifically on NG transition over a period that ranged from 3 to 12 months (Brown, 1999; Dearmun, 2000; Duchscher, 2001; Ellerton & Gregor, 2003). While these studies provided general information regarding the experience of transition, no research could be found that has extrapolated that knowledge to a formal framework for use in the development, implementation and evaluation of initiatives aimed at facilitating the NG transition. This doctoral research sought to further contribute to a substantive theory of role transition to professional nursing practice by distilling and distinguishing the salient, unavoidable and necessary aspects of transition into acute-care nursing from the more transient, context-related and yielding elements of transition for which support strategies can be effectively implemented. The models offered here are the culmination of a program of research and study that has spanned the past 10 years.

Assumptions and Guiding Questions

The first assumption underlying this research was that a role transition to professional practice for the NG Registered Nurse (RN) exists. The second assumption was that this role transition from student to professional practitioner is initially tendered with a perception of hard-earned confidence and feelings of excited anticipation of a new journey then quickly grounded by intense anxiety, guilt, stress and disappointment. The third assumption upon which this study

was based involved the fact that the transition experience of the NG, not unlike all experience, is an evolving and dynamic construct. Finally, this author's prior research and study led to a belief that the first six months, and in particular the first 3-4 months of professional practice are the most traumatic and stressful for the NG.

Several questions guided this work:

1) *What is the experience of the first 12 months of professional practice for the NG RN in an acute-care setting?*

2) *Using previous research and study of the initial transition experience of the NG as a guide to the process of discovery, what particular aspects can be elucidated that both motivate and mediate the experience of professional role transition in this context?*

3) *What common processes exist in the evolving experience of transition for NGs in the initial 12 months of their introduction into the professional practice setting?*

4) *What can be learned about the context of professional nursing practice through the NGs experience of entering professional practice through the acute-care setting?*

5) *At what points during the initial 12 months of professional transition are there significant changes in the experience of the NG and what details might be illuminated regarding these changes?*

Confidentiality and Ethics

The research study was formulated using the *Ethical Guidelines for Registered Nurses*, as outlined by the Canadian Nurses Association (2002) and approved by the supervising university's research ethics board, two university ethics boards at the location origins of the participant groups, and two health region ethics advisory committees. Assurance of

confidentiality regarding information exchanged during interviews (IV) or the reflective journaling (RJ) process was enacted at the time of consent. Code names were chosen by participants and assigned to all forms of data collection to ensure the anonymity of participants. At periodic times throughout the study IV participants were offered the opportunity to challenge or question the interpretation of RJ or IV transcriptions, as well as tentative theoretical conceptualization. While committed consideration was afforded to participants' perspectives throughout the interpretive process, the assurance of "fit" between the emerging theory and the data was determined to be the ultimate responsibility and obligation of the researcher.

Design and Method

Given the knowledge of role transition for the NG, it was felt that further research invited a generic interpretive inquiry approach with the use of grounded theory (GT) strategies for the analysis of emerging stories and themes and for the explication and extrapolation of core and thematic variables. This approach allowed for, facilitated and encouraged a deep and rich representation of the transition experience and ultimately allowed for the creation of a set of models for transition that are informed by and grounded in the ongoing theoretical, conceptual and evidence-based knowledge of the researcher. This study was considered to be a theoretical sampling in a program of research that intends to make evident the emerging GT of professional role transition for the new nurse. This step in that journey attempted to further embed the researcher in the lived experiences of female, undergraduate baccalaureate nursing graduates employed in acute-care practice environments. The qualitative and interpretive nature of the research method and process of analysis reflected a hermeneutic philosophical foundation (Schwandt, 2001). The study context within which these participants were situated, and out of which their experiences were emanating, was highly social and relationally hierarchical. This made the process of accessing relative insights into their experience, understanding the meaning of those insights and representing them through the research interactional and constructivist

(Benzies & Allen, 2001; Charmaz, 2004). The theoretical constructs that influenced and informed the interpretation of the data include role theory (Hardy & Conway, 1988), Benner's (1984) theory of nursing practice competency, Kramer's (1966) theory of reality shock, Bridges' (1991) transition theory, and developmental psychology as it relates to young adult women (Mercer, Nichols & Doyle, 1989; Parks, 2000).

As a researcher, I am a strong proponent of Glaser's (1992) concept of theoretical emergence and adhered closely to its foundational tenets; in particular by consistently and frequently revisiting Glaser's classic question "what is actually happening in the data?", and trusting that emergence would occur. Having said that, my long-standing relationship with the topic and my immersion in the community being studied makes it difficult to deny a constructivist influence upon the process that was used to clarify, verify and explicate the truth of the data interpretations (Charmaz, 2000; 2004). Charmaz elucidates the essential nature of entering the phenomenon being studied, claiming that the researcher's ability to "sense, feel, and fathom what the experience is like" (2004, p. 981) validates the humanity of the participant and gives voice to that which would otherwise remain silent. In the process of interacting with data and its sources, researchers unavoidably shape, and are shaped by that interaction regardless of the point at which they may find themselves on the relational continuum.

This qualitative research study was conducted over a period of 18 months utilizing the following data collection strategies: a demographic information form (Appendix A), a preinterview questionnaire (PIQ) (Appendix B), in-depth interviews (IVs) (Appendix C) and focus groups (FGs) (Appendix D) and reflective journaling (RJ) (Appendix E). Two groups of participants were targeted in two major cities in the province of Saskatchewan and an initial demographic information form was administered to all confirmed participants. In-depth IVs and FGs were conducted and monthly journaling occurred over a period of 12 months. A purposive sample applying a primary selection method was used to secure NG participants (Morse, 1991;

Morse, Barrett, Mayan, Olson & Spiers, 2002). Sampling was limited by the availability of participants. Based on the researcher's previous experience with studies of this nature it was determined that a minimum of 10 participants would adequately serve the purpose and aim of the study. Using this study as a theoretical sampling in the program of research intended to develop a GT on transition necessitated that the participant selection be specific and sensitive to that aim and purpose (Bogdan & Biklen, 1992; Field & Morse, 1985). Criteria for the selection of participants for this study included female nurses who had graduated with a Bachelor of Science in Nursing as their initial degree at a university level. Female nurses were selected based on prior literature which suggested that women's experience in the patriarchal based acute-care hospital setting is different than that of men (Ashley, 1973, 1976; Cleland, 1971; Clifford, 1992; Huston, 1995; Kutlenios & Bowman, 1994; Lovell, 1981; Reynolds, 1995; Roberts, 1983). Participants were selected who had established a minimum of casual status as GNs and were working at least 20 hours per week in a nursing role. This was to ensure a consistent and reasonable exposure to the acute-care working environment for all participants. No age limit was placed on participants choosing to volunteer for the study and all participants were required to speak English as a first language to reduce the variable of language as a barrier to narrative interpretation. All participants volunteering for this study were informed of their right to withdraw at any time and sensitivities to possible issues regarding the research process were attended to by the researcher over the course of the study (e.g., one participant had a particularly negative experience with journaling in her undergraduate education and was exempt from this data collection strategy during the study).

Data Collection

Although there is no formal directive which prescribes techniques or approaches for collecting data when using a GT approach to research (Glaser, 1992, 1998), literature published on the application of the GT method has been almost exclusively in the context of qualitative

data (Creswell, Hanson, Clark & Morales, 2007). The selection of a generic qualitative approach for this study was dictated by the aspects of this topic that were felt to require further explication with regard to their depth and scope at this time. In this study, the researcher was the primary instrument of data collection, interpretation and analysis, and utilized the strategies identified above. Questionnaires were e-mailed to all IV participants three days before the scheduled face-to-face IV (or via Canada Post at least one week prior), and prompted participants to generate a written response in the form of a narratively-based reflective exercise (e.g., write a letter to someone very close to you telling them what the past three months have been like for you as a new nurse). These exercises, while ultimately considered to be rich data themselves, were originally intended to stimulate a reflective thinking process by participants in preparation for the IV. Interview inquiry built on the issues inspired by the PIQs and reflective exercises. Creative strategies were designed for each PIQ, with the purpose of targeting the differentiated styles of participant expression (e.g., participants were asked to draw a picture of themselves as a nurse at one month using magazine or web-source diagrams and art to embody their perceived professional persona and to illustrate the relationship they had to their colleagues).

In-Depth Interviewing

Interviewing in qualitative research has been described as a "conversation with a purpose.... In this context, the participant is the knower, the expert, the teacher [and] the researcher is the learner" (Talbot, 1995, p. 476). Kvale (1996) defined a research IV as "[that which serves] to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena" (p.6). The importance of fluidity and spontaneous expression in research interviewing was the basis for the semistructured format of the guiding questions identified in this study (Bogdan & Biklen, 1992). Each participant was interviewed by the researcher and the IVs were audiotaped and subsequently transcribed. Interviews were held at 1-3-6-9-12-18 months postregistration at a place, on a date and at a time

mutually agreed upon by researcher and participant. The initial IV took place upon initiation of the study sometime between May 15 and June 15, 2005, and after the NGs had successfully completed their national licensure examination. A total of six sequential IVs occurred over the 18 month period and were grounded in transition issues anticipated by the researcher, concerns or issues that had surfaced during the constant comparative analysis (CCA) of journal reflections, and/or data from previous IVs or FG transcripts and reflective journals during the course of this study. Focus group IVs were utilized to explore a deeper understanding of the transition stage that marked that time period, were conducted with participants in another city but from the same undergraduate degree program, and offered further anecdotal evidence to support or refute prior participant IV statements.

Reflective Journaling

Reflective learning is a heuristic process, which progresses the rational-emotive experience to one of insight and perspective (Kessler & Lund, 2004). Boyd and Fales (1983) claimed that "reflective learning is the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective" (p. 99). Journaling was defined in this study as any written (i.e., typed, computer-generated, hand-written, audio-taped) or visual (i.e., computer-generated graphics, video-taped self-reflection or video-produced representations) reflection, and was expected to supplement data acquired through the PIQ and face-to-face IV techniques. Journals were requested by the researcher monthly for the duration of the study, and all journaling participants were contacted at some point during each month of the study to encourage the reflective process, discuss their comfort level with the RJ process, and to answer evolving questions about the study. The format of the reflection was intended to be open, and therefore no restrictions were placed on content or process. Guiding criteria and suggestions for initiating the RJ process were offered to the participants (i.e., spend 30 minutes after each shift talking about

the experiences and feelings brought on both through your work and through your relationships with colleagues and patients during that shift). Further to this, participants were encouraged to explore varying methods of RJ that nurtured their creativity and fostered an open and honest regard for the feelings, thoughts, and events that transpired during the RJ period (e.g., create a collage from clippings and magazine cutouts that represents your last month of being a new nurse – be sure to describe in words what the picture means to you). Participants were encouraged to provide liberal anecdotes to illustrate and provide support for their thoughts and feelings throughout the RJ process.

A most impressive finding was that while the journaling process was initially identified by all participants to be cathartic, facilitatory and both easy and helpful to engage in, many participants were clearly struggling with that same process by the 6^{th}-7^{th} month of their transition experience. By this time in the study process, journals were consistently and almost universally submitted late, had became rhetorical, and were subsequently deemed "empty" by many participants. In exploring this issue further, it was determined that there was a significant reduction in the utilization and effectiveness of RJ as a research strategy for exploring the transition experience after the initial 6 months. This was felt to be primarily due to: 1) an overwhelming physical, emotional, and intellectual exhaustion at about 6 months (well into the second stage of transition) that was further aggravated by thinking and talking about the experience, 2) a need of participants to conserve energy by withdrawing from any further drain on their already waning coping resources, and subsequent attempts to take back the control over their lives that this experience had seemingly extracted, and 3) both a numbing and muting of the experience and therefore expression of transition such that nothing "new" was being revealed to participants.

Focus Groups

Focus groups are an effective method of providing qualitative insights into opinions and attitudes. The advantages include a sense of closeness and common purpose among group members, the combined and internally validated insights of participants, a reduction of participants' inhibitions, needed support for the identification of sensitive issues, and a relatively low cost and time commitment compared to interviews (Fern, 2001). Focus groups have been found to be most effective as a social research tool because they provide for an interactive environment. Such a context enables participants to ponder, reflect, listen, and compare their experiences to others with whom they feel a certain commonality (Krueger & Casey, 2000). This homogeneity fosters group cohesion which in turn supports discussion (Fern). It was important in this data generating method for the researcher to attend to the opportunity for equal participation as this encouraged ease of sharing, facilitated the generation of or validation for thoughts, feelings and ideas, and contributed to the peer-supportive element that was presumed to be particularly helpful to participants in this study (Foulkes, 1964; Milliken & Schreiber, 2001). The intent of utilizing focused interviews in this research context was to acquire data from a group of "like" participants at similar stages in their professional development. The focused interviews followed other data inquiry methods and were therefore guided in their direction by the prior PIQs, RJs, and IVs as well as by the researcher's prior knowledge of the issues inherent in the particular period of transition that correlated with the time of the FG. The framing and construction of the topic areas for discussion in the FGs were further informed by the period-specific transition issues identified in the literature. Finally, data acquired through the use of FGs were used in the CCA of that particular period of the transition experience. While the FGs offered a rich opportunity to revisit certain themes and emerging codes, the sparcity of participants made this technique much less effective. Despite securing numerous participants for the initial two focus groups through phone and email confirmatory communications, and obtaining pre-interview assurance of their presence, only 1 individual showed up for both focus

groups (different individuals each time). While a somewhat time-consuming and ultimately frustrating logistical exercise, the two 'focused interviews' yielded exceptionally rich data. Knowing that the NG is exceedingly consumed by their own experience during those initial months, and given that the potential FG participants did not 'know' or have any face-to-face contact with the researcher, and did not sign a legal consent form prior to their attendance at the FG, the lack of follow-through commitment by these struggling professionals was not entirely surprising. Assessing the logistics of an ongoing commitment to this data gathering process in light of the ongoing difficulty engendering support for participation, the focus group approach was terminated as a researcher strategy after the initial two attempts.

Theoretical Sampling

Theoretical sampling is defined by all grounded theorists as the process of ongoing data collection "whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find it, in order to develop [a] theory as it emerges" (Glaser, 1978, p. 36). The explicit, consistent, and persistent use of theoretical sampling is the distinguishing ingredient of the GT approach to research that sets it apart from other methods. This study was itself a theoretical sampling from the researcher's prior work. Within this particular study, however, theoretical sampling was applied by developing PIQs that were grounded in a synthesis of prior literature, the researcher's two previously conducted major qualitative studies in this area, the researcher's close contact with and knowledge of NG practice experiences, and participants' journaling reflections within the ongoing doctoral study. Further to this, the theoretical directions of the FG question frameworks were generated by the CCA of the study's ongoing indepth IVs and participant RJs.

Given that the researcher is participating in ongoing data analysis for the purpose of building on emerging concepts, a degree of preconception was unavoidable and, in fact

methodologically necessary. The difference between this notion and the forcing of unsubstantiated codes out of the data is grounded in an understanding that the preconceptions have been generated from the author's original data on the professional role transition of NGs into acute care. As such, it is anticipated that ongoing inquiry over time, including that which has been intentionally infused into the design of this study will provide for a natural and fluid emergence of conceptual and theoretical ideas allowing them to develop as well as ground and guide further inquiry.

Coding and Analyzing

The primary strategy in the integrated coding and analyzing stages of the GT theorizing method, and one which is consistently applied despite the researcher's philosophical or research orientation is CCA. This technique of contrasting data first against itself, then against evolving original data, and finally against extant theoretical and conceptual claims facilitates the emergence of knowledge that "provides us with relevant predictions, explanations, interpretations and applications" (Glaser & Strauss, 1967, p. 1). Glaser and Strauss's original GT approach to research clearly places the researcher in the position of patient listener, waiting for the emergent theory with "abstract wonderment" (Glaser 1992, p. 24). Glaser (1998) was quite clear on his sense of the relationship of the researcher to the researched when he stated: "the goal [of GT] is not to tell people what to find or to force, but what to do to allow the emergence of what is going on" (p. 41).

The researcher took into account cautionary notations by Glaser (1978) and Strauss (1987) that drew attention to the rules governing levels of coding. As such, this researcher frequently asked a prescribed set of questions of the data from the onset: 1) what is the data a study of? 2) what category does this line or group of lines indicate? and 3) what is actually happening in the data? The importance of the microanalysis at the outset of the research process was duly noted by

the researcher and exceptional effort was undertaken to re-enter the data time and time again, in various forms, such that the microanalysis could yield a dense, rich theory. As well, due to the researcher's long-standing history with the topic, strategies were employed to safeguard the researcher against "pet" themes and ideas unless they were found to have emergent fit. On several occasions, the researcher sought external (i.e., research process and subject content experts) reviewers of transcripts, requested independent analyses that served to both validate and clarify the researcher's emerging ideas, and returned the thematic analysis to participants for their comments and questions. The natural emergence of theoretical codes came only after repeated re-entry processes of data analysis and ultimately provided the researcher with a consistent sense of two overall emergent cores entitled T*ransition Shock* and *Stages of Role Transition*, with the latter's three subsequent subcore variables identified as D*oing*, B*eing*, and K*nowing*. Further examination of the data assisted in the development of the aspects related to these core variables and processes. Along with an intentionally circular analysis of the relationship amongst established codes the researcher theoretically conceptualized through *advanced coding*, which consists of an explicit process of expansion of the previously coded concepts (Glaser, 1992; Strauss, 1987). Glaser (1978, 1992, 1998) understands this process to be a weaving back together of the necessarily fractured data through the use of a coding framework that assists the research to connect the causes, contexts, contingencies, consequences, covariances, and conditions of an evolving theory.

Memos

Writing memos is a constant, persistent and precedent facet of the GT research process that begins with the initiation of data coding and continues to the very end. This theoretical writing up of ideas, separate from the data focuses on relationships between codes and their properties as they become evident to the analyst; memo writing "captures the frontier of the analyst's thinking" (Glaser, 1978, p.83). Although memoing occurs throughout the research

process, Glaser adamantly warned researchers that "if the analyst skips this stage by going directly from coding to sorting or writing he is not doing grounded theory" (p. 83). The unequivocal importance of this stage in the approach to this research was underscored by frequent interruptions of the research process during which the researcher engaged in theoretical and conceptual reflection. A dictaphone was carried by the researcher and notes were made daily at times. For this researcher, memoing consisted of idea noting, drawing and writing that culminated in exhaustive pages of notes that explicated theoretical ideas, raised the data to a conceptual level, developed properties and aspects of each code and category, and hypothesized about connections between concepts, codes and categories of the emerging theoretical models. Ongoing publications by the researcher and exhaustive professional speaking engagements on the topic of NG transition as they related to the researcher's evolving findings, as well as the development of a new nonprofit Canadian nursing organization for NGs assisted in the coalescence over time of the emerging ideas.

Researcher Field Notes

Field notes are a "written account of what the researcher hears, sees, experiences, and thinks in the course of collecting and reflecting on. . .data" (Bogdan & Biklen, 1992, p.107). In order to differentiate the researcher's field notes from memos and thus optimize the application of both strategies, an intentional effort was initially made to restrict the use of field notes to research reflections, while memos were used to expand and explicate theoretical and conceptual thoughts and ideas relative to the study's emerging core variables (Stern & Covan, 2001). As the research process unfolded, however, it became increasingly difficult and perhaps even obtrusive to distinguish between stages, phases and methods by which theoretical emergence was facilitated and a decision was made to merge the process of generating field notes and memos. This facilitated a more fluid and less contrived representation of evolving ideas.

Detailed notes were made following all IV and FG sessions, upon receipt of all RJs, and at frequent intervals during the research process. Observations about behavioral and emotional responses of both the participants and the researcher were recorded, allowing these notes and memos to be an accurate methodological and process data trail that assisted in establishing rigor of the research and contributing to the ultimate trustworthiness of the study. Researcher field notes were utilized to reflect on personal and professional biases and preconceptions with the intent to make transparent their potential influence on interactions with the data. Further to this, memos facilitated the ongoing theoretical and conceptual emergence. This process of attempting to suspend, or at least recognize and explicate conceptual and theoretical preconceptions was incorporated into the research process prior to data collection and during interpretation of the participant PIQs, IVs, FG discussions and RJs (van Manen, 2003). An interesting shift in the research process occurred at the end of data collection as the researcher moved more toward the establishing of formalized theoretical images and specific paper outlines in an effort to elevate the conceptual ideas to that which could be logically and structurally embodied and articulated. There was less need to depend on existing research frameworks to ensure the explication of what was becoming known through the data and it seemed natural to modify reflexive strategies as the overriding themes and core theoretical variables emerged.

Data Interpretation

Constant Comparative Analysis

In applying a GT approach to this research, data collection and analysis became overlapping interpretive processes (Glaser & Strauss, 1967). According to van Manen (2003), as lived experience becomes a description of a particular phenomenon the researcher takes on specific responsibilities in transforming information. Each individual PIQ, IV, FG, and RJ entry was subjected to a CCA method developed by the researcher through the modification of

techniques used by Glaser (1992; 1998), Glaser and Strauss (1967), and Strauss and Corbin (1998): 1) the researcher reflected on all PIQ, IV, and FG guiding questions as they related to the researcher's theoretical and conceptual knowledge and research experience with NGs, 2) all raw data was transcribed and placed into a data management program (QSR NVivo ™), 3) all data was subjected to a line-by-line, incident-by-incident and paragraph-by-paragraph analysis and initial codes were assigned, 4) through the process of multiple manual and computer-generated coding processes data from PIQs, IVs, FGs, and RJs were compared and contrasted for similarities and differences as well as for conceptual interrelationships, 5) as codes proliferated (652) the researcher ultimately collapsed and integrated them into elevated categories or subsumed code aspects, 6) formulated categories were further organized into themes and the researcher maintained an awareness at all times of the emerging core variables of theoretical emergence (*Stages of Transition* and *Transition Shock*), 7) meaning (detailed descriptions of significance) was ascribed to data sets at multiple levels as the research process advanced, 8) member checks were used periodically throughout the analysis process to ensure credibility of the interpretations and to balance rigor with the preservation of the researcher's connection with the original narrative, 9) the researcher made note of and considered all participant challenges and questions regarding emerging aspects, codes, categories, themes, and core variables, 10) an exhaustive description of the emerging theory was produced, and 11) an essential structure of the participants' experience of role transition was explicated.

Throughout the research process, emerging concepts and categories were compared against the original data and established conceptualizations (Milliken & Schreiber, 2001). Further to this, the researcher negotiated internally with participants and externally with content and research process experts for the purpose of explicating basic social issues inherent in the role transition experience that were theoretically and conceptually sound, made sense to participants and spoke both from and to the data (Glaser, 1978). Having said this, the researcher recognized early that

patterns hidden in the data were not always easily reducible to technique. There was a creative and personal process occurring that May (1994) described as mystical: "Technique and rigor...cannot entirely explain what moves the analyst from confusion to insight, from chaos to order, and from simple description to understanding. The product is shaped, but *not completely defined* [original emphasis] by the process through which it was created" (p. 14).

Constructive Rigor

Without rigor "research is worthless, becomes fiction, and loses its utility" (Morse et al., 2002, p. 2). Constructive rigor, or the introduction and ongoing monitoring of strategies to establish and maintain research process credibility allows the researcher to identify serious threats to reliability and validity before the ethics of the research process have been compromised and the credibility of the findings put into question. This study optimized rigor by attending to the aspects of credibility, auditability, and fittingness (Chiovitti, 2003; Morse et al.).

According to Beck (1993), *credibility* is a term that relates to "how vivid and faithful the description of the phenomenon is" (p. 264). Ascertaining trustworthiness in GT research findings centers on whether the substantive codes, categories, themes and core variables accurately reflect the data from which they came (Carpenter-Rinaldi, 1995). With respect to credibility, the researcher: 1) let the participants' experience of transition guide and evolve the inquiry process, 2) checked emerging theoretical constructions against participants' intended meaning of the phenomena, 3) used participants' actual words in the naming of theoretical constructs whenever possible, 4) articulated and reflected upon personal views and theoretical insights about phenomena explored, and 5) remained open to both internal and participant bias and sensitive to the possibility of new ideas by thinking theoretically, creatively and insightfully when comparing data with itself and with extant literature, and relinquished ideas that were poorly supported (e.g., stages and timing). This abstracting, analyzing, synthesizing and iterating of theoretical concepts

was optimized through exhaustive and critical theoretical memoing and field notations, and by maintaining an explicit research audit trail (Beck; Chiovitti, 2003; Locke, Spirduso & Silverman, 1993; Miles & Huberman, 1984; Morse et al., 2002; Strauss & Corbin, 1998).

Auditability refers to the capability of another researcher to follow the methods and conclusions of the original researcher (Carpenter-Rinaldi, 1995). Beck (1993) described it as the consistency of the research study demonstrated by virtue of a transparent audit trail of decisions made at every stage of data analysis. As suggested by Chiovitti (2003), the criteria for decisions around data analysis came primarily from asking the following questions: 1) what is happening in the data as a whole? 2) what is being conceptually represented by this particular narrative? 3) is the conceptual label part of the participant's vocabulary? 4) in what context is this particular code being used by the participant? 5) is the code related to another code? and 6) are there other codes that reflect similar patterns? (see also Glaser, 1978; Strauss, 1987).

Fittingness, also referred to as *transferability*, pertains to the probability that the research findings will have meaning to others in similar situations (Carpenter-Rinaldi, 1995) or "whether a working hypothesis developed in context A might be applicable in context B" (Lincoln and Guba, 1985, p. 124). Making a decision on the transferability of findings is largely influenced by the quality of information one has about both contexts. This base of information can be offered to prospective readers through what Lincoln and Guba refer to as a "thick description....that must specify everything a reader may need to know in order to understand the findings" (p. 125). The parameters and theoretical aspects of this research project relative to the sample, setting and nuances of the evolving stages of theory generation were clearly articulated in the proposal and will be explicated during publications whenever possible.

Summary of Findings

Paper #1 – The experience of transition shock: Understanding the initial stage of adaptation to acute-care professional practice for newly graduated Registered Nurses

Transition shock was the initial core variable to emerge from the data analysis, and did so almost immediately and quite dramatically. While I did not set out to rewrite Kramer's (1974) reality shock theory, the unrelenting presence and significance of the findings granted me the confidence to move forward with a cautious sense of clarity and a deep level of conscience that served to empower rather than dissuade the development of this idea. The theoretical construct of transition shock focuses on the antecedents (aspects of the new graduate's roles, responsibilities, relationships and knowledge) that both motivate and mediate the intensity and duration of the experience and qualify the early stage of professional role transition for the NG. The detail offered in relation to these antecedents is intended to facilitate a more comprehensive use of the model by identifying multiple root issues and events through which the transition experience might be further understood and supported.

This work builds and expands on Kramer's (1974) theory by demonstrating that the NG engaging in a professional practice role for the first time is confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural changes that are both expressions of, and mitigating factors within the experience of transition. These factors may be further aggravated by unfamiliar and changing personal and professional roles and relationships as well as unexpected and enhanced levels of responsibility and accountability that students are unable to be afforded during their education. Further to this, the current assumption underlying the contemporary transition experience is that NGs will be able to apply clinical knowledge to a new context of practice that may be as yet untried, may be contextually unrecognizable to the

novice practitioner, or may be simply unknown. An impressive finding and one which serves as a core variable in the experience of transition shock is the "surprise" expressed by participants as they move into a professional workplace role. The predominance of this variable reveals an inadequacy in the preparation of senior students for the reality of the transition experience. Furthermore, the extent of the struggle to adjust to their new reality, and the fact that while the experience qualitatively changed over time but did not significantly abate by the 12 month mark of their transition, suggests that insufficient orientation and support existed for these new professionals in the workplace.

Paper #2 – A process of becoming: The stages of new nursing graduate professional role transition

Elucidating and then edifying the stages of role transition that occur for the NG during the initial 12 months of their introduction to professional practice was the intended focus of this dissertation. It seemed a natural paper to write, and indeed emanated fluidly from both a theoretical and representative (i.e., model) perspective. The theory of transition presented in this paper incorporates a journey of *becoming* where NGs progressed through the stages of *doing*, *being* and *knowing*. The initial 3-4 months of the NGs' journey is an exercise in adjusting and adapting to, as well as accommodating what they find in the realities of their new work, professional and life worlds. For participants, there was little energy or time to lift their gaze from the very immediate issues or tasks set before them, and their "shock" state demanded a concerted focus on simply "surviving" the experience without revealing their feelings of overwhelming anxiety or exposing their self-perceived incompetence.

The second stage of professional role transition for these participants encompassed the next 4-5 months of the NGs' postorientation period and was characterized by a consistent and rapid advancement in their thinking, knowledge level and skill competency. As this period

progressed and the NGs gained a comfort level with their professional roles and responsibilities, they were confronted by inconsistencies and inadequacies within the healthcare system that served to challenge their somewhat idealistic pregraduate notions of the profession. An increased awareness of the divergence between their professional "self" and the enactment of that self in their new role motivated a relative withdrawal of the NGs from their surroundings. The primary task for these graduates at this stage was to make sense of their role as a nurse relative to other healthcare professionals and to find a balance between their personal and professional lives. The third and final stage of evolution for these nurses during the initial 12 months of their careers was focused on achieving a separateness that both distinguished them from the established practitioners around them and permitted them to reunite with their larger community as professionals in their own right. With an increase in both familiarity and comfort in their nursing roles, professional responsibilities and relationships with coworkers, the NGs had the time and energy to begin a deeper exploration and critique of their professional landscape, making visible the more troubling aspects of their sociocultural and political work environments. Likely fed by a residual exhaustion from prior stages, the majority of these NGs expressed a growing dissatisfaction with shiftwork, the conditions of their work environment and their relative powerlessness to effect change within that environment. For some, this was simply a case of adjusting to the work world for the purpose of achieving a sense of job satisfaction. For others, sacrificing particular professional expectations and aspirations and conceding to what they perceived as inadequacies in the system within which they would spend their life working was terminally demotivating and inspired a search for alternate avenues of professional fulfillment (e.g., changing employment, leaving the province and country, making plans to return to school or disengaging from and exacting a distinct separation between work and home life).

The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering,

exploring and engaging. While this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. Further to this, data manifested ongoing but transient regressions precipitated by the introduction of new events, relational circumstances and unfamiliar or complex practice situations or contexts into the graduates' assumed location on the transition continuum that is represented by the stages model presented here.

Paper #3 – Heroes of their own story: New graduates in acute care

Perhaps the most unanticipated, but undoubtedly the most fulfilling interpretive outcome of this dissertation was the gentle but persistent "voice" of the new graduate that insisted on being heard. While it became clear through the process of my research and study over the last 10 years that NGs experience role stress, moral distress, discouragement and disillusionment during the initial months of their introduction to professional nursing practice in acute care, it was unclear just what the relationship was between these experiences and the passage of time. Furthermore, only one study was located that sought to tell the story of the new graduate journey into professional practice (Penney, 2000) and no literature was found that did so with an intent to explicate the stages through which NGs advance during their initial professional socialization journey. The first-person narration of the story of transition as told by me through the shared experiences of these participants was, in many ways the most illuminating, clarifying and crystallizing act of data analysis that I undertook. Interestingly, it was the last of the formal iterative processes to come out of my doctoral research and perhaps unexpectedly for me, engendered little change in the original theoretical conceptualizations presented in the prior two papers. For a variety of logistical reasons, I did not engage in an intentional review of any one of the previously written papers prior to, or during the writing of another. This seemed particularly significant during this final work. As I immersed myself yet again in the account of the study participants, I did so with the conscious intent of not only speaking on their behalf, but choosing

quite deliberately which of the over 3500 pages of transcripts best represented their collective voice in relation to a particular process, issue, event or period of time. All the narratives presented in this paper were painstakingly selected. As onerous a task as that might seem, it was truly the easiest writing I did during this dissertation. One might reasonably conclude that the ease of this final venture was directly related to my intimate knowledge of the transition experience born of a long-standing relationship with the topic. Alternatively, it could be argued that the comfort afforded this process was a result of the "up-close-and-personal" connections I had established with the data over the course of writing the prior two papers. Upon reflection however, I feel more confident that the relative effortlessness of this act was a manifestation of the living nature of the story; it was simply there, clear and present, waiting for me to find it.

The story of transition presented here is a composite of the narrative shared with me by the participants over an 18 month period. As illuminated in the prior papers, this story exposes a staged, mostly progressive and nonlinear process whereby the graduates explored, discovered, engaged, separated, critiqued, embraced and endured their transition to professional nursing practice. Perhaps the compelling nature of this story is that it poignantly illustrates a proverbial "coming of age" and as such, resonates in some way, at some level with all of us. There is the excited anticipation of arriving at a long-awaited and hard-earned goal to realize, as in this case that "it's just a job, like every other job" you've ever had. While embarking on a professional life has its moments it is often ultimately revealed to be more reality than romanticized fiction - more bee than honey. This account reflects the age-old adage that "all is not as it seems" or, more to the point what we dreamed; this is a story about growing up.

Contribution to Nursing

Transition Theory

The theoretical construct of NG transition that currently frames and supports the planning, development, implementation and evaluation of educational preparation for transition and workplace enhancement initiatives, orientation and facilitation programs for new nurses is based on antiquated research that may not comprehensively represent the contemporary professional nursing and healthcare organizational contexts within which transition is taking place (Kramer, 1974). While there is research that discusses and illuminates the experience of transition (Dearmun, 2000; Duchscher, 2001; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Schoessler & Waldo, 2006) and numerous authors have provided insight into the various elements inherent in making one's initial role transition into nursing (Amos, 2001; Andersson, Cederfjall & Klang, 2005; Brown, 1999; Casey, Fink, Krugman & Propst, 2004; Chang & Hancock, 2003; Charnley, 1999; Clare & VanLoon, 2003; DeBellis, Longson & Glover, 2001; Delaney, 2003; Duchscher, 1998; Gerrish, 2000; Godinez, Schweiger, Gruver & Ryan, 1999; Goh & Watt, 2003; Horsburgh, 1989; Jasper, 1996; Kapborg & Fishbein, 1998; Kelly; Kilstoff & Rochester, 2004; Oermann & Garvin, 2002; Ross & Clifford, 2002; Thomka, 2001; Tiffany, 1992; Walker, 1998; White, 1996; Whitehead, 2001; Winter-Collins & McDaniel, 2000; Wong, Lee & Wong, 2000), only four have attempted to elucidate the journey of transition and its stages (Duchscher; Dearmun; Kelly; Kramer).

The outline of stages provided by Dearmun (2000), while congruent with Kramer (1974) and Duchscher's (2001) research in many ways, has unaccounted for "lapses" in time (e.g., the first stage is identified as lasting three months, the second stage begins at approximately six months, and the final two stages are not specified in terms of their time-periods) that make the

theoretical findings difficult to strategically apply and effectively utilize in practice. While Kelly (1998) offered an overview of evolving conceptual themes of transition that mirrored the above work, her writing did not explicate time periods for what she identifies as transition "stages"; did not identify motivating or mediating factors for movement from one stage to the next, and; blurred processes with events in the experience of the NG. Kelly suggested that "coping with moral distress" [p. 1140], "alienation from self" [p. 1140], and "coping with lost ideals" [p. 1139] are distinct "stages of transition" rather than evolutionary processes of professional self-concept development which are, themselves, only one aspect of the journey of transition.

Kramer provided an exhaustive conceptual and theoretical description of the NG experience of transition in the 1960s, and offered detailed suggestions for the resolution of many of the negative aspects of the NG professional role transition through a process of pre and postgraduate socialization. Unfortunately, she did not delineate the time periods over which her stages occur and this lack of correlation could make the application of her transition resolution strategies an overwhelming exercise for NG supporters. Specifically, employers are looking for application-ready frameworks into which they can efficaciously incorporate existing NG support structures, or develop and then integrate initiatives that can address relatively predictable needs. The models of *Transition Shock*© and *Stages of Transition*© that have been developed through this research offer new graduates, seasoned nurses, nursing managers and educators, and healthcare administrators a theoretically comprehensive, time-specific, process-oriented framework for understanding and supporting the introduction of new nursing professionals to their acute-care careers. Given the current concerns around our ability to attract and retain qualified and committed nurses to the profession, and given the time and fiscal limitations within which most institutions are working these models offer a relatively accurate means of enhancing the cost and outcome effectiveness of targeted supports that attend to the right issue at the right time with the right approach. As was articulated in the feedback of this participant:

> I was able to read the papers you wrote. I thought they were exceptionally well done. Most of the things in the papers related to exactly what I was going through at each time period. I really liked the biography one, it was like someone was writing exactly what my experience was like during my first year as a nurse. I think you hit everything right on. I am excited to see the end results.

Nursing Knowledge and Practice

The provision of quality health care depends upon the quality of the nursing work environment and the extent to which the hospital environment empowers nurses to deliver a high standard of care (ACHHR, 2002; CIHI, 2003). With as many as 33-61% of new recruits changing their place of employment or poised to leave nursing altogether within the first two years of professional practice (ACHHR; Bowles & Candela, 2005; Buchan & Calman, 2005) and less than 50% of practicing nurses willing to recommend nursing as a career option (Heinrich, 2001), the cost to employers and the risk to patient safety resulting from an inadequate supply of this vital health human resource is prohibitive (Lin & Liang, 2007). While the demand for nurses is growing much faster than the rate at which NGs are entering the workplace, the healthcare community at large has yet to satisfactorily address the issues underlying the suboptimal quality of the nursing workplace (PricewaterhouseCoopers, 2007; Ulrich, Norman, Buerhaus, Dittus & Donelan, 2005). Maximizing nursing work means changing the practice framework from one of task mastery to one of decision-making and clinical judgment that empowers nurses to identify and then interdependently manage patient care issues (Kovner, Brewer, Wu, Cheng & Suzuki, 2006; Laschinger, Almost & Tuer-Hodes, 2003; Laschinger, Finegan, Shamian & Wilk, 2003). Concurrently, we know that being able to maintain a personal and professional life balance along with being supported to enact prized professional values in the practice environment are variables that determine the job satisfaction, role fulfillment and intent to stay in the workplace of the newest generation of health professionals (Coomber & Barriball, 2006; Laschinger, Finegan & Shamian, 2001; PricewaterhouseCoopers). Understanding what our graduates

experience when they reach the professional practice environment provides us with insight into what is working and what might be missing in existing undergraduate preparatory education, workplace orientation and transition facilitation programs. While it is accepted practice to "teach to the ideal" of what we would like practice "to be," there is no denying that graduates must be equally prepared to manage what "is." This unavoidable tension between industry (i.e., real or actual practice) and education (i.e., ideal or strived for practice) cultivates a significant component of the professional role transition experience. The theoretical frameworks and conceptual models developed through this research can serve as tools that inform and guide educational and healthcare service sectors about what is required to prepare a graduate for the realities of work and what facilitates a healthy professional role transition for new nurses. In doing so, we may better understand and be able to accurately and adequately promote, an optimal work environment for all nurses.

Research Program Plans

During the next phase of my scholarship, I will continue to develop a program of research in transition that incorporates the following projects:

1) Develop an overlying framework of transition facilitation strategies that address the various stages of NG transition.

2) Develop and implement an undergraduate transition preparation course:

    a) Develop the core curriculum for, and teach an undergraduate course that seeks to prepare the pregraduate for the role transition to professional practice, utilizing regional industry-based seasoned practitioners and nursing unit managers as anticipatory socialization agents.

    b) Coordinate the development of a transition facilitation program within an acute-care center.

c) Implement and evaluate the impact of 1) transition preparation, 2) transition facilitation, and 3) both transition preparation and facilitation on the professional role transition experience of the NG into acute care.

3) Explore the professional role transition into acute-care nursing of students completing a second undergraduate degree in nursing (Accelerated BScN Program).

4) Explore the experience of male NGs making their initial entry into professional practice.

5) Explore the experience of NGs making their initial transition into professional practice within a rural health setting.

6) Explore the transition experience of mature nurses who are reentering the professional nursing workforce after an extended period of professional practice inactivity.

7) Explore the experience of professional role transition for the Licensed Practical Nurse (LPN) in acute care.

8) Using the nursing transition model developed here as a framework, examine the evidence related to the transition experiences of other professional disciplines. Compare existing evidence and begin a program of research with the intent to develop a larger theoretical construct that encompasses the whole of professional role transition.

Appendix A

Demographics Data Form

Personal Information

Participant Name:_____

Selection of Code Name: _____

Age:_____ Total # Weeks as a Registered Nurse:_____

City and Unit of Employment:_____

Type of Nursing Unit (i.e. burn unit, orthopedic surgery, cardiology):

_____

Married:_____ Single:_____ Divorced:_____ Children:_____

Work History

Places Employed	Nursing Role	Status (FT/PT/Casual)

Do you think that your previous work experience is currently assisting you in your new role as a Registered Nurse?

YES_____ NO_____

If YES, how is it assisting you?

Why did you choose this particular unit to begin your professional nursing career?

Orientation Phase

How long was your orientation period on this unit?

What did your orientation consist of?

1) ***Classroom Teaching***

Please Provide Details of what you were taught the length of the classroom sessions:

2) ***Buddy Experiences***

Tell me as much as you can about the nurse with whom you were buddied:

3) ***Mentorship or preceptorship***:

What do these terms mean to you?

Mentor

Preceptor

How were you mentored or preceptored as a new graduate:

3) ***Other Orientation Experiences***:

Was there anything else involved in your orientation that we missed?

Appendix B

Pre-Interview Questionnaire for ***1 Month***

1) What is your current level of stress working as nurse?

Low _____
Moderate _____
High _____

2) What stresses you the most?

3) What do you do to relieve your stress?

4) What do you find **most** satisfying about working in your current job?

5) What do you find **least** satisfying about working in your current job?

6) What do you find **most** satisfying about working with the senior nurses on this unit?

7) What do you find **least** satisfying about working with the senior nurses on this unit?

8) Have you ever thought about leaving this nursing unit?

YES_____ NO_____

If **YES**, what are the reasons that would cause you to leave?

If **NO**, what is it that keeps you here?

Preparation for 1 Month Interview:

Draw a picture of yourself as a nurse right now. Include in your drawing the people that you work with (physicians, nurses, aides, unit clerks, other professionals you can think of). Feel free to use a 'cut and paste' approach from magazines if this helps you.

Please bring this pre-interview questionnaire and the illustration this with you to the interview.

Appendix B

Pre-Interview Questionnaire for ***3 Months***

1) What is your current level of stress working as nurse?

Low _____
Moderate _____
High _____

2) What stresses you the most?

3) What do you do to relieve your stress?

4) What do you find **most** satisfying about working in your current job?

5) What do you find **least** satisfying about working in your current job?

6) What do you find **most** satisfying about working with the senior nurses on this unit?

7) What do you find **least** satisfying about working with the senior nurses on this unit?

8) Have you thought about leaving this nursing unit?

YES_____ NO_____

If **YES**, what are the reasons that would cause you to leave?

If **YES**, what would have to happen for you to stay?

If **NO**, what is it that keeps you here?

9) Since you graduated, have you ever thought about leaving **NURSING altogether**?

YES_____ NO_____ WHEN did you think that?_____

If **YES**, what are the reasons that would cause you to leave nursing?

If **YES**, what would have to happen for you to stay?

If **NO**, what is it that keeps you here?

Preparation for 3 Month Interview:

Write a letter to someone very close to you. Tell them what the past 3 months have been like for you as a new nurse. Give examples that illustrate your feelings. Don't censor yourself – say whatever comes to your mind and whatever is in your heart. Please bring it with you to the interview.

Appendix B

Pre-Interview Questionnaire for ***6 Months***

1) What is your current level of stress working as nurse?

Low _____
Moderate _____
High _____

2) What stresses you the most?

3) How are you currently feeling about being a nurse in the hospital?

4) What do you find **most** satisfying about working in your current job?

5) What do you find **least** satisfying about working in your current job?

6) Is there a particular nurse you have connected with on the unit where you work?

YES_____ NO_____

If **YES**, what is it about that nurse that connects with you?

7) Are you thinking about leaving this nursing unit?

YES_____ NO_____

If **YES**, what are the reasons you want to leave?

If **YES**, what would have to happen for you to stay?

If **NO**, what is it that keeps you here?

8) Since the last interview, have you ever thought about leaving **NURSING altogether**?

YES_____ NO_____ WHEN did you think that?_____

If **YES**, what are the reasons that would cause you to leave nursing?

If **YES**, what would have to happen for you to stay?

If **NO**, what is it that keeps you here?

Preparation for 6 Month Interview:

Think of one clinical situation in the past 3 months (since we last met) that made you feel really good as a nurse – write it down and remember as much about it as you can (what happened, how did you feel, how did your thinking contribute to this situation, what would you change next time to make it easier). Now, think of a situation that made you feel badly as a nurse. Give as much detail about that situation as you can (what happened, why did you feel bad, how did it affect you as a nurse?)

Appendix B

Pre-Interview Questionnaire for ***9 Months***

1) What is your current level of stress working as nurse?

Low _____
Moderate _____
High _____

3) How are you currently feeling about being in the nursing profession?

4) What do you find **most** satisfying about being a nurse?

5) What do you find **least** satisfying about being a nurse?

6) What plans do you have for yourself in the nursing profession?

7) Do you ever thinking about leaving this nursing unit?

YES_____ NO_____

If **YES**, what are the reasons you want to leave?

If **YES**, what would have to happen for you to stay?

8) Have you thought about leaving nursing?

YES_____ NO_____

If **YES**, what are the reasons that would cause you to leave nursing?

What would you do if you left nursing?

Preparation for 9 Month Interview:

You are speaking to a new nurse who has just graduated. What will you tell that nurse about what it is like in the 'real' world? Use both your thoughts and feelings as you describe nursing. What advice do you have for that nurse about the first 6 months of their practice as a professional?

What 3 things would you have liked to change about that experience for yourself?

Appendix B

Pre-Interview Questionnaire for 12 *Months*

1) What is your current level of frustration working as nurse?

Low _____
Moderate _____
High _____

2) What is the ***one*** thing that frustrates you about being a nurse right now?

3) What do you most enjoy about being a nurse?

4) What do you want to do with your career?

5) Over the past year, did you ever thinking about leaving nursing?

YES_____ NO_____

If **YES**, what were the reasons you wanted to leave?

6) What was the one thing you loved most about the move from student to nurse?

7) What do you know about the healthcare system now that you didn't know when you graduated?

8) Is there anything we might have done for you ***during your nursing education*** to assist you to make the change from being a student to being a professional nurse?

9) Is there anything we might have done ***in the hospital or on your nursing unit*** that would have made the initial transition to being a nurse easier?

10) What was the most difficult part of becoming a professional nurse?

11) Talk about one memorable moment in your nursing career so far?

12) What fosters your hope in the nursing profession?

13) What drains or erodes your hope in the future of the nursing profession?

14) What would it take to increase your hope in the nursing profession?

Preparation for 12 Month Interview:

You are asked to design a 4th year nursing course that will prepare senior nursing students to nurse in the 'real' world? What would be the content of that course, how would you teach it, and when would it start?

What are the two things that most supported you (or that WOULD HAVE most supported you if you had access to them) in the first year of your practice as a nurse?

Appendix C

In-Depth Interview Guide for ***1 Month***

1) How does it feel to be out of school?

2) What is it like to be a newly graduated nurse?

3) What does a day at work consist of for you?

4) What is the biggest different for you between being a professional nurse and being a nursing student?

5) How prepared were you to be out in the 'real' world.

6) How is the real world different than what you knew as a student?

7) How has your life outside work changed since you graduated?

8) What is the most difficult adjustment for you right now?

9) What are you most nervous about at work right now?

10) Who are your current support systems?

11) What disappoints you the most about your role as a practicing nurse?

12) What is the unit like where you work? Tell me about the people who work there.

13) What kind of a relationship do you have with the Nursing Unit Manager?

Appendix C

In-Depth Interview Guide for ***3 Months***

1) How are you feeling?

2) What has changed for you over the past couple of months?

3) What is it like to be a nurse after 3 months?

4) How are you balancing your worklife and your homelife?

5) Tell me about your relationships at work.

6) What is it like working with the physicians on your unit?

7) Who do you feel most comfortable around at work?

8) What is a typical shift like for you?

9) Recount an example of a clinical situation that was beyond what should have been expected of you – that made you feel uncomfortable?

10) What is different in your role as a nurse, or in your work, than you thought it was going to be when you were a student?

11) What is your greatest fear as a new nurse?

12) Is it OK to ask questions on your unit? Can you tell me what a typical question might be for you right now?

13) What do you think other nurses and your manager expect of you?

14) What is exhausting you the most right now?

15) Recount a clinical situation that went really well recently? Tell me about it.

16) Recount a clinical situation that went poorly – why did it go poorly and how did it make you feel about yourself as a nurse?

17) Is there anything you need right now that you are not getting?

Journaling and Pre-Interview Questionnaire Reflections

Appendix C

In-Depth Interview Guide for ***6 Months***

1) What is it like to be a nurse?

2) What has changed for you over the past 3 months?

3) If you could have just one thing to make this an easier time for you, what would it be?

4) What changes have you noticed in your thinking over the past several months?

5) What is different about your practice now that you have been nursing for 6 months?

6) What is it about the nurses on your unit that you find most welcoming? What do you find most intimidating?

7) What the culture of your nursing unit like?

8) What do you think about when you think about nursing as a profession? Has your view of the profession changed?

9) What really bothered you when you first started, but that you feel more comfortable with now? What changed your perspective on that?

10) What do you not enjoy about being a nurse?

11) Are there differences between what you thought you would be doing as a nurse and what you are actually doing?

12) Do you have someone that you can go to for advice on clinical situations? Are they on the clinical unit where you work? Do you work consistently with them? How important is it to have someone to go to?

13) Are you encouraged at work?

Journaling and Pre-Interview Questionnaire Reflections

Appendix C

In-Depth Interview Guide for ***9 Months***

1) How have you changed as a nurse since you graduated?

2) How was the practice of nursing in the real world different than you expected?

3) What it is like to work with the physicians on your unit.

4) Are nurses given the opportunity to practice to their full potential? If not, why not?

5) What feelings were prominent for you at the very beginning of your transition?

6) What was the most difficult time period after you started working?

7) What qualities do you most admire in the nurses around you?

8) What about the nursing practice that you see around you most concerns you?

9) What dialogue has transpired between you and other new graduates? Has this been a strong support for you? What is your impression of the experience of the other new graduates with whom you have communicated?

10) What are the differences between school and work? How have you come to terms with these differences?

11) What aspects of professional nursing do you like least? How are you coming to terms with those aspects of your profession?

12) How do nurses relate to other nurses?

13) Do you think there are differences between the way particular age groups approach nursing and work? What differences have you noticed?

Journaling and Pre-Interview Questionnaire Reflections

Appendix C

In-Depth Interview Guide for ***12 Months***

1. Now that you have been nursing for a year, do you feel any different about yourself?
2. Do you think others feel differently about you? Why?
3. How does the healthcare system feel about nurses?
4. In what way are you respected as a nurse in the hospital?
5. What is lacking in the relationship between nurses and the hospitals where they work?
6. How do nurses relate to other nurses?
7. Over the past year, what has been the most influential experience you have had as a nurse?
8. Is there anyone with whom you work who reflects the values of nursing you aspire to? Tell me about that person.
9. What do you think about your profession now?
10. What plans do you have for your nursing career? How do these plans intersect with your personal plans?
11. What has changed most about your nursing practice over the past year?
12. How has your life been influenced by your role as a nurse since you graduated?
13. What was the most difficult aspect of making the transition from student to nurse?
14. What 2 things would you change to make the transition easier?

Journaling and Pre-Interview Questionnaire Reflections

Appendix D

Focus Group Guide for ***1 month***

1) How does it feel to be out of school?

2) Where are all of you working right now?

3) What do you focus on at work?

4) What is the biggest difference between being a professional nurse and being a nursing student?

5) What is the most difficult adjustment for you right now?

6) What do you need most right now?

Reflections from Interviews

Appendix D

Focus Group Guide for ***3 months***

1) What is going on for you right now?

2) What has changed over the past couple of months?

3) What is your greatest challenge at work right now?

4) How would you characterize your relationships with physicians and other nurses?

5) What is the primary difference between what you thought nursing was going to be and what it is?

6) What is exhausting you most right now?

7) What are your greatest fears right now?

8) What is most satisfying for you right now?

Reflections from Interviews

Appendix D

Focus Group Guide for ***6 months***

1) What is nursing?

2) What has changed for you over the past couple of months?

3) What is your greatest challenge at work right now?

4) How do you deal with complex clinical situations? Have you noticed a change in your thinking?

5) What did you learn in your nursing program that you most apply right now?

6) What did you learn in your nursing program that seems unavailable to you now?

7) What is it like to go from being a student to being a nurse?

Reflections from Interviews

Appendix D

Focus Group Guide for ***9 months***

1) How have you changed since you graduated?

2) What is the focus of your career right now?

3) Do you think nurses practice to their full potential in the hospital?

4) What is the nature of the relationships between doctors and nurses in your hospital?

5) What was the most difficult time for you after you graduated?

6) What do you most love about nursing? What most concerns you?

7) Tell me about the nurses you work with.

Reflections from Interviews

Appendix D

Focus Group Guide for ***12 months***

1) Now that you have been nursing for a year, how are you different as a nurse and as a person?

2) What is the focus of your career right now?

3) In what way(s) are you respected or disrespected as a nurse?

4) What has changed most about your practice over the past year?

5) What experience from the past year stands out most for you?

6) What was the most difficult aspect of moving from being a student to being a nurse?

7) What 2 things would you change to make the transition easier?

Reflections from Interviews

Appendix E

Reflective Journaling Guide

The following is a collection of my thoughts and suggestions regarding your journaling experience. These are not rules, but some guidelines to get you started. I encourage you to be **CREATIVE** and **UNIQUE** in your journaling! There are no limits.....

I suggest that you spend some time each week reflecting on your experiences as a nurse – please write down clinical situations or situations with co-workers (even if it is on a scrap piece of paper at work so that you can remember it later) that can be examples of, or explanations for your feelings or thoughts. Include them in your journal each month.

1) This journal is a collection of your thoughts and your experiences – make it your own.
2) You are not restricted to the written word – feel free to draw diagrams, paste magazine or photographed pictures in your journal, or use an audio or videotape if that method will better reflect your thoughts, ideas, or concepts about being a nurse.
3) There is no required writing format for this journal – create what you want.
4) This is a place where you can share without fear of being judged.
5) I believe ALL that you write is valid and has significant meaning to you and significance for the nursing profession.
6) Journal in a place where you feel comfortable.
7) Take time to collect your thoughts after every shift.

Some Suggestions:

- ☑ Talk to me about your last shift – what happened, what you thought, how you felt, how you sorted it through.
- ☑ Tell me about a particular decision you made during your shift – analyze it and tell me what you liked or didn't like about it.
- ☑ What changes have you noticed in your thoughts and feelings over this past month – what facilitated those changes?
- ☑ Tell me about relationships you are developing (or not developing but wish you were) at work – what is the culture of your unit like?
- ☑ Tell me about your co-workers, manager, and educator – what do they do to assist you in your transition and what challenges you in your relationships with them?

Some Journaling Strategies:

- ☑ Use a computer to generate images or print pictures that represent your experiences.
- ☑ Handwrite or audiotape your journal.
- ☑ Produce a video-tape of yourself talking about your experiences – if you would like, video-tape images (a sunset, a tall tree, a dark cloudy sky) while narrating your feelings or thoughts.
- ☑ Spend 30 minutes after each shift thinking about and journaling through your experiences that shift. Be as expressive as you can – provide examples from practice.
- ☑ Create a collage of pictures from magazines, etc. that provide a visual of how you are feeling – write or dictate an accompanying narrative explanation.

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Paper #1 – The experience of transition shock: Understanding the initial stage of adaptation to acute-care professional practice for newly graduated Registered Nurses

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Keywords: new graduates, hospital, role transition, transition shock, socialization, professional practice, acute-care, reality shock, culture shock, acculturation, role theory, role adaptation, transition theory

Abstract

The majority of new nursing graduates make their initial transition to professional practice within the hospital healthcare environment. In the early 1960s, Marlene Kramer (1974) offered a construct of "reality shock" to explicate the process of transition, illuminating the challenges to making the role change from student to practitioner. The concept of *Transition Shock* presented here builds on Kramer's work by outlining how the contemporary NG engaging in a professional practice role for the first time is confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural changes that are both expressions of, and mitigating factors within the experience of transition. The *Transition Shock*© model developed by the author focuses on the aspects of the new graduate's roles, responsibilities, relationship and knowledge that both motivate and mediate the intensity and duration of the transition experience and qualify the early stage of professional role transition for the NG.

The experience of transition shock: Understanding the initial stage of adaptation to acute-care professional practice for newly graduated Registered Nurses

These are challenging times for new nursing graduates (NGs), the majority of whom make their initial transition to professional practice within the hospital healthcare environment. With approximately half of the Registered Nurses (RN) in Canada and the United States (US) currently over 45 years of age and with this number increasing steadily, a dramatic dearth of RNs is currently a reality throughout North America, with dire predictions of escalating shortages within the next five years (Advisory Committee on Health Human Resources, 2002; Buerhaus, Staiger & Auerbach, 2003; Buerhaus, Donelan, Ulrich, Norman & Cittus, 2005; Canadian Institute for Health Information, 2003; Human Resources and Services Administration, 2002). Experts claim that this nursing shortage is unlike anything we have experienced to date (Cowin & Jacobsson, 2003; Mee & Robinson, 2003; Murray, 2002; Tanner, 2003). A lack of respect, an unwelcoming hospital culture, inappropriate utilization of nursing knowledge, a disproportionate focus on fiscal management as opposed to quality work environments, and the contemporary preponderance of attractive alternatives to hospital nursing are contributing to the current acute-care nursing workforce deficiencies (Barney, 2002; Lin & Liang, 2007; May, Bazzoll & Gerland, 2006). Reports claim that 33-61% of new recruits will change their place of employment, or leave nursing altogether within their first year of professional practice (ACHHR, 2002; Bowles & Candela, 2005; Buchan & Calman, 2004; Cowin, 2002; Dearmun, 2000; Winter-Collins & McDaniel, 2000). Equally concerning is data that claims less than 50% of practicing nurses would currently recommend nursing as a career option (Heinrich, 2001) while 25% would "actively discourage someone from going into nursing" (Baumann, Blythe, Kolotylo & Underwood, 2004, p. 13). The cost to employers may include orientation of replacements to lost RN staff, sick-time and absenteeism costs, as well as increased patient mortality and morbidity resulting from both

new and experienced nurse burnout and novice nurses being placed in unfamiliar practice areas or inappropriately advanced decision-making and clinical judgment roles without access to experienced colleagues for clinical collaboration and leadership (Beecroft, Kunzman & Krozek, 2001; Buerhaus et al., 2007; Cardona & Bernreuter, 1996; Cho, Laschinger & Wong, 2006; Ebright, Urden, Patterson & Chalko, 2004; Hall, Doran, & Pink, 2004).

The importance of exploring the process of NG adaptation to professional practice in acute-care nursing relates to the ongoing challenge of healthcare institutions, schools of higher learning and policy makers to both understand and respond to the issues that may be driving these energetic and motivated nurses out of acute care, or out of the nursing profession altogether. While it is clear that the journey of transition for the NG is often stressful, frustrating, discouraging and disillusioning, what remains unclear are the stages of that journey. As well, insight into the possible precipitating factors of and potential alleviating strategies for the difficulties incurred during the professional role transition of the new nurse may be aided by indepth knowledge of the stages of that transition. *Transition shock* is presented here as the most immediate, acute and dramatic stage in the process of professional role adaptation for the NG. The design of this stage subsumes elements of transition theory, reality shock, cultural and acculturation shock, as well as theory related to professional role adaptation, growth and development, and change. Transition shock is used here as an encompassing term that more accurately represents the whole of the researcher's data than appears possible with the singular application of any one of the aforementioned theories. Admittedly, the melding of these well-established frameworks into the transition shock experience remain underdeveloped in the nursing community and require further exploration, clarification, validation, and verification through ongoing study and research.

Background to the Study

Bridges (1991) claimed that persons in transition must begin with the recognition of a need for change and then develop or access skills that can assist them in "negotiating the perilous passage across the 'nowhere' that separates the old from the new" (p. 14). Transitions are fluid processes that occur over time (Meleis & Trangenstein, 1994), a characteristic distinguishing them from change which is often associated with the outcome (i.e., behavior change) of such a process (Lewin 1951). Of particular significance to the topic of initial professional transition in nursing is literature that attempts to identify the intangible process of professional socialization, or the "status passage" (Bradby, 1990; Glaser & Strauss, 1971; Van Gennep, 1960) from nursing student to registered practitioner (Holland, 1999; Meleis, 1997). This progression often includes the anticipations and anxieties experienced prior to the transition to professional practice, some emotional preparation for the anticipated event, and an attempt by senior students to gain some practical experience that might suitably prepare them for the realities of the transition process (Bradby). Feeding into the process of transition is the developmental profile of the "typical" or "traditional" NG. This is a young adult, most often female, who is idealistic, informed, intellectual and who holds high expectations for the significance of his or her contribution; has minimal practical work experience and experience with transformative change and thus has limited life skills to manage the same; lacks experience working with, delegating to, and managing others; struggles with balancing his or her time between responsibilities and tasks; is developmentally immature and therefore easily influenced by experts and intimidated by an organizational culture that conflicts with the perspective of reality acquired as a student, and finally; wants desperately to earn the respect and admiration of colleagues whose acceptance is a pivotal aspect of cultural socialization (Bradby; Buckenham, 1994; Crane, Jones & Sharpe, 1988; Duchscher, 2001, 2003; Duchscher & Cowin, 2004; Goh & Watt, 2003; Manojlovich & Ketefian, 2002).

Understood within the context of this research, the initial professional role transition of the NG consists of a non-linear process or journey that moves the new practitioner through developmental and professional, intellectual and emotive, skill and role-relationship changes, and contains within it experiences, meanings and expectations. Further to this, the experience of transition is presumed to be influenced by developmental and experiential histories, and situational contexts that both prescribe and cultivate expectations about professional roles and responsibilities, work ethic and culture. In this author's experience, the transition experience of the NG is felt with varying intensity, is founded upon relatively predictable fundamental issues, and exists within individually motivated and fluctuating states of emotional, intellectual, and physical well-being. The development in professional self-concept and changes to personal and professional self-image that occur during this transition are evolutionary and understood to vary in accordance with the individual's level of personal maturity, past work and life experience, academic success, employment context and professional role support availability.

Conceptual Framework of Transition Shock

William Bridges (1980) begins his seminal dialogue on the concept of transition with this excerpt from *Alice in Wonderland*: "'Who are you?' said the caterpillar... 'I - I hardly know, Sir, just at present', Alice replied rather shyly, 'at least I know who I was when I got up this morning, but I think I must have been changed several times since then'" (Carroll, 1967, p.47). Illustrated so poignantly here, transition represents that "confusing nowhere of in-between ness" (Bridges, p. 5) that serves as the channel between what was and what is. The "in-between ness" that is the initial transition from student to professional practitioner is the subject of this paper. The experience of transition to professional practice for the NG has been most notably and historically studied by Marlene Kramer (1974). Kramer built on the earlier phenomena of *culture* and *acculturation shock*, which address the "surprise" reaction of individuals to changes in social norms and values that are perceived as radically different from what those individuals had grown accustomed to or were led to expect (Bock, 1970; Ward, Bochner & Furham, 2001). In particular,

acculturation shock refers to the adjustment individuals undergo when adapting to, or assimilating into a new set of cultural mores. This kind of shock is seen most often in people who suddenly leave a controlled environment where variants to the dominant cultural patterns have prevailed, and enter into a more committed or active involvement in the governing cultural unit.

Kramer (1974) further coined the term *reality shock* to describe the discovery that school-bred values conflicted with work-world values. Based on reality shock, NGs initially experience an excitement as they arrive at a long-awaited goal. Soon, however, familiar cues from the NGs' educational experience such as rewards, sanctions, and ascribed role distinctions are either lost or unrecognizable and NGs come to realize that "the honeymoon is over" (Kramer, p. 5). Shock and rejection set in as the NGs are exposed to a daily assault on their professional values (Kramer). As Kramer's and this author's research demonstrates, the journey from student to professional practitioner for many NGs is chaotic, unsupported and painful. Initially perceived as exhilarating, this transition experience often turns traumatic as graduates become aware of the contrasts between *practicing* nursing as a student, and practicing *nursing* as a fully responsible and accountable professional. Disturbing discrepancies between what they have come to understand about nursing from their undergraduate education and what they experience in the "real" world of healthcare service delivery leaves NGs with a sense of groundlessness (Delaney, 2003; Duchscher, 2001, 2003). Once in the hospital environment, the NG is immersed in a firmly entrenched, distinctively symbolic and hierarchical culture that exposes him or her to dominant normative behaviors that have been described as prescriptive, intellectually oppressive and cognitively restrictive (Crowe, 1994; Duchscher, 2001; Kramer, 1966). Mohr's (1995) research findings claimed that the hospital environment moves NGs away from the ideal of professional nursing practice adopted by them in their educational socialization process and toward a more productivity, efficiency and achievement-oriented context that emphasizes institutionally imposed social goals. Resulting role ambiguity and the internal conflict that it precipitates have been cited as turning the creative energy of these novices into job dissatisfaction and career

disillusionment (Chang & Hancock 2003; Duchscher; Gerrish, 2000; Greenwood, 2000; Winter-Collins & McDaniel, 2000).

Introduction to the Research

This study was conducted as part of a PhD (nursing) program at the University of Alberta, Canada. The researcher employed a generic qualitative approach of interpretive inquiry, using a grounded theory process to guide the ongoing analysis and interpretation of the data. Upon receipt of ethics approval from two provincial university ethics boards and two regional health authority ethics committees, fourteen female graduates from a 4-year baccalaureate undergraduate nursing program were purposefully selected to participate in 1:1 interviews at 1-3-6-9-12-18 month periods, complete pre-interview questionnaires and submit monthly journals (initial 12 months) detailing their experiences. Additionally, focused interviews were conducted in a separate city in the province of Saskatchewan with all participants originating from the same provincial nursing program.

Subjects were sought formally through the undergraduate educational program where requests for volunteers were posted on the website of their final nursing course, and informally through the random approach of senior students by the researcher and several undergraduate colleagues. All participants who were ultimately chosen had been hired into an acute-care nursing role with the promise of a minimum of casual employment status. To remain in the study, participants were required to be working at least 20 hours per week for the duration of the study; this was to ensure a consistent and reasonable exposure to the acute-care working environment for all participants. Two participants left the study over the course of the first three months; overwhelming family responsibilities were cited for one participant while the other left without notification, explanation or obvious provocation. No age or gender limits were placed on the selection process, though all participants who volunteered were female, ranged in age from 19 to 28 years, and were entering the professional workforce for the first time. Only English speaking

participants were chosen to reduce the variable of language as a barrier to narrative interpretation. The study was considered the theoretical sampling of a specific context of transition within the framework of a larger grounded theory program of research that seeks to illuminate an evolving substantive theory of professional role transition for the newly graduated nurse.

Study Limitations

All qualitative research studies are vulnerable to the very elements that provide them with their rich thematic insights (Sandelowski & Barroso, 2002). Small sample sizes and the embeddedness of the researcher within the narrative have the potential to infuse a narrow, superficial and biased interpretive process into the analysis (Creswell, 2007). This can limit the trustworthiness and usability of the ultimate end-product for others. It is therefore important to note that the theoretical model of transition shock resulting from this research is inextricably linked to the author's 10 year history of study in the area of the NG's professional role transition. The intent of this particular arm of the research program was to further examine, build upon and mature the particulate aspects of the NG transition experience into acute-care such that an accurate overall representation of this experience and the processes encompassed within could be confidently introduced into the scholarly community. Possible sources of misinterpretations for this study include situational contaminants such as the interviewer's previous interactions with the subjects as nursing students, the use of the researcher as the primary instrument for interpretation and data analysis, the relatively small and demographically homogeneous sample population, and the limitation of data collection and analysis to a qualitative interpretive research approach. It should also be noted that great care was taken to institute rigorous data collection, analysis and interpretive procedures that could serve as checks and balances to the truths being purported. For example, participants were used to verify and clarify evolving narratives and thematic explications, experts in both research process and transition content were asked to read

and provide interpretive commentary related to the transcripts, and a detailed set of researcher field-notes, theoretical memos and audit notes were kept throughout the research period.

The Experience of Transition Shock

Transition shock is defined here as the experience which results from the rapid and intense movement from one known circumstance to another which is relatively less familiar. Important to this experience for the NG is the contrast between the relationships, roles, responsibilities, knowledge and performance expectations required within the more familiar and oftentimes mastered academic environment to those required within the professional practice setting (see *Transition Shock Model*© in Figure 1). For participants of this study, the experience of transition shock felt "like I just jumped into the deep end of the pool." The element of surprise that precipitates the transition shock experience is predicated upon pre-existing expectations about the impending change that may not have been entirely accurate, could not be predicted or fully revealed prior to the transition, or were not presented in the context within which they would be experienced.

When faced with what was an alarming contrast to what most of the participants in this study anticipated, stress and distress ensued. Stress turned to strain when there were inadequate supports either built-in or introduced to facilitate a normative adjustment to that which was being experienced as different (Hardy & Conway, 1988). Generally speaking, the differences that motivate a *shock reaction*, as opposed to a more tempered *upset* are usually related to the coexistence within the situation of a perceived threat to personhood or self. For these graduates, the initial transition from a structured life that was known, relatively predictable and often mastered into a new set of expectations and responsibilities that were at best semi-familiar but not fully understood posed numerous threats to both their personal and professional selves. While initially curious and excited to tackle the challenge of managing the transition from student to

professionally practicing nurse, participants quickly realized that they were quite unprepared for the responsibility and the functional workload of their new roles:

> I find myself crawling right now. Since finishing school you realize how far you have come, however your balloon gets busted pretty quick once you realize how much you don't know and how much there is yet to learn. Even after four years of school, I feel things blew up in my face and I had a pretty rude awakening. 'Been knocked down by a slamming door'....I guess that is how the experience has been so far. On the whole, when I think of the last few months, I feel knocked down, energy drained, worn out, overwhelmed.

Important to the concept of transition shock was the marked expectation of all participants that the quality of both their personal and professional lives would be greatly enhanced upon entry into this new experience. They anticipated that they would have the long-awaited time and energy to pursue personal ambitions that, for the past four years at least had been subverted to the higher purpose of achieving their professional education. They seemed equally ill-prepared for the toll this initial transition would take on their personal energy and time as on their evolving professional self-concept. While they anticipated that some adjustments to their professional work situation would be necessary, prior to the transition they never doubted that their choice of career and the investment of the years of study that this required would be affirmed through: a positive work experience: a welcoming collegial environment; a moderately challenging but easily achievable extension to the roles and responsibilities they had grown accustomed to; the thrill of actualizing the professional role they had earned the title to; and the fulfillment of being recognized for the knowledge they had acquired and the commitment they had made to caring for others. Further to this, virtually all of the participants underestimated the concurrent personal adjustments that would be required as they moved into what would prove to be a new stage of their life. In a letter written to her best friend (i.e., a strategy employed by the researcher) this participant summarized the initial transition this way:

> The last time we spoke, we talked at length about our fears of almost being finished school...but that conversation does not seem to do the reality justice now that I am done. And though I find it hard to articulate my experience on this roller-coaster couple of months, I will try. The last time we spoke, we were both very excited and anxious to be

> done school. I was looking forward to making money and starting my career. Basically, for as long as I can remember, I've been in school. School comes with its typical expectations but being a member of such a well respected profession, I didn't know what all that would entail. So as the time grew nearer, my excitement faded. The reality of the responsibility that lie ahead for me began to be more than I could take. I found myself being withdrawn, grumpy, and closed off. Please understand that this was nothing you did personally, and it was not a deliberate act on my part. But rather, it was an attempt to disguise the chaos that was occurring in my head. I guess it was my body's reaction to the sudden uncertainty of my new life. Suddenly not going to school became a huge shift in my routine. Instead of my life revolving around school, suddenly it revolves around uncertainty and wonder. The stress of applying for jobs was more than I wanted to deal with. I had so many feelings of self-doubt, wondering if I would meet the managers expectations, the fear of not being prepared enough, having not studied or been exposed to enough....I have been telling everyone that this is where I want to work. Now that I have made it here and I've hyped it up so much, I feel as though I couldn't leave even if I wanted to....None of my friends or family would judge me for leaving, but I guess I would feel like I was disappointing myself. I want to apologize for the mood swings, the exhaustion, the highs, the lows, the tears, the anxiety, the near panic attacks, and the over-reactions. If I have been difficult to read lately, please don't feel bad. I don't even know how I am going to be feeling half the time. I feel as though my emotions are all balled up together and crammed into a tiny jar, which at any moment could break and release any combination of feelings. It is as if I am re-living my adolescent years.

There was a surreal nature to the initial orientation period and participants remained locked into a more transient sense of belonging. As one graduate revealed,

> It hasn't sunken in yet actually. I was amazed the other day because I took my shoes to work and I could actually leave them there. Like I have a locker and I can leave my stuff there. It's hard to get used to the fact that this is kind of a permanent thing.

Within days of being afforded the full weight of responsibility for their professional roles and coming to the stark realization that the 'whole' of their life was undergoing a radical transformation, the majority of these participants began to struggle with some aspect of the adjustment to their new lives. As one participant eloquently stated: "Up to this point, it has been 'I can do this', it's just *how* am I going to do this? Now it's *can* I do this at all?"

While this process was neither linear nor prescriptive, the personal and professional adjustments evolved and progressed most intensely through the first 1-4 months of the participants' post-orientation (PO). At the termination of this time period the exhaustion and isolation that both fed and resulted from the disorienting, confusing and doubt-ridden chaos that

represented their new-found reality motivated a deliberate withdrawal from the intensity of the shock period. The participant expressions of this transition shock experience are presented here as emotional, intellectual, sociocultural and developmental, and physical (see *Transition Conceptual Framework©* in Figure 2).

Emotional

The range, overwhelming intensity and labile nature of the emotions expressed by participants during this initial stage of transition was truly impressive. Using words and phrases or expressions such as "terrified" and "scared to death," these participants claimed that relentless anxieties were routine during those initial weeks. There was often a reactive and polarizing nature to their emotions:

> It's a big change and it's really overwhelming. You're happy about it one minute and bawling about it the next. You're just not sure what to think. It's exciting to be done. You're a nurse now. And then you get there and you just have one bad day and you're like "I never want to go back there again. I can't do this. No one should have passed me in nursing. I'm not good enough to be doing this." Then you talk to someone.

Several participants longed for someone to simply talk to about what they were going through, while others wanted to be comforted and to connect with someone who understood their experience and accepted them without need for explanation. Several talked frequently about "wanting to escape" from the onslaught of emotions and expectations by retreating to places, people and events that were familiar and offered the comforting qualities of reassurance and affirmation. During the initial weeks following their orientation to the new professional environment graduates expressed fears of failing the patients, their colleagues, managers, prior teachers and even their parents. There existed nagging doubts about whether or not all that had gone before was preparation enough for what lay ahead.

While one might expect some trepidation around skill level competence and the establishment of new collegial relationships in a NG professional, this data demonstrated that the

stability, predictability, familiarity and consistency of both the introductory clinical experiences and the individuals with whom the graduates interacted significantly influenced their response to existing role transition stress. Graduates who had confirmatory encounters with patients and colleagues, who were afforded workloads that resembled those they had successfully managed as senior students, who had peers or a mentor with whom they engaged in validating dialogue about their experience, and whose confidence was enhanced by frequent affirming and encouraging feedback had a muted experience of transition shock. Unfortunately, this was not the rule; the majority of graduates in this study could feel their anxiety "dancing on the edges of my words and memories." Most participants displayed overwhelming, and at times physically and psychologically debilitating levels of stress during the initial 1-4 months PO. This more traumatic adjustment often correlated with inadequate and insufficient functional and emotional support, a lack of practice experience and confidence, insecurities in communicating and relating to newfound colleagues, a loss of control over and lack of support for the enactment of their professional practice values and anticipated roles, physical, emotional, and intellectual exhaustion, and unrealistic performance expectations by the institution, their colleagues and the graduates themselves.

Not uncommonly, participants described dominant seasoned Registered Nurses (RN) and Licensed Practical Nurses (LPN) with whom they were required to interact as inadvertently challenging both the process and content of their practice foundation. At times these challenges were perceived as intentionally seeking to diminish the already negligible level of confidence with which they were working. The following is a graphic example of what several participants identified as "nurses eating their young" or as this graduate referred to it, a "hazing" routine:

> There was this older nurse. Actually I would call her the matriarch of the unit. That's what I would tell other people because she's pretty much the boss...like she was the oldest nurse there and she's got everyone kind of under her thumb. So the thing is when I did my senior rotation like I thought, "Oh, this is a wonderful unit. Everyone helps you out. Everyone's really nice" and yada yada yada, and so I thought like this is wonderful but then when I came back on my own just as a nurse, like people weren't so nice. They weren't so helpful

> and so after watching for awhile, I realized that she's kind of the big cheese around there. There's probably four or five of them. They are you know the older nurses and they like to – it's like an initiation thing. Like if you can handle their grouching and complaining then you make it through. Actually, we had one guy on our unit – this is so sad actually. He started on our unit and he had some medical conditions and whatever else. He was a grad nurse. He started phoning in sick a couple of times. So you know then the rumors started but I don't blame him cause after seeing how the unit is, like I can see how people go on stress leave and start phoning in sick when they're not. So I remember one day they said to one nurse 'why don't you ask him to work this shift for you that you want off' and she was like "well, no I don't think so because he's just going to phone in sick and I don't need to be having whoever's taking my shift booking off sick." And that was the first time I heard them talk about him and then there was a whole bunch of other times and then he had phoned in sick one time and they had noticed on the call display that it was an in-hospital number, but it was the emergency room so they had figured that out. That's not a big deal right, but then we have a computer system at work and you can look up people. They looked it up and he was on the psych unit. They looked up where he was. They found him. He was in the psych unit. And so everyone on the floor knew he was in the psych unit and to be honest, like I'm not surprised. I think the whole reason he was there was because he had such a hard time making it on our floor. And since then he's accepted a position in another province and left.

Much of the relational conflict between seasoned and novice nurses seemed to stem from differing interpretations of NG needs as they related to practice demands and coworker expectations. With alarming consistency, graduates feared "being talked about" by their senior colleagues. While at once recognizing the impropriety of such an act, receiving the approval of their nursing colleagues was paramount and graduates often subverted their own feelings and convictions in an attempt to secure endorsement by their professional group. In this passage, the graduate demonstrates the potentially devastating impact of a potentially innocuous interaction on what is an initially fragile self-confidence and self-esteem:

> I just said, "You know, if you need help let me know" and I continued to ask her throughout the night and she asked everyone but me when she needed help. Even the aide and the LPN knew they probably weren't as knowledgeable about that particular thing, but they were there longer so she asked everyone but me. That was kind of awful, kind of disappointing. She didn't feel I was capable and there's no way she would know if I was you know – she had no past experiences with me. I think she felt that I wasn't capable or maybe I couldn't handle it or I was new so I wouldn't know what to do so I was disappointed....and I was thinking it was something that I did. I was kind of hurt too because she asked the aides and the LPN over me and that wasn't even in their scope of practice.

Conversely, several participants poignantly revealed the transforming capacity of both supportive statements and displays of acceptance by senior colleagues on the development of their evolving professional self-concept and on their ability to pass through the particular moment and keep going. Interestingly, more than half of the participants used the metaphor of *drowning* when both describing and visually representing the overwhelming experience of the first 1-2 months of transition. Startling pictures were drawn and collages designed that clearly illustrated the loss of control and subsequent powerlessness associated with the transition shock experience. Many of the NGs' initial practice situations presented as conflicting, disorientating and sometimes even opposing. These seeming contradictions kept the graduates actively searching for reassurance and validation regarding their professional values and clinical competence. The precarious level of trust the graduates had in themselves motivated strong sensitivities to how they were being received by others. Even so much as a suspect "look" from a colleague was interpreted by some as a display of distrust or wavering confidence in their abilities.

The energy being consumed by their attempt to stabilize the emotional roller coaster they found themselves on motivated a predictable, but nevertheless remarkable exhaustion in all participants by the 3rd-4th month of transition. As one participant poignantly stated: "What is nursing to me now? Getting through the day!" Without question, the primary fears for the new graduates during this stage of their transition consisted of: 1) being "exposed" as clinically incompetent, 2) failing to provide safe care to their patients and inadvertently hurting them, and 3) not being able to cope with their designated roles and responsibilities. The dreaded outcome was rejection by their peers as valued and contributing members of the professional community. New graduates went to great lengths to disguise their feelings of inadequacy from their new-found and reverently esteemed colleagues. Projecting a calm, controlled, and competent exterior was a strategy employed by the graduates in an attempt to minimize the assault to their self-concept that a lack of approval from, and conflict with colleagues would represent.

All study participants initially utilized their new graduate peers as their primary support system. The issue of feeling understood took on notable significance and it was commonly suggested of even well-meaning family and friends:

> I don't think (name) truly understands. She doesn't know what it's like to be a nurse and she doesn't even know the things that we do or how much responsibility I have. She would be scared to know what I do.

The loss of the support system that the NGs employed during school was intensely felt. Not having immediate access to prior faculty or peers to provide intellectual counsel, emotional support, or practice consultation and feedback potentiated the novice practitioner's feelings of isolation and self-doubt. Many of their new graduate colleagues were working different shifts, were employed in other institutions, or had moved to rural or distant geographical locations and virtually no formal professional feedback mechanisms were established within the workplace for any of these participants. This was an important link to the ongoing professional development of those who had even minimal access to it, and sorely missed by those who did not.

Finally, many graduates expressed struggles with maintaining the practice intents and standards that they had consolidated during their education. The majority of NGs in the study shared feelings of frustration and guilt around their inability to enact the practice principles they believed were a basic requirement of their professional role. There was a sense of culpability for the perpetuation of substandard practice that served as a powerful, but insidious role transition destabilizer:

> I can remember learning the principles of sterile technique in school....Now I'm standing here watching an experienced nurse pull off a dressing with no gloves, and slap another dressing back on the incision without even cleaning it, and I don't say anything.

Physical

The physical response of the NGs to the transition shock experience was grounded in the all-encompassing energy being consumed just trying to perform in their new role at the level

expected of them, all the while without revealing how difficult this was for them: "There is change everywhere. I don't have much stability at this exact moment. I know once I get settled, I'll be OK, but right now my life is chaotic." Changes to established life-pattern routines such as modified living arrangements, terminated or advancing intimate relationships, and the acquisition of debt through the purchase of cars and homes served as both exciting distractions and unexpected burdens to these already disoriented graduates. In addition to undergoing personal and developmental changes, these young professionals were being expected to make advanced clinical judgments and practice decisions for which they felt minimally qualified but completely responsible. The strain of this new level of professional accountability was heightened by unclear practice expectations from managers and colleagues, inaccurate assumptions by the graduates of what a "successful" transition would look like, unanticipated role-relationship struggles with colleagues, the physical demands of adjusting to shift-work, and a virtual absence of normalizing feedback on which to base their experience and their role transition progress. While initially anticipated and experienced as exciting and even stimulating, these elements of the transition ultimately joined together to feed a terminal level of exhaustion that peaked at approximately three months PO.

Fed by doubts and insecurities, these new practitioners seemed unable to control the relentless debriefing of their practice actions and decisions. They all described spending their wakeful hours thinking about what had transpired on their last shift and preparing for what might happen on their next shift. Sleep time was consumed by dreams about work, bringing about a state of "perpetual work" that contributed significantly to their growing exhaustion:

> I dream about work quite frequently. I still wake up and I'm dreaming – like it's everything. A recent one had to do with scheduling, but even things like I dream about starting IV's, I dream about handing out pills, I dream about machines beeping – I just dream about everything. I can remember seeing myself insert the IV but I have no idea how it turned out, I just remember panicking - waking up and panicking....I wake up convinced that I'm late for work at two in the morning. Like, you've got four hours left to sleep. It's almost like I was afraid to fall into a deep sleep because what if my alarm didn't go off? What if I slept in?

Sociocultural and Developmental

For the young adults that composed this study, the transition shock experience was, in large part, about finding their way in a world for which they had been prepared but were not wholly ready. The disconnection between who they were as women and young professionals and who they thought they were supposed to be as nurses, the behaviors they witnessed in the role models that surrounded them and how the realities of the practice environment facilitated, supported, reinforced, challenged or censored professional codes of behavior dominated this initial transition period. During the first four months, the primary sociocultural and developmental tasks for these new graduates appeared to be finding and trusting their professional selves, distinguishing that self from the others around them, being accepted by the larger professional nursing culture, balancing their personal life with their professional work, and finding a way to meld what they had learned in school with what they were seeing and doing in the "real" world. The initial period of professional role transition was a remarkably confusing time in the lives of all but one of the participants. The negative case in this study was a young woman whose 3-year pregraduate experience as a unit aide, unit clerk and senior assist (i.e., a senior nursing student employed in a healthcare support role similar to that of an LPN for several years prior to graduation) in the neonatal intensive care unit where she took her initial graduate nurse position, significantly altered her transition experience and virtually eliminated the shock-like reaction. While her initial transition included moments of struggle, none had either the acuity or intensity of the other participants. The information gleaned from the presence of this outlier illuminated the complex nature of the shock experience while making clear the importance of practice context familiarity, predictability and consistency, transition support, graduated role and responsibility advancement, and role clarity in minimizing the experience of transition shock.

Relationships with colleagues were critical forecasters of the transition shock experience. Functioning within a hypersensitive and self-critical state, the graduates felt any and all tremors of

disapproval, disrespect or doubt as they did likewise of acceptance, praise or simple encouragement. One participant summed it up with this eloquent statement: "I have just needed and wanted someone to ask me how it is going and really listen." At times participants struggled to distinguish between their personal need to be liked and their professional desire to be respected. The former appeared to hold more initial importance to them with the latter gaining ground within 4-6 months of their introduction to practice. For several participants, their yearning to "crack into" the team appeared motivated as much out of a fear of being alienated or abandoned as out of a need to belong:

> There's that kind of, you know 'belong to a group' kind of thing. If you're helping out, it's more like you belong because you're part of the team. Because you want to belong. You want to belong because you want the nurses that you work with and the LPNs to trust you and you want to trust them. You don't want to step on anybody's toes because if you do, what if they leave you in a bad situation and kind of like 'handle it on your own' and you're not going to get that support from them.

Regardless of the reasons, most participants alluded in some way to a desire to be included in the "clique" that constituted the culture of their nursing unit. Several talked about socializing with colleagues as a way to feel more a part of the community, while others felt "there's not much hope of getting in and I don't even know if I want in." As mentioned earlier, it was in this context that participants expressed concerns about being talked about critically by their colleagues; this was seen as a sign of disapproval and as a lack of faith in their abilities, both intensifying their feelings of self-doubt. The need for acceptance from those they respected and aspired to be like as professionals was strong. All participants spoke of wanting, but not adequately receiving, both affirming and critical feedback from either their senior colleagues or those they perceived in an evaluative role such as managers and educators. In the absence of formal feedback, these novice practitioners looked for other indicators by which to measure the safety, competence and relative progression of their practice:

> I don't think anyone said much to me about you know "Oh, you did well." There's actually one nurse I remember I had a horrible day and she said "is everyone still alive?" and I said "Yes." And she said "Well then, it's a good day."

In many of the statements regarding their desired relationships with seasoned nurses, the graduates appeared to be seeking professional mentorship. They spoke of wanting guidance on clinical decision-making and judgment, modeling of how to relate to other professionals such as physicians, feedback on skill performance, and seasoned tips on how to get all their tasks done and still have time to provide therapeutic support to patients and families. Often, they spoke of their senior colleagues with awe, not entirely sure of the path that might take them from the stumbling novice they saw in themselves to the polished practitioner they witnessed in others. As the months progressed, thoughtful discrimination replaced the randomness of simple availability in their selection of practice guides.

A strong theme during the initial four months of their introduction to professional practice was the evolution of a more mature, professional sense of self. This developmental change was both exciting and daunting to these young women, dictating modifications to established relationships with friends and family, and transforming the way participants viewed themselves. A number of them talked about "growing up" and reflected on their struggle to renounce the safety and security of a more protected, comfortable routine and less responsible way of life.

> It's bittersweet actually. Like, finally I'm making some money and you know not having to explain and justify everything that you're doing to your facilitators. But at the same time it's scary. It's really scary not to have that support and right now I'm the only new grad on my ward so it's pretty lonely. It's intimidating at times and you're there making decisions that you're not sure if you really know or if you're correct in the decisions you're making. For me, I'm not at the point where I'm confident in my abilities yet and I feel like I just want somebody to reassure me that "Yes that's right."

While recognizing that something had been lost, these novices could see that much was to be gained during this difficult first stage of their professional transition. All of them grieved the loss of the youthful freedoms associated with being a student, while at once acknowledging and

appreciating the new-found respect and lifestyle advantage that comes with being a professional. Ultimately, this changed level of responsibility was accepted by all as an unavoidable reality of both "being an adult" and "being a professional." For several of them, the notification of their successful passing of the national qualifying examination marked the end of this stage: "I'm glad it's finally over. There's kind of an end to it and you can put the school part behind you now." For other participants, acceptance came more as a product of their resignation to the inevitable rather than the enthusiastic embrace of a long awaited stage of maturation.

Graduates spent a good part of the initial transition period trying to discern their nursing role in relation to others. It was commonly asserted that "being a student you are doing all the different roles so that when you come out you're a little bit confused." During the initial several months, the NGs found themselves distracted by the focus on tasks relative to the other nursing responsibilities with which they associated their professional role such as patient advocacy, teaching and counseling. This change initially surprised them and then served as a source of significant conflict with regard to their developing role identity. An underdeveloped level of organization and a desire to fit in to the culture of the units where they worked fostered a focus on completing their tasks "on time" (e.g., charting and other paperwork, answering phones, ordering tests) rather than spending quality time with patients and families. In the weeks and months to come some would settle into an acceptable role balance while others would never quite come to terms with the disjunction between what they expected their role as nurses to be and what it was. In data that extended beyond this transition shock stage, it became quite clear that this role conflict served to critically erode the NGs' job satisfaction.

Relating to other professionals within the clinical environment was an energy-consuming adjustment. Struggling with moderate to low levels of self-confidence, these apprentices found it intimidating and ultimately devaluing to interact with both senior physicians and nurses whose behavior reinforced hierarchical rather than collegial relationships. It was particularly difficult for

them to find a professional comfort level in communicating with physicians. They often "rehearsed" phone conversations with seasoned nurses or spent excessive time and energy planning, preparing for and trying to anticipate questions that the physician might have in hopes of coming through the impending dialogue with a minimum of distress. Distinctions were made between those medical practitioners who themselves were at varying levels of professional preparation (e.g., jursis, interns or residents) and attending physicians with respect to the degree of intimidation posed by interactions. Attending physicians were consistently found to be more abrupt, less receptive, and at times verbally abusive and belittling to these young nurses. Conversely, participants often related positive professional and collegial interactions with younger physicians who were perceived by them as being "on a more even playing field."

Concurrently, a tremendous learning curve existed for participants around the cultural traditions of their nursing profession. Many detailed prescriptive and hierarchical relationships amongst the nursing staff and passive-aggressive styles of communication between nurses and physicians. It was not unusual for these contemporaries to feel the sting of a more seasoned practitioner; there was a common lament that "they [seasoned nurses] forget what it's like to be new." In a related finding, considerable stress was involved in supervising, delegating and providing direction to other licensed and non-licensed personnel, many of whom were senior to the NGs in both practice experience and age. The graduates claimed that they had never been prepared to take on those roles or allowed to practice them during their undergraduate education. While most participants could cite a nursing elder who had shown them compassion and support, many described ongoing situations with senior nursing colleagues that undermined their confidence and appeared intended to subvert them within the culture into which they were being initiated. While not entirely surprising, this social posturing was impressive in its perceived malevolent nature and controlling intent. Part of the relational difficulty for the new graduates originated from their inability to clearly distinguish the lines between their personal and

professional selves; there was a need to "put on the nurse." With the reconstruction of their identities still in its infancy, these young nurses frequently felt torn between past ways of being that were not working as they had prior to the transition, and new relationships that had not yet crystallized into what they needed them to be. The strain was evident in this participant's experience:

> It is nice in terms of the money. The money made it nice because we got married when I was a student so we both really appreciate the money but I just find that our marriage has changed since my going from a student to becoming a real nurse. It has actually made life worse I think. I don't think our marriage will fail but it's made our marriage a little more strained just because I come home so stressed out. You know the time that you thought you would have to spend with your family, you don't have as often.

As the first few months unfolded, time was increasingly spent getting reacquainted both with themselves and with their expanding circle of friends and colleagues. It is not difficult to understand the marginalized behavior that was evident as they initially struggled to balance work and home; they marveled at their seasoned colleagues' aptitude for maintaining this equilibrium:

> I don't know how long it will take. I see those other nurses and they come in and talk about their family and what they did this weekend. I wish I was like that. I come in and I'm "Oh, so how is this person and how's that person and what happened with so and so." And they don't want to hear it. They're like "Who cares? Like just forget about that right now – we're not working yet."

While a particularly difficult aspect of the initial two months of the transition experience, entry into the next stage of their professional development would be characterized by a distinction between these "two lives." Each in their own way, graduates came to "realize now that my career is alot different than my personal life. I don't have to go home and sit with a book in my lap. I can do what I want to do."

Intellectual

The introduction of the graduates in this study to their new professional practice environment began with some form of orientation to the workplace, their nursing role and the

context within which they would be practicing. Most received several days of classroom introduction to institutional policies followed by several days of unit–specific nursing procedure and transfer-of-function instruction and certification. During this early period graduates maintained their high level of energy, eager and inspired by an exciting anticipation of finally being able to practice independently; being in a learning role was familiar to them and they held a curious fascination about what lay ahead. Most of the graduates identified this "next step" as similar to the increase in challenge they had long experienced when moving from one clinical student rotation to another. Additional role expectations were interpreted as a more advanced conceptual application of that which they already knew and similar to the graduated progression which had been required of them as students from year to year. What was not apparent to them at this point, but became apparent in retrospect, was the ongoing but oftentimes "silent assistance" that many senior nurses provided in an attempt to lighten the burden and lessen the transition shock for their young colleagues. Still not feeling the full weight of their professional responsibilities or nursing workload during this orientation period, all but one of the study participants were shocked by the change they experienced once orientation was done and they were "on their own in the real world." Rapidly and abruptly, the experience was transformed from one of excitement and wonder to one of overwhelming fear, doubt and all-consuming stress. The "real" transition had begun.

Some of the difficulty in making the switch from partial to full responsibility for these grads lay in the approach of senior nurses, clinical educators and nurse managers to orientation. The majority appeared to have a limited understanding of the relative inflexibility of the NG practice capabilities and expected that they would be able to manage the workload of a seasoned practitioner within several weeks. Further to this, no one mentioned to these participants that they would experience a transition, nor accounted for that experience either in the content or process of their professional initiation. Many of the "buddy" experiences (i.e., usually two 12-hour days

and two 12-hour nights) were based on workload division rather than on a preceptor-based tacit knowledge-transfer model. The availability of, and ongoing access to seasoned nursing practitioners varied considerably in this study. More often than not, graduates did not reach out to their senior counterparts because the workloads of the staff to whom they were expected to turn were as demanding as their own. The feeling that they were burdening these already taxed practitioners, combined with the potential threat to their self-confidence and ultimate acceptance by their colleagues should they be exposed as ignorant or inexperienced served as critical deterrents to their reaching out for assistance when they needed it. Having said that, the data was encouraging in so far as all participants identified safety issues and interpreted threats to their patients' clinical well-being as motivation enough to approach a seasoned colleague, regardless of the risk to themselves.

Several participants claimed that they were "slower" than their colleagues in making decisions and completing their daily routines. Much time was being spent "thinking back" through what was for them, relatively linear and prescriptive theory and instruction from prior undergraduate faculty or current institutional educators. The stark difference between what they had come to know and what they were seeing play out in the reality of their new professional practice settings was striking: "Putting a catheter into that little plastic whatever does not help you whatsoever because that doesn't teach you about the guy that does not want that catheter in and is trying to kick you." When reflecting back on their nursing education, participants either regretted the missed opportunities for learning that they had not recognized at the time, or blamed their education for not preparing them adequately or appropriately for the contemporary context within which they would be expected to practice. Rather than situating even a modest degree of responsibility on employing institutions for having unrealistic presumptions about the appropriate level of knowledge application in the novice practitioner, graduates had the self-expectation that they "should know it all."

It is worthy of mention and further discussion at this point that over 50% of the participants in this study began their professional careers in "float" positions. For the purposes of transparency and the reader's application of the data, the design of floating for the graduates in this study consisted of full-time, part-time or casual employment in anywhere from 2-5 separate medical, surgical or specialty units. Graduates could be assigned to any one of those units on any given day and were often relegated to different units each shift they worked. They were rarely provided with prior knowledge of where they would be assigned from one day to the next, or informed about whether or not they would be utilized as supernumerary or be given the full responsibility as the lead RN on their assigned unit. Orientation to this position consisted of a general hospital orientation followed by several day and night buddy shifts on each unit. Orientations were frequently consecutive such that the graduate would have minimal practice knowledge of one unit before being oriented to the next. For several NGs, this meant it would be 2-3 months before they returned to the units to which they had originally been oriented. In those situations it was like beginning their transition experience all over again.

Without exception, graduates self-reported that securing a float position within the design outlined above served to extend, intensify or delay progression through their transition experience and they suggested that this option not be considered when introducing nursing graduates to professional practice. For the novice practitioner "it's like a new job every time you go somewhere new." The primary issue related to floating was a lack of consistency in both the staff to whom the graduates looked for mentorship and collegial support, and the patient population for whom they were caring. The influence of these inconsistencies was further aggravated by a lack of predictability in their assignments which prevented them from anticipating and thus preparing for the unit-related issues, clinical knowledge expectations and practice requirements of the area to which they were going. The issues with consistency, predictability and familiarity made it difficult for the novices to control their exposure to clinical contexts and prevented them from

gaining confidence, establishing relationships with staff or receiving needed feedback on their progress from practitioners who had observed them over time. While these matters posed difficulties for every graduate, those who floated were more likely to revisit the issues of transition time and time again and tended not to progress through them to increased levels of comfort as easily or as quickly as those graduates in full-time, stable employment situations.

During the transition shock period, the new nurses in this study were able to reasonably manage a workload that consisted of a nurse-patient ratio of less than 1:8, a relatively controlled, balanced and stable level of acuity in their patients and practice assignments that provided them with seasoned practitioner-assisted decision-making and clinical judgment. So much was changing for them during the first four months that expecting them to function in accordance with their pretransition intellectual or practical capacity was simply unreasonable. Many examples were given of graduates whose focus on every detail of their role prevented them from hearing or seeing much of what was going on "around" them:

> We haven't had a code while I've been up there working but you know housekeeping pulled the cord from the wall and it goes off and all of a sudden people are running. I was like, "What's going on?" Someone said "That's the code bell" and I said "Oh, I didn't notice." I hope that changes because the first few times it was like, "Oh my God, what if I don't hear it?" I don't necessarily pick up on those things cause there's constantly buzzing and beeping and you're in the middle of something that you need to finish before you go on to something else. I hope that the other nurse hears the call bells or patients calling or beeping down the hall.

There were frequent concerns expressed about whether or not they were doing what was expected, or what would be considered safe, and whether or not they would be able to notice that which was outside of the norm given the intensity of their focus and the boundaries of their practice experience. Much of what went on for the new graduates in this study was unknown to their colleagues and, often times even their closest friends and families. Rather, the tremendous emotional, intellectual, spiritual and physical struggles were occurring "beneath the surface," intentionally concealed from others for fear a sharing of these chaotic thoughts and feelings

would both threaten their evolving confidence and self-concept or influence the perception of their competence by those around them. As one participant stated, "I know you think I'm coping really well and I know that I look like I'm doing alright, but inside I don't feel that I'm doing alright all the time."

Not infrequently, participants claimed that the senior nurses with whom they worked did not understand or empathize with the difficulties they experienced when dealing with situations that were "second nature" to their seasoned colleagues. Universally, graduates expressed anxieties around "missing something," or inadvertently and unintentionally bringing harm to someone under their care as a result of their ignorance or inexperience. They were exceptionally hard on themselves when they felt they had "failed" to identify or appropriately intervene in a changing clinical situation. Despite the fact that many of the situations described were beyond the novice's intellectual or practical capability, their behavior was self-deprecating. Without exception, all participants expressed a foreboding sense of fear as they anticipated their first "code" situation. The combination of the situation's high level of acuity, the potentially critical nature and clinical significance of the outcome, and the graduates' lack of confidence in and experience with crisis management contributed to high levels of intimidation for these graduates around this eventuality.

Not uncommonly, participants' descriptions of clinical situations exposed a prescriptive approach to their thinking. The limits to their problem solving and subsequent clinical judgments were not surprising, given that they had never actually seen or had an opportunity to work through many of the scenarios they were being presented with:

> I'll do assessments and although they have certain conditions I can't really put the two together. I can't work my mind around it but they're probably connected. Lab reports – that's another thing. I'll look at lab reports and I'll be like, "I know they have this health issue, but I can't see the connection. Like how are the kidneys involved?"

The value of seasoned nurse mentoring relative to the graduates' evolving clinical pattern recognition and tacit knowledge integration was clear throughout the initial stages of the transition experience. Strategies to manage clinical scenarios that presented themselves as outside the scope of the graduates' previous experience were unavailable to their consumed minds. During this early stage of their transition logical analysis, or the ability to manipulate rote "know-how" to meet the needs of varying clinical contexts proved exceedingly difficult for them. One participant described this experience as being "in a private little bubble and things are going on all around me and I cannot hear them, I cannot see them."

A relatively disturbing finding from graduates going through this initial transition shock period was the frequency with which they expressed concern about being placed in clinical situations beyond their cognitive or experiential comfort level. Over 30% of participants in this study were either requested to go to, or simply assigned shifts in an observation unit. Some graduates spoke up, stating their discomfort and even identifying to the scheduler the perceived impropriety of such an assignment. Others felt either too new to make demands about their placements, or interpreted the appeal for their work placement as a statement of confidence in their abilities making it difficult to refuse the request. In many of these cases, the charge nurse making the assignment was unaware of the graduate's nominal seniority and when made aware, quickly changed the assignment. In other situations it was clear that the intent was to "staff the unit" and matching clinical acuity with nursing expertise was not a priority.

Implications and Recommendations

The transition shock experienced by NGs when they enter practice as fully functioning professionals contributes to the stress and strain of this initial socialization period. Building on Kramer's (1974) earlier work in this area, transition shock moves the reader beyond an understanding of the graduates' response to their new reality as being primarily about a gap between what they were taught in school and what they come to know in their work world. This

research demonstrates that the NG engaging in a professional practice role for the first time is confronted with a broad range and scope of physical, emotional, sociodevelopmental, cultural and intellectual changes that are both expressions of, and mitigating factors within the experience of transition. These factors may be further aggravated by antecedents that are related to unfamiliar and changing personal and professional roles and relationships, unexpected and enhanced levels of responsibility and accountability that are unable to be afforded the graduates during their student experience, and expectations that they will apply clinical knowledge to everyday practice situations that has often been untried, is contextually unrecognizable or is simply unknown.

The element of surprise is an important contributing factor in the experience of transition shock. While growing evidence now exists regarding the effect of various orientation and transition facilitation programs on the role socialization process of the NG (Bowles & Candela, 2005; Beecroft, Santner, Lacy, Kunzman & Dorey, 2006; Newhouse, Hoffman, Suflita & Hairston, 2007; Ward & Berkowitz, 2002), there is no literature available outside of Kramer's (1974) work that demonstrates a relationship between formal pregraduate transition preparation and the experience of moving into a professional nursing practice role. The limited scope of knowledge regarding professional role transition in undergraduate nursing theory may be contributing to the students' unfamiliarity with, and lack of preparedness for what awaits them after graduation. Reduced readiness of graduates for issues they may encounter at the time of workplace entry may impede opportunities for students and their future employers to negotiate support structures that can assist novice professionals to navigate their new work environment.

There is an advancing movement within industry toward the development and enhancement of workplace orientation and transition facilitation programs for NGs (Beecroft, Kunzman, Taylor, Devenis & Guzek, 2004; Gazza & Shellenbarger, 2005; Halfer, 2007; Marcum & West, 2004; Newhouse et al., 2007). While many of these programs recognize the issues inherent in the early experience of the NG, few incorporate formal transition theory into either the content,

structure or process of their programs. A focus on institutional policies, procedures, structures and philosophies is essential for the fundamental understanding of any work context. This research suggests that it is important to further enhance the grounding of NG orientation programs in the evolving knowledge of NG transition. Such a program would encompass knowledge (e.g., theory taught in creative and interactive ways that accommodate varying learning styles and modes of knowledge transmission) and practice (e.g., role playing or contextually based learning scenarios that engage both novice and seasoned practitioners) related to the stages of transition and the experience of transition shock (e.g., what to expect and when); intergenerational and inter/intraprofessional communication (e.g., work ethic and style differences as well as role distinctions); workload delegation and management (e.g., delegating to individuals older and more experienced than yourself and prioritizing the competing demands a full workload); lifestyle adjustment (e.g., financial management and adjustments to alternating-shift work), change and conflict management (e.g., dealing with loss and change and navigating evolving relationships with family, friends and colleagues); unit-specific skills (e.g., special nursing and medical procedures and emergency protocols); and professional roles and responsibilities (e.g., working with physicians, seasoned nursing colleagues and multiple disciplines). Theoretical knowledge, though an essential component to a comprehensive workplace orientation approach, should be balanced with supernumerary employment status to afford the NG time and opportunity to learn and practice skills without being encumbered by the overwhelming weight of responsibility that comes with managing a full clinical workload (Beecroft et al., 2006; Glasberg, Eriksson & Norberg, 2007).

In conjunction with important theoretical knowledge and practical experience, it is suggested that institutions accomodate an evolving program of mentorship between new and seasoned practitioners in the workplace (Thomka, 2007). This research demonstrates that the initial shock stage of transition is fraught with insecurities around clinical and professional

competence. Whether these anxieties are reduced or further exacerbated may be related to the NG perception of an authentic proverbial embrace by the seasoned colleagues they work with. The successful integration of novice nurses into their collegial network is a primary developmental task of this socialization period (Etheridge, 2007; Newhouse et al., 2007). Appropriate mentorship supports that allow for changing roles and relationships between mentor and mentee, and that correlate with the evolving stages of transition will more likely meet the dynamic needs of the graduate and may enhance the job satisfaction of seasoned professionals (Coomber & Barriball, 2006; Glasberg et al., 2007; Rowe & Sherlock, 2005).

In seminal research that explicated the evolving skill acquisition and competency in nurses as they gained increased levels of practice experience, Benner (1982; see also Benner & Wrubel, 1982) established that novice nurses think and act differently from their seasoned counterparts. More contemporary authors have provided ample evidence to suggest that the critical thought and subsequent clinical judgment of the NG lacks the depth and breadth that comes with experience (Roberts & Farrell, 2003; Taylor, 2002; Welk, 2002). Similar evidence was found as it related to the initial transition shock experience of the NG entering professional practice during this study and made apparent the importance of purposefully and slowly graduating the clinical responsibility and practice autonomy of these novices. It is crucial that those staffing acute-care units, choosing to float new nurses, or employing NGs in high acuity practice areas recognize the precarious nature of the NGs' cognitive processing ability during the early stages of their professional socialization period. New graduates should be initially placed in consistent and relatively stable clinical scenarios, provided with regular and frequent feedback that reinforces and redirects their developing skill and knowledge, offered opportunities for the safe sharing of work experiences with NG peers as well as seasoned colleagues, and encouraged to collaborate on the development or enhancement of approaches that optimize their learning environment and quality work experience. These are elements that enhance the graduates' feelings of connection

with their workplaces, allow them time to process familiar experiences and generate a portfolio of appropriate clinical responses, and increase their level of self-confidence such that they can continue to grow and manage increasing clinical and professional challenges. Young professionals entering nursing practice for the first time need permission to "practice" their skills and "try out" their cognitive thought processes and responses. Serving this need in the NG requires an environment that is willing and able to work with a degree of uncertainty in its employees, is set up to identify and respond to the subsequent changing and evolving clinical abilities and comfort levels of new staff, understands and accounts for the reticence of NGs to self-disclose their clinical inadequacies or insecurities, and encourages reasonable risk-taking within a safe professional context that necessarily provides easy access to expert and supportive seasoned practitioners.

Conclusion

The concept of transition shock is presented here as the initial reaction by new nurses to the experience of moving from the protected environment of academia to the unfamiliar and expectant context of professional practice. The model representing this experience depicts the initial 3-4 months of professional role transition for the newly graduated nurse as a process of adjustment that is developmental, intellectual, sociocultural and physical and which is both motivated and mediated by changing roles, responsibilities, relationships and levels of knowledge in the personal and professional lives of the new professionals. The theory presented here suggests that educational institutions and industry employers focus on providing preparatory theory on role transition for senior nursing students, extending workplace orientations that offer a balance between theoretical knowledge and clinical skill practice, and providing structured and compensated mentoring programs that foster healthy partnerships between seasoned and novice practitioners.

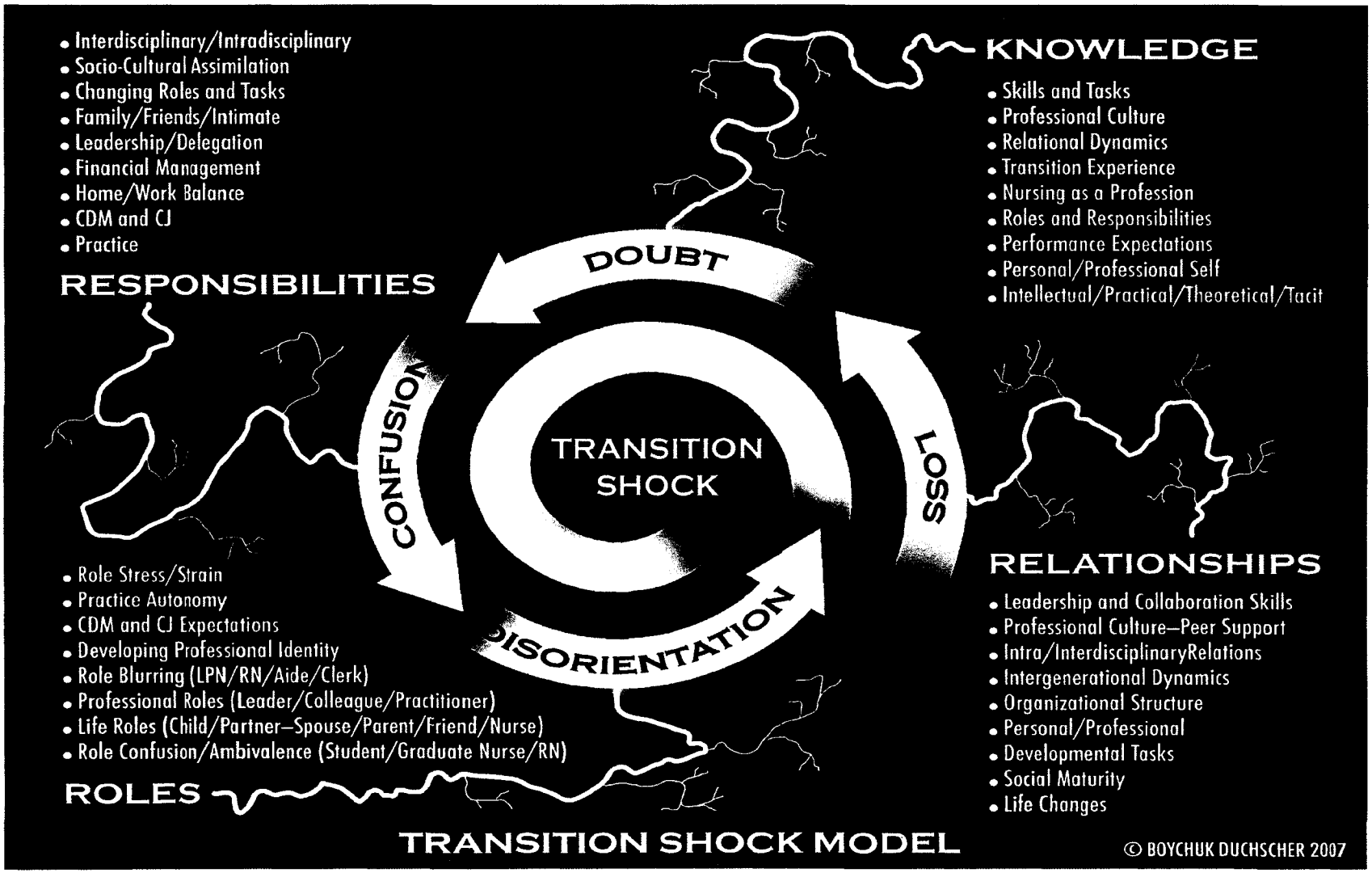

FIGURE 1. TRANSITION SHOCK MODEL

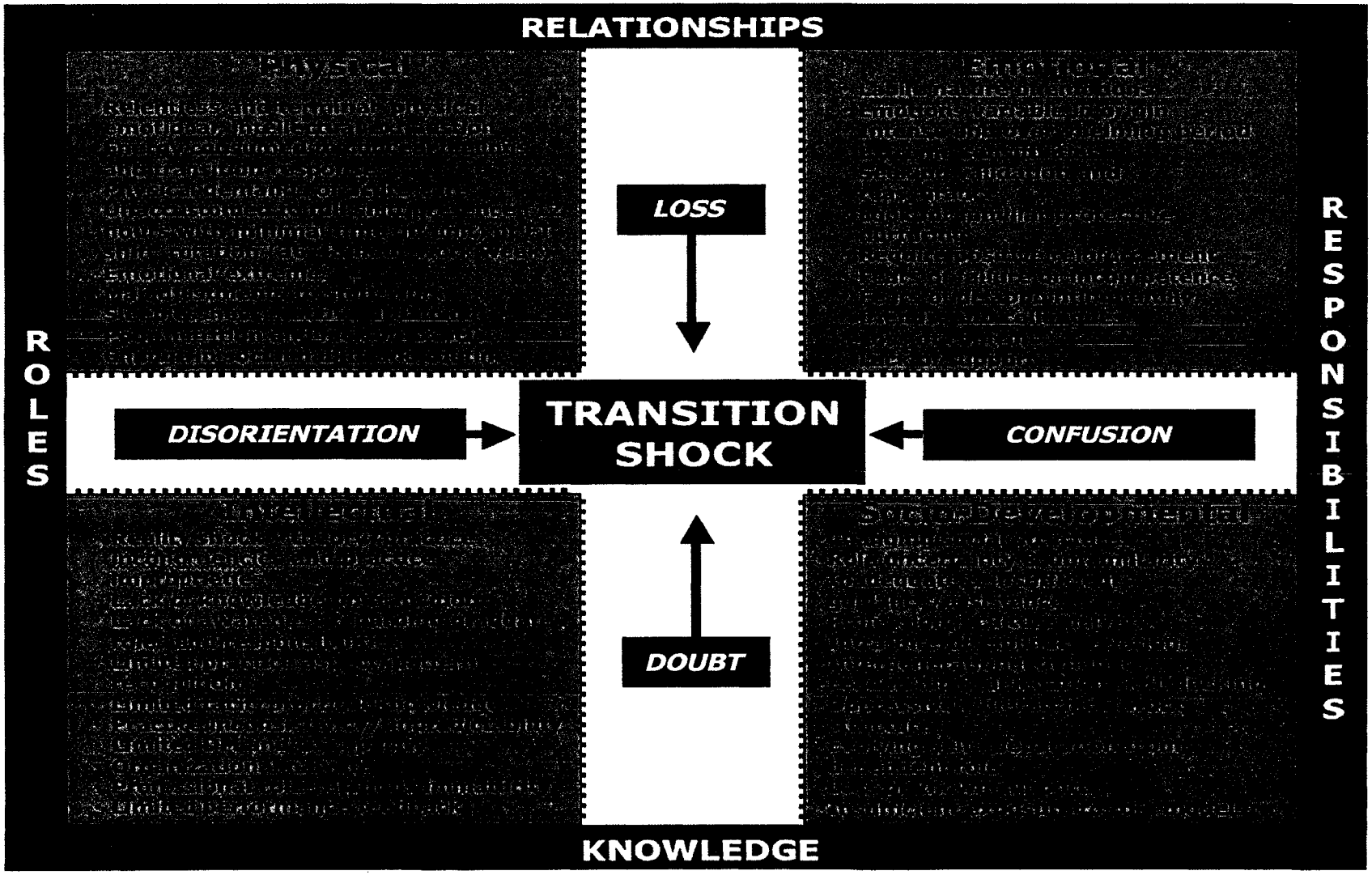

FIGURE 2. TRANSITION CONCEPTUAL FRAMEWORK

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Running head: STAGES OF TRANSITION

Paper #2 – A process of becoming: The stages of new nursing graduate professional role transition

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Keywords: new graduates, hospital, role transition, socialization, role confusion, self-concept, nursing self-concept, role theory, professionalization, professionalism, novice, transition, stages

Abstract

Newly graduated nurses are entering the workforce for the first time and finding that they have neither the practice expertise nor the confidence to navigate what has become a highly dynamic and intense clinical environment burdened by escalating levels of patient acuity and nursing workload. This research utilized qualitative methods to build upon and mature aspects of the new nurse's transition experience into acute care. The theory of transition presented in this paper incorporates a journey of *becoming* where new nursing graduates progressed through the stages of *doing*, *being* and *knowing*. The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. While this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. The intense and dynamic transition experience for NGs presented here should inspire educational and service institutions to provide preparatory education on transition as well as provide extended, sequential and structured orientation and mentoring programs that bridge senior students' expectations of professional work-life with their reality of employment as graduate nurses.

A process of becoming: The stages of new nursing graduate professional role transition

The provision of quality health care depends upon the quality of the nursing work environment and, in particular, the extent to which the hospital environment empowers nurses to deliver a high standard of care (Advisory Committee on Health Human Resources, 2002; Budge, Carryer & Wood, 2003; Canadian Institute for Health Information, 2003; Laschinger, Almost & Tuer-Hodes, 2003; Manojlovich, 2007; Laschinger & Finegan, 2005). The current global shortage of nurses is unprecedented, with demands for full-time nursing professionals growing faster than the rate at which new nurses are graduating from educational institutions (Barney, 2002; Purnell, Horner, Gonzale & Westman, 2001; Shields, 2004). The challenge of replacing nurses who have left the workplace, and a desire for knowledge about the resources required to support those just entering it are motivating healthcare institutions and nursing leaders to explore exactly what constitutes a quality work environment (Buerhaus et al., 2007; Canadian Health Services Research Foundation, 2006; Coomber & Barriball, 2006; Government of Canada's Sector Council Program, 2006; Lin & Liang, 2007; May, Bazzoll & Gerland, 2006; Page, 2005; Shields & Wilkins, 2006). Growing rates of seasoned nurse attrition are resulting in the replacement of highly competent and experienced practitioners with newly graduated nurses (NGs) who have neither the practice expertise nor the confidence to navigate a clinical environment burdened by escalating levels of patient acuity and subsequent nursing workload intensity (Roberts & Farrell, 2003; Taylor, 2002). Compounding this human resource management crisis is evidence of a disorientating, discouraging and ultimately exhausting initial work experience for young nurses that is resulting in high levels of NG burnout within 18 months of their introduction to professional practice (Cho, Laschinger & Wong, 2006; Laschinger & Leiter, 2006).

This paper presents the results of a research study that revealed a staged experience of transition occurring over the initial 12 months of an introduction to professional practice for NGs. Inherent within this initial role transition were processes that progressed these novice

practitioners through increasing levels of knowledge and broadening scopes of practice, and contributed to the ongoing development of their personal and professional selves. It is intended that the model of transition stages offered here be used as a guide by clinical educators, unit managers and hospital administrators who are recruiting, orientating, mentoring and seeking to successfully integrate this newest generation of nurses into their workplace.

Background to the Research

Although the terms *socialization*, *professionalization* or *professionalism* and *transition* may sometimes be used synonymously in the literature, *professional socialization* refers to the acquisition of knowledge and skills, norms and values of the professional nursing culture; as such, it is broad and relatively timeless (Reutter, Field, Campbell & Day, 1997). Further to this, professionalization most often refers to the evolutionary development of position and relative status within a profession, while professionalism represents the individual and group expression of that professional standing (Herdman, 2001). The experience of transition for the NG entering professional practice, while not completely separate from the constructs of socialization and professionalization, is differentiated here as the process of making a significant adjustment to changing personal and professional roles at the start of one's nursing career. While not explicit, the period of time over which the initial transition to professional practice in nursing is generally thought to occur encompasses the first 12 months as a Graduate and then Registered Nurse (RN). Understood in the context of this research, transition for the NG consists of a nonlinear experience that moves the new practitioner through personal and professional, intellectual and emotive, skill and role relationship changes and contains within it experiences, meanings and expectations. While it is reasonable to presume an individualized and thus peculiar nature to the experience of NG transition, the first 12 months of work experience encompass a complex but relatively predictable array of emotional, intellectual, physical, sociocultural and developmental

issues that in turn feed a progressive and sequential pattern of personal and professional evolution.

Of the background literature reviewed prior to initiating this research, 54 research studies were found that explored the transition experience to professional practice for NGs. Of those studies, 45% originate from the United States, 20% from Australia and New Zealand, 16% from the United Kingdom, 10% from Canada, and 8% from Europe. Of the 10% of Canadian studies related to this topic, 4% (2 studies) originate with this author. Eighty-two percent of the total number of studies reviewed used a qualitative approach to inquiry. The majority of these research studies looked at points in time (3, 6, or 12 months postregistration) or ascertained retrospective participant reflection to explicate an experiential perspective of the transition experience. Of the 82% of qualitative studies on this topic, only 5 (11%) looked specifically at NG transition over a time period that ranged from 3-12 months (Brown, 1999; Dearmun, 2000; Duchscher, 2001; Ellerton & Gregor, 2003; Kelly, 1996, 1998).

Study Limitations

The verbal, written, and pictorial recounting of one's experience, broadly referred to here as participant narrative, and the use of interpretive inquiry predicates the retrospective evolution of meaning that both emerges and is co-constructed through the researchers data analysis process and the unavoidable interactions between researcher and participant (Chase, 2005; Polkinghorne, 2005). It can be argued that the small sample sizes characteristic of qualitative inquiry and the embeddedness of the researcher within the narrative have the potential to infuse a narrow, superficial and biased interpretive process into the analysis (Creswell, 2007). It could be further argued that any telling of one's own story assumes an unavoidable relative subjectivity that biases all "truths" by virtue of what is recounted and how that is done (Caelli, Ray & Mill, 2003; Sandelowski, 1993). Equally, the researcher's undeniable subjectivity as the instrument of data collection and interpretation is a hallmark of qualitative research, providing the rich grounding

that allows for the deep discovery and understanding of complex phenomena, processes or perspectives (Merriam, 1998).

The *Stages of Transition Model* © that resulted from this research is inextricably linked to the author's 10 year history of study and research in the area of the new nurse's professional role transition. The intent of this particular arm of the author's grounded theory research program was to further examine, build upon and mature aspects of the NG's transition experience into acute care such that an accurate overall representation of this experience and the processes encompassed within could be confidently introduced into the scholarly community. Possible sources of bias within this study include situational contaminants such as the interviewer's previous interactions as a faculty member with some of the subjects as nursing students, the use of the researcher as the primary instrument for interpretation and data analysis, the relatively small and demographically homogeneous sample population, and the limitation of data collection and analysis to a qualitative interpretive research approach. It should be concurrently noted that great care was taken to institute rigorous data collection, analysis and interpretive procedures that could serve as checks and balances to the truths being purported. Participants were used to verify and clarify evolving narratives and thematic explications, experts in both research process and transition content were asked to read and provide interpretive commentary related to the transcripts, and a detailed set of researcher fieldnotes, theoretical memos and audit notes were kept throughout the research period.

Conceptual Framework of Transition Stages

Transitions have been defined as passages or movements from one state, condition or place to another "which can produce profound alterations in the lives of individuals and their significant others and have important implications for well-being and health" (Schumacher & Meleis, 1994, p.119). While neither distinguishing specific time periods over which transition phases unfold, nor illuminating factors that encourage or inhibit progression through the said phases, Bridges (1991) suggested that all transitions consist of: 1) an *ending*, characterized in the

case of the NGs professional role transition by a struggle to differentiate between the educational orientation of a student and the professional reality of a practicing nurse that is accompanied by the necessary letting go of more familiar ways of being; 2) a *neutral* phase, set apart for the NG by a sense of confusion, disequilibrium, and detachment brought on by the distortions embedded in an idealized practice understanding; and 3) a *reorientation*, where new nurses re-establish a sense of connectedness through the acceptance of a new reality and a stabilizing of their emotions and intellect. While the Bridges model is helpful in guiding our general understanding of transitions, greater detailing of the relationship between transition theory, the context within which the NG is evolving, and those factors which inhibit or facilitate movement through the process are required if NGs are to anticipate a satisfying and progressive professional trajectory at the start of their careers.

To assist NGs to make a healthy professional transition, it is important to understand how nursing knowledge develops in clinical practice. Benner's (1984) application of the Dreyfus Model of Skill Acquisition to the study of nurses has been instrumental in providing insight into how practice competence evolves. While the NGs transition experience is not included within Benner's theory of novice to expert practice, it should be noted that she neither independently studied nor sought to exclusively elucidate skill acquisition as it relates specifically to the NG professional role transition. Only three studies could be found that incorporated Benner's model in the study of transition experiences of NGs (Duchscher, 2001; Ferguson, 2007; Schoessler & Waldo, 2006). Despite this, Benner's theory is used widely as a framework for understanding the progressive development of knowledge and skill in new nurses, and contains within it the explicit assumption that advancing skill levels in nurses are a product of their practice experiences and evolution. According to Benner, there are general changes one can expect to see in skill performance over the professional life experience of a nurse: 1) the movement from an initial reliance on abstract principles and rules to concrete experience; 2) a shift from reliance on analytic, rule-based thinking to intuitive processes; 3) a change in the learner's perception of the

situation from one in which it is viewed as a compilation of equally relevant bits to an increasingly complex whole; and 4) the passage from detached observer to involvement and full engagement in clinical situations.

Most appropriate for the purposes of this research are the two initial stages of skill advancement in the theory of novice to expert practice. Benner (1984) identifies *novices* as students with virtually no experience on which to draw and, therefore individuals who use objective attributes which have been taught to them. By virtue of their inexperience with clinical scenarios, novices use context-free rules to guide their task performance; rules that ultimately mitigate against successful application in the dynamic and unpredictable context of acute care. The *advanced beginner* level of skill acquisition in Benner's model is presumed to encompass the nursing graduate. At this level of practice, the nurse demonstrates "marginally acceptable performance" (Benner, 1982, p.403) and is able to recognize some recurrent aspects of meaningful clinical situations. This new practitioner takes in only "parts" of the "whole" situation, needing still to concentrate on remembering the rules and linearly applying the practical structures that were taught.

The process of transition to professional practice in nursing graduates has been reported most notably in the work of Marlene Kramer (1974). According to Kramer, the experience of role transformation from student to staff nurse evolves in a fairly predictable pattern, moving the novice from an initial *honeymoon* phase where graduates are excited and exhilarated at having arrived at a long-awaited goal, through a *shocking* assault on their professional values that leaves them disorientated and disillusioned, through to the *recovery* and *resolution* phases earmarked by a return of a sense of balance (Kramer & Schmalenberg, 1978). Schmalenberg and Kramer (1979) further claimed that the resolution phase of the transition experience does not necessarily mean acceptance of, and assimilation into the new nursing culture. As the final phase of the graduates' adaptation into their new professional role, those who are not assisted to make a successful transition to their new working role may: 1) dilute or discard ethical and practice standards in

exchange for institutional routines and bureaucratic compliance, 2) limit their work commitment and turn their conflict inward, leading to work environment fatigue and burnout, 3) express their discontent by "making waves" and contributing to a reduction in morale and an increase in unit dissention and discontent, or 4) align themselves with the institution, developing a pervasive disdain for a profession that led them to believe in a practice ethos that they now recognize as unrealistic and unachievable (Kramer & Schmalenberg). This failure to successfully integrate into the new organizational climate is believed to be one of the major factors leading to rapid NG turnover (Cho et al., 2006; Gardner, 1992; Oermann & Bizek, 1994).

Dearmun (2000), Duchscher (2001), Ellerton and Gregor (2003), and Kelly (1998) provide the next level of formalized analysis of NG transition stages that informed this author's research. These authors used similar research approaches and data collection strategies. Slight differences in study periods existed for Dearmun and Ellerton and Gregor by extending the period of study out to 12 months while Kelly conducted her final interview of participants at 18 months, asking them to reflect on the initial 12 month of practice. Duchscher remained focused on exploring the initial 6 months of NG practice. Remarkably similar thematic conclusions were presented that reflected the prior workings of Bridges (1991), Kramer (1974) and Benner (1984). Dearmun and Duchscher both claimed that the initial 3 months of NG transition is consumed by an adjustment to new roles and responsibilities, an acceptance of the differences between the theoretical orientation of their education and the practical focus of their professional work, and the NGs' integration into an environment that emphasizes teamwork as opposed to individually-based care provision. A further finding was that a significant change in the graduates' perception of their experience is noted at approximately 5-7 months, propelling them to yet another stage of greater consolidation and meaning making (Duchscher). While Kelly offered an overview of evolving conceptual themes of transition that mirrored the above work, her writing did not explicate time periods and tended to blur processes with events (e.g., the author presents "coping with lost ideals" [Kelly, 1998, p. 1140] as occurring late in the journey of transition while

concurrently identifying "coping with moral distress" [p. 1139] as one of the earliest conflicts for graduates). In all of the research reviewed on NG transition stages, varying degrees of attention were paid to the emotional impact of the transition on the NG and its significance to the NG's ability to advance through the stages. With the exception of some of Kramer's work in the 1960s, none of the studies mentioned above have formally acknowledged the significance of either developmental or sociocultural origins to, nor physical expressions of role transition stress for NGs. Finally, few studies since Kramer have distilled out the nuances of the transition experience at various stages or sought to clarify the relationship of the stages of growth and change in the NG to the passage of time. It should be noted that the unfortunate premature death of one the primary researchers in Ellerton and Gregor's research rendered data dissemination, beyond a single publication that reported on the NGs three month transition mark, inaccessible to date.

Several remaining authors have more peripherally enhanced our understanding of the phases and stages of transition for the NG (Brown, 1999; Casey, Fink, Krugman & Propst, 2004; Chang & Hancock, 2003; Goh & Watt, 2003; Ross & Clifford, 2002; Schoessler & Waldo, 2006; Tiffany, 1992). Issues commonly cited as troublesome for NGs at various points in time throughout the initial 12 months relate to a lack of clinical knowledge and confidence in skill performance, relationships with colleagues, workload demands, organization and prioritization as they relate to decision making and direct-care judgments, and communicating with physicians. While many of these studies measured or identified particular concerns at points in time (e.g., scheduled testing by instrument, interview or focus group), few gave insight into what aspects precipitated their occurrence or supported their presence, precisely when the issues originated, or what factors may have impeded or mediated the resolution of those issues. The importance of exploring the ongoing and longitudinal process of role transition in nursing relates to the challenge for institutions of healthcare, schools of higher learning, and policy makers in this country to both understand and respond appropriately and effectively to issues inherent in the

transition of NGs to professional practice that may be driving these energetic and motivated nurses out of acute care or out of the nursing profession altogether.

Methods

This research employed a generic qualitative approach of interpretive inquiry, using foundational knowledge on the NG's introduction to the workplace to frame an exploration of the process of transition that occurs over the first 12 months of practice. Fourteen female graduates who originated out of the same 4-year baccalaureate undergraduate nursing program were purposefully selected from two major cities in the province of Saskatchewan, Canada. Research strategies included a demographic survey at the start of the research, six face-to-face interviews at 1-3-6-9-12-18 month periods followed, in the initial two cases, by focus groups with a different set of participants located in the second major city, preinterview questionnaires requesting the completion of a process-revealing exercise such as letter writing, collage construction or picture drawing, monthly journals and ongoing email communication with all participants over the 18 months. An ongoing and fluid exchange of inductive and deductive interpretive processes guided the analysis of the data and QSR NVivo ™ was used to manage approximately 3500 pages of narrative transcription.

Data revealed an intense and dynamic transition process that was sequential, event-sensitive and primarily progressive in relation to the passage of time. Numerous issues motivating and perpetuating the stress inherent in the transition experience were uncovered during the analysis of the data and are included here. The relationship between those issues and the passage of time was an important finding and is represented in the proposed *Stages of Transition*© model of transition (Figure 1). The intent of this research was to offer further validation to new graduates experiencing their initial professional role transition by contributing aspect knowledge to the author's evolving theory of NG transition to the acute-care practice setting. Distinctions between the unavoidable or necessary elements of transition and those which are more yielding and supportive of the NG will make it possible to generate a guide that can facilitate the

implementation of supportive and interventional strategies that more accurately reflect the challenges being experienced by NGs at specific stages in their transition.

Stages of Transition

The initial 12 months of transition to professional acute-care practice for the graduates of this study was a process of *becoming*. Both a personal and professional journey, participants evolved through the stages of *doing*, *being* and *knowing*. The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. While this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. Further to this, data manifested ongoing, but transient regressions precipitated by the introduction of new events, relational circumstances and unfamiliar or complex practice situations or contexts into the graduates' assumed location on the transition continuum that is represented by the stages model presented here. The following description attempts to categorize significant processes as they related to periods of time. Application of this knowledge should take into consideration that no model can be accurately prescribed to the dynamic and fluid nature of an individual's experience. Rather, models serve as frameworks that allow opportunities for attention to be paid to general variables that can suggest needed context-specific exploration. It should be noted therefore, that the timelines associated with the stages presented here are fluid and any deployment of stage-specific strategies should be individualized.

Doing

The initial period of professional role transition for these acute-care nurses encompassed approximately the first 3-4 months of the study. All participants had undergone a period of orientation prior to the study commencement and were working > 50% maximum hours on varying acute adult and pediatric medical surgical units in different hospitals, as well as one who

worked in a neonatal intensive care unit. The majority had been hired into temporary part-time or casual positions but were working full-time hours, and 30% of the participants were shared (e.g., float position) between 2-5 different units on an ongoing basis. None had yet written their RN qualifying examinations and all were therefore working under the probationary title of Graduate Nurse. The initial transition from a structured life that was known, relatively predictable and often mastered into a new set of expectations and responsibilities that were at best semifamiliar but not fully understood posed numerous challenges to both their personal and professional selves. While initially curious and excited to tackle the challenge of managing the transition from student to professionally practicing nurse, the participants quickly realized that they were quite unprepared for the responsibility and the functional workload of their new roles:

> It's strange. I don't really feel like I am finished school. Like I walked to work one morning and as I was walking, I was thinking, "I'm getting paid to do this," because it's like I was still in school. And then, within my orientation week I was told that the staff had just run off this nurse who wasn't doing very well. They told me that they had made it so miserable for her that she would leave....and I think they were proud of it – that they had gotten rid of her. I think its maybe to maintain quality control but it's definitely one of my fears that I won't be accepted. That if I am failing they won't come along side me, but will show me the door.

The vast majority of these NGs entered their professional transition with expectations and anticipations that were more idealistic than they were realistic. Not uncommonly, they blamed the shocking disparities between what they had anticipated regarding their roles as nurses, and what they were being expected to do in the "real" world on their lack of educational preparation. Even when asked, none of the participants at this stage had considered the culpability of their workplaces in failing to prepare them for, or gradually introduce them to the roles and responsibilities of a fully practicing nurse. They readily identified surprise at the intense and heavy workload of ward nurses, struggled with the non-nursing duties they were expected to assume, and ultimately expressed disappointment at the low value placed on their contribution to assigned units and nursing's contribution to institutional operations in general.

This first stage of entry into professional practice was marked by a tremendous intensity, range, and fluctuation of emotions as graduates worked through the processes of discovering, learning, performing, concealing, adjusting and accommodating. Upon entry into hospital nursing, these newcomers quickly discovered that while they may have been prepared to be nurses, they were not ready to assume responsibility for a workload of patients that was double that which they had previously cared for as students. Within several weeks of being hired, these novices were afforded full patient loads equal to their senior nursing counterparts, but without reasonable access to expert counsel or practice support. None of the participants in this study was formally mentored, and all but one went from "buddy" experiences to full responsibility without graduated progression. The negative case in this study was a young woman whose 3-year pre-graduate experience as a unit aide, unit clerk and senior assist (a senior nursing student employed in a healthcare support role similar to that of an LPN for several years prior to graduation) in the neonatal intensive care unit where she took her initial graduate nurse position, significantly altered her transition experience. Despite her broad experience in a multitude of roles within this unit, this participant was given an extended period of orientation with the limited responsibility of feeding, changing, and handling these neonates conferred upon her during the first 3 months. Very intentionally and very slowly, this novice practitioner was watchfully introduced to increasingly complex levels of care and responsibility. Understandably, her initial transition stage held neither the acuity nor the intensity of the other participants.

The discovery that all was not as they had expected it would be sent the NGs of this study into a flurry of learning and subsequent performing. Understanding what was expected of them, doing it well, and completing their tasks on time was their primary concern. The reasoning behind this focus became clearer upon hearing that numerous graduates were chastised by select senior coworkers on the unit, or called at home after their shift because of something they had forgotten to do. The clear majority of the situations about which these graduates were called were

noncritical, leaving them with the perception that they were unsupported and at times being intentionally undermined. Uncertain of who they could trust with their profound vulnerabilities, and driven by an understandable but impressive need to belong, these graduates went to great lengths to disguise their emotions from colleagues and worked to conceal any feelings of inadequacy. Projecting a controlled and competent exterior was a strategy often painfully employed by these graduates in an attempt to minimize the risk of disapproval from colleagues.

Because so much of what they were experiencing was new to them, the functional learning curve that dominated this stage of transition was steep for all participants. As a result, what had in many become a solid professional identity by the end of their undergraduate years was fracturing under the weight of performance anxiety and self-doubt; these graduates felt stressed "about absolutely everything." The new practitioners' adequate and sometimes advanced entry level skill and knowledge were constantly challenged by their wavering confidence, their limited experience with the application of that skill and knowledge, and a lack of predictability of and familiarity with the many variations in clinical contexts. These antecedents were further aggravated by inconsistent practice area placements, the feeling by NGs that they lacked the essential background knowledge of their patients that they had come to depend on as a student, and overall insecurities with regard to executing unit-specific routines and tasks. The relentless requests to assist with, or perform procedures for which the graduate had little or no reference caused significant levels of anxiety. Yet again, these situations posed a high level of risk to graduates of being exposed as incompetent and subsequently reducing their credibility in the eyes of their colleagues. In cases where the graduate was not assigned a senior nurse who was afforded workload relief to preceptor them, where they experienced even the subtle suggestion of rebuff from a colleague, or when coworkers' caseloads were perceived as equally demanding to their own, newcomers spent precious time trying to independently discern the necessary equipment and processes to competently carry out particular requests, make patient care decisions, or fulfill

routine nursing expectations. As a result, multiple and unnecessarily repetitive steps were often taken in attending to a naively prescriptive and linear application of what was required.

During this initial stage of their transition, the new nurses in this study felt able to reasonably manage a workload that consisted of a nurse-patient ratio of less than 1:8 but were often left caring for anywhere between 8-16 adult patients without consistent support from another Licensed Practical Nurse (LPN) or RN. High levels of stress were associated with: caring for patients who were clinically unstable; being expected to multitask (i.e., answering phones, speaking with physicians, processing orders, dealing with multiple patient and family issues concurrently) while providing direct care to patients (i.e., starting IVs, dispensing medications, performing dressing changes); caring for patients who were critically ill or dying; or dealing with families who had numerous questions or demands. Many examples were given of graduates whose need to intently focus on every detail of their role prevented them from hearing or seeing much of what was going on around them. As a result, graduates universally expressed anxieties around "missing something" or inadvertently and unintentionally bringing harm to someone under their care as a result of their ignorance or inexperience. Not uncommonly, participants' descriptions of clinical situations exposed a prescriptive approach to their thinking. One participant suggested that this early practical application of their knowledge was akin to "being in a private little bubble and things are going on all around me and I cannot hear them, I cannot see them." The limits to their problem-solving and subsequent clinical judgments were not surprising, given that they had never actually seen or had an opportunity to work through many of the scenarios they were being presented with. Strategies to manage complex clinical scenarios seemed unavailable to their minds that were consumed with completing tasks and routines within the rigid timeframes imposed by the structure of the units where they worked. It was understood that failure to adjust to or comply with existing routines could garner exclusive attention; an

outcome that conflicted with the developmental task of "fitting in" to their dominant professional culture.

Contributing to their stress was the expectation that they would delegate appropriate tasks and responsibilities to other licensed and non-licensed personnel, many of whom were older in age and far advanced in clinical experience and practice seniority to them. The graduates claimed that they had never been prepared for, nor allowed to practice the skill of delegation during their undergraduate education. Further to this, these new practitioners spoke of the time-consuming paperwork involved in recording and managing their patient care responsibilities. They found themselves frustrated by what they perceived as archaic ways of thinking about nursing by some of their more senior colleagues, and expressed disappointment regarding the rigid and distracting allocation to their role of non-nursing tasks. While these graduates felt the immediate need to accommodate "what" was being practiced without asking "why," they would later identify these issues as primary factors contributing to their lack of professional fulfillment in an acute-care nursing role:

> I was so focused on knowing the routine, knowing what I'm doing, getting things done, knowing the way different nurses like things done, knowing where I fit in, what I'm supposed to be doing, when I'm supposed to be doing it. I had total tunnel vision. I was just focused on getting the job done and getting out of there on time. Then I would go home and I would feel guilty for not being more.

It is important to mention that during this stage of their transition, the graduates' overall energy was being necessarily divided between the demanding professional adjustments cited above and parallel, but no less significant sociocultural and developmental changes occurring in their broader lives. These young women were experiencing varying but nonetheless acute changes to established life-pattern routines such as changed living arrangements, terminated or advanced intimate relationships, and the acquisition of unprecedented debt through the purchase of cars and homes; all serving as both exciting distractions and unexpected burdens. Concurrently, these normally high-spirited young nurses were adjusting to intimidating levels of clinical

responsibility, navigating new professional associations while struggling to let go of long-standing personal relationships that no longer fit with their evolving selves, seeking acceptance into a tradition-bound and hierarchical nursing culture, and adjusting to the physical demands of intensive, alternating and sometimes unpredictable or inflexible day/night shift schedules. It was in the context of undergoing this tremendous inventory of developmental change that these nurses were making advanced clinical judgments and practice decisions for which they felt minimally qualified and completely responsible. They were exceptionally hard on themselves when they felt they had failed to identify or appropriately intervene in a changing clinical situation regardless of competing demands. Further to this, in spite of the fact that many of the situations in which they were placed were beyond their intellectual or practical capability, their behavior was consistently self-deprecating. During this initial four months, the graduates expected that they "should know it all" and endured tremendous guilt when the excessive demands on their time, energy, and intellect rendered their care marginal. The prevailing self-talk at this stage was: "OK just isn't good enough."

For several participants, the notification of their successful passing of the national qualifying examination marked the end of this stage of the transition experience: "I'm glad it's finally over. There's kind of an end to it and you can put the school part behind you now." For most, however, movement beyond this stage of the transition experience was inspired by a combination of growing comfort and familiarity with practice routines, professional roles and responsibilities and a desperate need to withdraw from the profound intensity of the prior months. The overwhelming exhaustion that both fed and resulted from this disorienting, confusing and emotionally chaotic stage dictated a necessary change to their level of engagement with their world.

Being

The next 4-5 months of the NGs' postorientation (PO) transition experience was marked by a consistent and rapid advancement in their thinking, knowledge level and skill competency. Concurrently, this stage sparked disconcerting doubt in the participants regarding their professional identity by challenging pregraduate notions of nursing and exposing the inconsistencies and inadequacies in the healthcare system. As one participant articulated:

> The reason I'm finding this part of the transition to be the most difficult is because the excitement about being done and the shock that I was in has worn off. I feel as though I'm on a raft that is drifting farther and farther away from the shore (my safety net of being a student or a new grad). And I'm floating toward an island where the experienced nurses are but I keep losing sight of them due to all the waves.

The high degree of frustration and subsequent energy consumption that characterized the prior stage of their transition continued at a slower, but nonetheless relentless pace. To cope with the ongoing drain on their resources, many of these graduates sought refuge in their personal lives, separating themselves from their work environment (e.g., refusing overtime) and putting a distance between themselves and their colleagues (e.g., choosing to forego staff functions). Fundamental to this stage was an increased awareness of themselves professionally, an exploration of the role of the nurse relative to other healthcare professionals, and a fundamental search for balance between their personal and professional lives. During the initial half of this stage (between 3-5 months PO) the participants became increasingly comfortable with their roles and responsibilities as nurses. This comfort permitted them, during the latter half of this stage, to begin a concerted examination of the underlying rationale for nursing and medical interventions and the appropriateness and effectiveness of the healthcare system. Scrutinizing the practice context and its relationship to the graduates' professional role aspirations would take on more importance during the final stage of their transition. During the course of this second stage, the

participants would disengage, question, search, reveal, recover, accept and ultimately re-engage in their chosen career; the difference was that this time it would be on their terms.

As one participant suggested, the initial segment of this second stage found these nurses "caught up in a turn." There was awareness that something was different but they would spend several months struggling with the changes brought about by their commitment to become a "real" nurse. They grieved the loss of what had been while not entirely sure they were ready for the leap into what was. Many questioned why they had left the comforts of their established school routine only to expose themselves to a daily onslaught of daunting responsibility that left them feeling perpetually incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless. This downward spiral motivated a protective withdrawal from their surroundings as they attempted to recover a sense of control over their lives. They expressed a strong desire for clinical placements that offered them stable patient situations and several of the participants changed to casual employment status so that they could choose the hours they would be required to work. Most had tired of the constant "newness" and were looking to escape the barrage of learning, growing and changing; they wanted to be surrounded by familiarity, consistency and predictability.

Participants' sense of self-trust was tenuous during the initial phase of this stage and many sought validation for their decision-making and clinical judgments from senior coworkers whose level of practice they respected and admired. Unlike the first transition stage, where they required more prescriptive directives about what should be done in particular clinical situations, participants were now expressing more of a desire for clarification and confirmation of their own thinking and acting. Knowing they could make decisions and implement nursing actions that were not only safe and appropriate, but astute, was important to their wavering confidence. An interesting finding was that this developmental shift toward greater interdependence on the part of the NG was inadvertently interpreted by some senior nurses and managers as a statement of self-

reliance and a cue that the NG no longer needed or wanted support and mentoring. Several participants expressed concern that they were being "pushed into a leading role where I feel heavy responsibility rests on my shoulders at a time when I feel I am not quite done following." Not uncommonly, during the initial several months of this second stage (approximately 3-6 months PO) graduates were placed in leadership positions (e.g., put in charge of units, students, or made responsible for orientating new staff) that they deemed as inappropriate and unsafe. A relatively disturbing finding was the frequency with which the graduates were placed in clinical situations beyond their clinical competence, cognitive or experiential comfort level. Over 30% of participants with less than 5 months of experience were either requested to go to, or simply assigned shifts in an observation unit. All of them expressed significant discomfort at these requests, though the majority felt either too new to make demands about their placements or interpreted the appeals for advanced responsibility as a statement of confidence in their abilities, making it difficult to refuse the requests.

The start of this stage was a delicate time for the NGs as the desire to both hold on and let go were equally strong leaving them conflicted, confused and sending discordant messages to those around them. Concurrently, these NGs identified overly vigilant supervision of their practice as a display of doubt in their abilities, while at once expressing feelings of abandonment when left without experienced nurses to reach out to in situations that were unfamiliar, unexpected or unstable. The peak of this struggle for most in the study occurred at around 5-7 months when a crisis of confidence, mitigated by the intersection of insecurities regarding their practice competency and their fear of failing their patients, colleagues and themselves motivated a renewed commitment to maturing their practice that would carry them through the next several months. The energy that once went to simply "getting through the day" was replaced by a post-crisis efficiency born of the graduates' new-found awareness that they had, in fact, developed

organizational skills, were able to prioritize clinical situations and could safely perform their professional roles at the elevated level of expectation:

> I'm more confident to say "I'm not sure about this assessment" and I'm more confident in calling the physician and passing this on to him...if I'm unsure, I don't hesitate to do that anymore – to call the physician. Before, I used to hem and haw and I'll go talk to this nurse and "Well, what do you think about this" and finally you end up calling him anyway. I'm just more confident in "OK, this is abnormal and this is normal."

Having acquired a sense of mastery over the daily routines, they were able to lift their gaze and begin to examine and reflect upon the relative meaning of their work and the place of that work in the rest of their life. Over the course of the remainder of the second stage the graduates would find more middle ground, claiming less often that "the good days are great and the bad days are horrible"; an increasingly moderate perspective on their professional experiences became evident. While acts of support, or lack thereof, by seasoned nurses continued to significantly influence these novices, they were more able to recover from assaults to their confidence and move on with some sense of conviction. Having been previously frustrated by their perceived lack of progress, the graduates relaxed into a more comfortable space that permitted the mild angst that came with what they did not know to coexist with the growing confidence in what they did know. As one participant claimed: "I think back six months and it's like a whole different job, a whole different place, a whole different me." The distance afforded them by virtue of their newly liberated confidence would allow them to begin thinking more critically about clinical practice situations and examining their complicity to established routines:

> Prioritizing is definitely different. I've noticed that I've started to think critically about what and how I've been taught to do things. How some, you know, older nurses they do it this way, this way, this way (hand gestures) and if this isn't done by midnight then the world is coming to an end kind of a thing. You kind of sit back and go "OK, well that's not necessary you know. If I don't get it done till whatever – 2am/pm or 4am/pm – then that's not a huge deal." Like as long as I get my medications out and get my patients taken care of, then everything else can get done as I have time to do it....You can just look back and go "OK, if that's the way you like to do it, that's good but I don't see the importance of doing everything by the book." By what book? By their book I guess.

An essential element to the NGs recovery during the latter part of this stage was the time they spent reacquainting themselves with personal aspirations that had been subverted to the consuming process of their professional growth. Less cognitive, physical and emotional energy was needed to manage the now familiar nursing procedures and clinical situations. Participants required less energy to debrief about work, affording them more time to adjust to and accept the changes to their personal and work-life schedules and enjoy their new-found liberation. Within several months (i.e., at approximately 6-8 months PO) a rejuvenated spirit would reawaken a tempered interest in learning that would have them starting to seek out challenges to their thinking, putting themselves in new and unfamiliar practice situations and planning more long-term career pathway options. They would begin to look around them at the state of healthcare and nursing, confident that they could do what was required of them while at once accepting the mild tremors of uncertainty that they had come to know as a part of their professional life. They had arrived at a point where they could contentedly reside in *being* a nurse; they worked the shifts required of them at their optimal level of competence and returned home to an easier life now consumed by attending to their personal responsibilities, socializing with friends and families, reigniting past hobbies and developing long-awaited interests. While slowly re-engaging in their professional community during the latter half of this stage (i.e., beginning to be more social at work with their colleagues), they were not yet ready to commit to a deeper or broader involvement in nursing outside of their work environment. The division between occupation and recreation was intentionally distinct; they were intent on recovering their "self," regaining a measure of emotional strength, re-establishing a sense of balance in their lives and crystallizing their growing level of skill competence and knowledge confidence.

Knowing

The third and final stage of the new graduates' initial 12 months of practice was focused on achieving a separateness that both distinguished them from the established practitioners around

them and permitted them to reunite with their larger community as professionals in their own right. During the 3-5 months leading up to the one year anniversary of their graduation, participants excitedly anticipated the arrival of what they perceived to be the first significant marker in their career. While unable to explicate the precise origin of its relevance all graduates identified 12 months PO as the period which symbolized the end of their initiation into the profession:

> I remember I had that in my head from when I was a student and one of the nurses had said something about you kind of had six months to ask any question you want without anybody thinking that's a stupid question. So then, in my head I had this timeline, like "OK, I have six months." Then I sort of got there and realized that's ridiculous because everybody asks questions and you're always learning. But now, it's almost like that year is a big time, an important date.

Concurrently, the majority of graduates harbored some apprehension about moving out of the learner role into one which they believed would hold greater expectations and a reduced margin of error allowance.

During this final stage of their initial professional role transition experience graduates continued the recovery they had started during their second stage. Some participants were experiencing a shift in their primary supportive relationships from non-nursing pregraduate friends and family members to coworkers and nursing colleagues, while others were crystallizing intimate relationships through engagements and weddings. There was a sense, particularly during the initial months of this final stage that the graduates just wanted to coast; they were content to "get up and go to work and come home to my life.... my eyes and ears are open, but my mouth is closed." Work itself was providing more stability and there were more good days than bad days. Especially toward the latter half of this stage, increasing time would be spent exploring and critiquing their new professional landscape and graduates would begin to take notice of the more troubling aspects of their sociocultural and political environments. Fed by the residual exhaustion of the prior stages, there was a universal and growing dissatisfaction with shiftwork, the

conditions of their work environment, and a sense of their relative powerlessness to effect change within their environment:

> This is something that is a big issue on my ward and that affects me as a nurse. My increasing problem working as a nurse lies within staffing issues. How can I do the job that I am taught to do when I have too many patients to do my job properly. This brings on a lot of stress. This month I have been stressed out even before I get to work worried about how many people will call in sick and who won't be replaced. Will that leave me with 6 patients or 16, depending on if it is a night shift or a day-shift. I also get called every day off to come in to work. It seems like my phone is always ringing. Then the kicker is when your manager tries to mandate you to work. I have been mandated to work after working a night shift and not slept all day because my family was in the city and I hadn't had sleep in 30 hours. I told my manager it was unsafe for me to return and I refused. I feel guilty because I know how short staffed we are and when we need people, we need people bad.

While participants identified themselves as only moderately stressed at both the 9 and 12 month study time periods, the factors contributing to their level of stress had changed from their individual capacity to cope with their roles and responsibilities to frustrations in dealing with the system (i.e., institution or healthcare) at large. An overwhelming majority of the participants offered disconcerting descriptions of nurses as "being at the bottom" of the hierarchy of authority and power. The polarizing experience of having the individual confidence, collective professional intellect, and theoretical and practical insight to contribute to organizational (i.e., staffing requirements) and clinical care management decisions (i.e., admissions and discharges of specific patients) about which their consultation as nurses was never solicited left many of the graduates feeling frustrated, disillusioned and disrespected. For some, this discontent would culminate in yet another, though much less dramatic reduction in their momentum. For many, this served as the point of origin in their search for professional fulfillment outside of their existing acute-care bedside role:

> I wish I could say that work is going great. I wish I could say that nursing is everything I ever thought it would be and more. I wish I could say that I am learning so much everyday that I amaze myself. But I can't. Sometimes it takes an army of courage to drag myself from my so comfortable bed to the stressful place. Working with other nurses that don't respect me, doctors on horrible power trips. I feel the same I felt when I first started, unable to keep up with everything occurring around me, patients unsatisfied with

> their care, families asking me questions I can't answer, coworkers that have to take the brunt of the extra work needing to be completed, and physicians intimidating me more than ever. There was a couple of amazing months there where I felt comfortable in my position, confident in my problem solving skills, aware of my new time management skills, proud of my assessment skills. Now I feel I am back to square one wondering where those nine months of experience had disappeared to.

An interesting finding was that concurrently, particularly during the initial 2 months of this final stage, several of the new graduate participants expressed concern when given the full responsibility for advanced decisions or responsibilities such as being placed in charge-nurse roles or requested to orientate new staff. Perhaps some explanation for this seeming contradiction can be found in the tremendously labile nature of the cognitive, practical, and emotional states of the new graduate that was evident throughout this study. While these new practitioners grew steadily and rapidly throughout the initial 12 months of their practice transition, not infrequently one of these elements either lagged behind or was propelled prematurely beyond the other.

By the 12th month study marker all graduates had reached a relatively stable level of comfort and confidence with their roles, responsibilities and routines. Many spent time "comparing" their practical skill level and cognitive prowess with the newest graduates entering their clinical environments, making mention of the differences they noticed between themselves and their new graduate colleagues:

> Perhaps I noticed such a difference because I reported off to a new grad. And the contrast between our reactions is what made me realize I have changed. I watched as her eyes became bigger and bigger as I gave report. She almost started panicking before I was even done and stated she felt really overwhelmed. I remember exactly how she felt, but I was surprised (and relieved) that I no longer felt this way about work.

Further to this, being able to answer questions rather than simply ask them, and being able to assist others with their workloads were both identified as notable signs of their progress. Several participants suggested that these changes were attributed to advancements in their organization and prioritization, while others claimed that "all of a sudden you look back and its like how did I get from there to here, because it's gradual and it happens without your realizing it." As another

participant stated, "you know it could be exactly the same scenarios but my ability to cope has changed," illuminating the grounded perspective expressed by the whole of the study group at this final stage.

Discussion and Recommendations

Bridges (1991) claimed that prior to embarking on a transitional process individuals must recognize in themselves a need for change. This "defining moment" for the NGs of this study was dually *developmental*, because many of them were experiencing total and independent responsibility for their lives for the first time, and *situational* as they explored the new dimensions of their professional roles separate from being students. All transitions are fluid over time; a characteristic that distinguishes them from the more outcome-oriented construct of change (Lewin 1951; Meleis & Trangenstein, 1994). Of particular significance to the topic of transition is literature that identifies the process of socialization into nursing (Clark, 2004; Hinshaw, 1977; Holland, 1999; Nesler, Hanner, Melburg & McGowan, 2001; Simpson, 1967). This *status passage* (Bradby, 1990a; Glaser & Strauss, 1971; Van Gennep, 1960) often includes some level of anticipation, anxiety and emotional preparation prior to the event, an attempt by senior students to gain some practical experience that might suitably prepare them for the realities of practice, an unavoidable *reality shock* (Kramer, 1974) upon entry to practice, and finally a process whereby graduates accommodate and adjust to their new reality (Bradby, 1990b; Duchscher, 2001; Kramer; Schumacher & Meleis, 1994; Turner, 1982; Wells, Barnard, Mason, Ames & Minnen, 1998). Feeding into this often difficult process of transition is the profile of the "typical" NG (traditional 1st degree graduate) as an individual who is very informed, idealistic, highly motivated, intellectual and who maintains high, if not unrealistic expectations of him or herself and others. These young professionals generally have limited practical nursing experience, lack social and developmental maturity and struggle with basic clinical and work management skills such as communicating with and delegating to others and balancing time with responsibilities and

tasks. A relative naiveté renders NGs vulnerable to indiscriminate influence by those perceived as experts and to intimidation by organizational cultures that conflict with the protected perspective of reality they acquired as a student. Their initial focus is on doing what is necessary to gain the respect and admiration of colleagues whose acceptance is a critical aspect of their developmental need to fit in to their new professional culture (Buckenham, 1994; Crane, Jones & Sharpe, 1988; Duchscher, 2001, 2003a; Goh & Watt, 2003; Manojlovich & Ketefian, 2002).

What has been demonstrated by the model presented here is that the measures undertaken to address the issues inherent in the NG's initial period of introduction to professional practice are sensitive to time and the relative position of the NG on the continuum of his or her individual transition experience. As outlined above, new graduates begin with a rather prescriptive and linear approach to both their thinking and their practice (Duchscher, 2003b). While they are adjusting to changing roles, routines, responsibilities and relationships NGs require all their energy and focus for each separate task at hand (e.g., giving medications, speaking with physicians, performing a dressing change). As Benner (1982) so clearly articulated, "the heart of the difficulty that the novice faces is the inability to use discretionary judgment" (p. 403), which mitigates against a successful linear application of theory to clinical practice because "no rule can tell a novice which tasks are most relevant in a real situation or when an exception to the rule is in order" (p. 403). The limited capacity for multitasking (e.g., speaking with a colleague about a clinical finding on a patient other than the one they are working with at that moment) and the challenge inherent in higher-order decision-making (e.g., dealing with a patient who has become acutely unstable) that requires the melding of variant sources and levels of information-complexity make functioning in the dynamic environment of acute care exceedingly difficult for the NG (Ferguson & Day, 2004; Roberts & Farrell, 2003; Taylor, 2002). Allowances should be made for a reduced workload and the NG should be given dependable access to a consistent seasoned clinical colleague who is also afforded work relief, who is being compensated for and educated about their advanced leadership role, and with whom the NG has a trusting relationship.

It is unreasonable to expect undergraduate educational institutions to prepare graduates to competently perform all of the skills required by a contemporary acute-care workplace. It is therefore essential that during their orientation period NGs be allowed to repeatedly practice the multitude of nursing and transfer of function skills required by their transitioning unit. Supernumerary staffing arrangements allow the NG to take advantage of the varying needs by staff for the performance of skills in a range of clinical situations. The novice can then perform and further learn required skills under the watchful eye and skillful preceptoring of many different clinical experts while serving to offset the unit workload. This inadvertently cultivates an environment of teamwork amongst the staff and satisfies the much sought after sense of belonging for the NG.

Prolonged orientation periods (12-24 weeks) that are grounded in a balance of classroom theory and clinical practice wean the graduate into the rigors of being a fully responsible and accountable professional practitioner (Cowin & Duchscher, 2007). Graduates require consistency, predictability, stability and familiarity in their initial clinical practice situations for at least the first 4 months. Floating NGs between more than two units or expecting them to orientate students and new staff, work rapid-turnover shift schedules, take charge of units, or rotate into high-acuity observation subunits is unreasonable during the initial stages of their transition and may contribute to an unsafe environment for patients and staff. Further to this, NGs may initially perceive the working of overtime shifts as a way of endearing themselves to management and senior colleagues and establishing their place in the unit culture. Other graduates may see this additional work as an opportunity to gain experience while paying off the debt they have acquired during their education. Regardless of the motivation, this practice will rapidly deplete the modest energy with which this novice is already working and should be actively discouraged.

As graduates advance through the stages of transition, their needs necessarily change. During the second stage of transition, the NGs of this study had in many ways advanced through Benner's (1982) novice level of competence and into the stage of an advanced beginner. In

general, the NGs' comfort with the routines of their unit and their familiarity with roles and responsibilities that have been established by virtue of the experience they have gained over the initial months of their transition serve as a foundation from which they can draw to both predict and respond to presenting situations. While it may be reassuring to both NGs and their colleagues that they are capable of "acting" like a nurse, it is prudent to remember that they don't necessarily "feel it inside" (Benner, p. 59). As participants in this study revealed, the graduate is comfortable with more common events that consist of stable client presentations and consistent relationships and expectations. But graduates placed in complex and rapidly changing situations experience "terror in which they recognize that they are in over their heads and lose all capacity to plan or act" (Benner, p. 57). What is needed at this point in the transition experience is a process whereby graduates can be permitted to relax and enjoy their hard-earned comfort level while being challenged to slowly advance their thinking and practice within the safe confines of a mentored relationship.

After approximately six months of graduated and facilitated clinical learning, the graduate is ready to be introduced to more unstable patient populations (e.g., step-down or observation units) assuming the close availability of seasoned staff (e.g., not scheduled as the sole nurse in high-acuity units or left alone during breaks without readily accessible clinical back-up). At this point, NGs should be assisted in making, and taking responsibility for decisions and judgments related to changing patient situations with the coaching of advanced clinicians. Opportunities for advancing knowledge that can be immediately applied in the clinical context within which the NG is working would be received enthusiastically (i.e., dealing with grieving families, defusing an angry situation). It is important to note that while advancing their education is seen as a natural progression for them, the depth and breadth to which that succession is enacted should be closely monitored. Advancing the graduate beyond their capacity (e.g., ACLS, Charge Nurse Training) would be easy to do at this stage, but could prove counterproductive in the long run. These new professionals have been through a significant growth experience and need time, particularly

during the initial several months of the second stage of transition (4-6 months) to recover their sense of balance and restore their depleted energy reserves. Encouraging the graduate to pursue personal enhancement activities and "settle" their lives outside of nursing will set the stage for a more longterm commitment by the graduates to their work environment. This is a time when efforts could be made to actively draw NGs into the cultural "inner circle" of the unit by inviting them to develop or participate in activities that facilitate bonding with extended senior staff (e.g., help plan the staff Christmas Party). They will soon be entering a stage of transition where they will be forecasting their career plans; fostering a sense of supported collegiality may influence decisions they make at this point about their future (Jackson, 2005).

During the final stage of transition (8-12 months) the graduate maintains a variable tension between a contented enjoyment of his or her work and the inherent tendency toward mobility and career advancement that is characteristic of this generation (Duchscher & Cowin, 2004). Mentors and managers working with NGs would be well-served to join with them in formulating a two and 5-year career trajectory that addresses their most immediate plans and supports, both educationally and organizationally, their projected professional aspirations. It is in this stage that NGs are seeking to establish a separateness that both distinguishes them from and permits them to reunite with the practitioners in their larger community. This is a time of excited anticipation of arriving at another milestone in their professional maturation process, but carries with it some anxieties about being able to live up to a higher level of expectation. The need for reassurance that the NG is, indeed, worthy of this advancement may be served by a healthy critique of the surrounding professional landscape. Assisting NGs to develop a sense of agency involves assisting them to understand the complexities of working within a bureaucratic system, the process of actualizing successful and sustainable change within a corporate structure, and the unavoidable necessity of accepting particular aspects of one's work environment as unalterable (Benner, Tanner & Chesla, 1996; Pask, 2003). The awakening of this process of exploration

should be expected in the evolving relationship between a mentor and a more senior graduate and is considered a healthy, essential step in the NGs sociodevelopmental maturity.

New graduates will likely express some discontentment about the encroachment of work on their personal lives; a concern that may be exacerbated if the NGs did not receive reasonable support early in their transition. Experiences of being restrained in the enactment of their professional role, growing frustration with the apparent complicity of their colleagues to the improprieties of the practice environment, and the feelings of powerlessness that these issues may engender in NGs should be considered a natural part of their professional development. It is possible that the deleterious influence of these factors on the NG's sense of agency may be muted by opportunities to actualize some form of change in the unit or the institution during the latter half of this stage (10-12 months). Having an institutional or region-wide, rather than a unit-based approach to advancing the career pathway of a NG, and being open to challenge and change at all levels of the organization are not only desirable attributes of the contemporary workplace but may well determine the recruitment and retention capacity of all future health human resource institutions.

Conclusion

The stages of transition model offered here is intended to serve as a framework for managers, educators and healthcare administrators to use when planning initiatives aimed at recruiting and retaining NGs. This model suggests that allowing graduates to adjust to and accommodate what "is" within a context of support that assists them to gradually develop their thinking and practice gives them both the motivation and the vehicle to complete the necessary professional developmental tasks that can move them forward through the stages of professional role transition. Each stage has within it particular processes that respond favorably to initiatives targeted to the issues most temporal during that period of time. The intense and dynamic transition experience for NGs presented here should inspire educational and service institutions to provide preparatory education on transition as well as provide extended, sequential and structured

orientation and mentoring programs that bridge senior students' expectations of professional work-life with their reality of employment as graduate nurses.

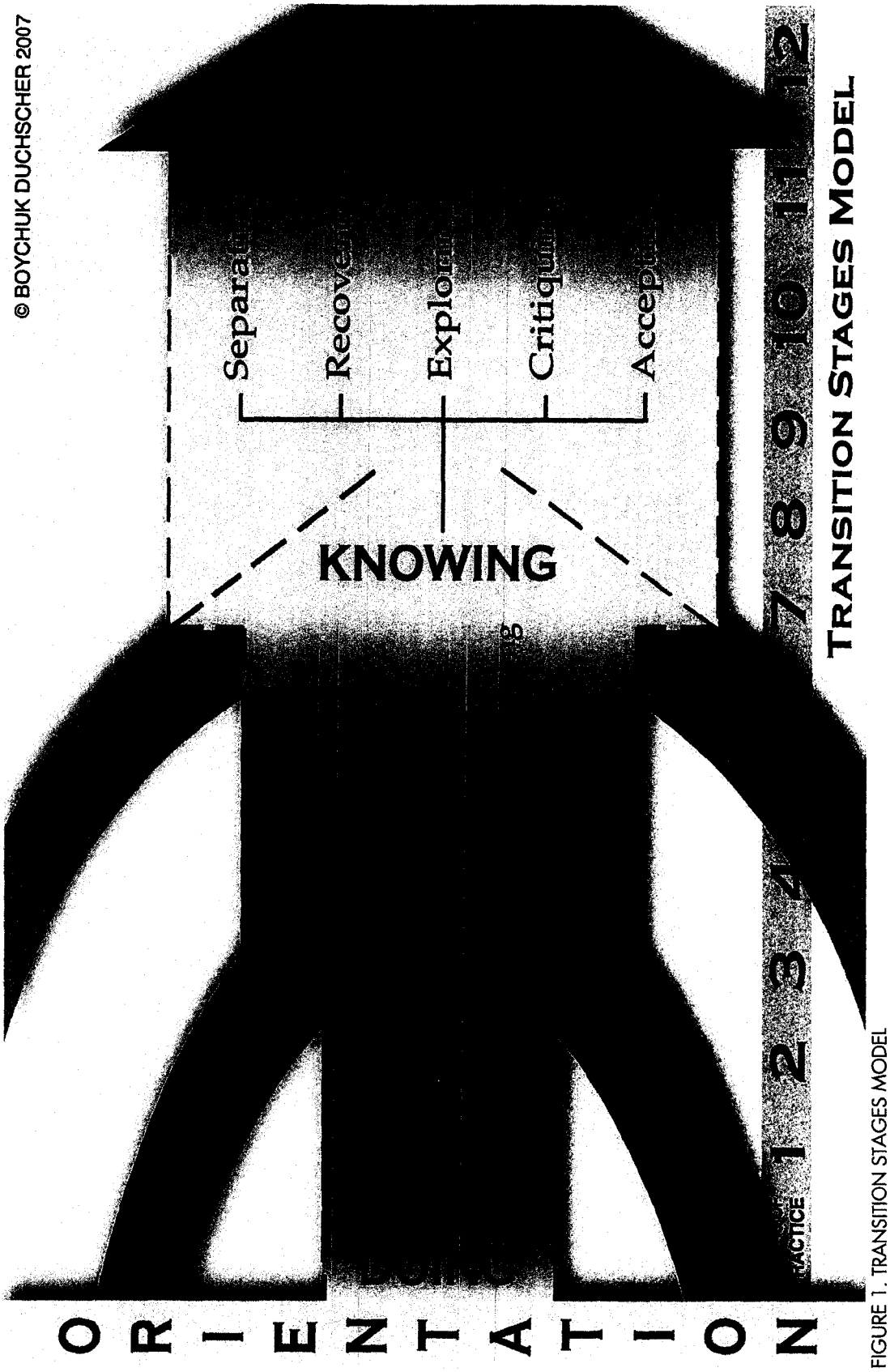

FIGURE 1. TRANSITION STAGES MODEL

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Paper #3 – Heroes of their own story: New graduates in acute care

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Keywords: new graduates, hospital, role transition, storytelling, narrative inquiry, journey, narrative, qualitative, interpretive

Abstract

The introduction of new nursing graduates into professional practice most often occurs within the context of the acute-care institution. The qualitative study presented here recounts the story of initial role transition as it was experienced by 14 newly graduated nurses during the initial 12 months of their introduction to professional practice in a hospital setting. These new nurses claimed they were unprepared for, and inadequately orientated to a level of practice that far exceeded that to which they had grown accustomed during their education. Recollections of this experience illustrate that the stress of their transition was made worse by practice contexts that were unfamiliar, inconsistent and unpredictable, and where little to no feedback on performance, clinical competence or progress was forthcoming. This paper suggests extended orientations, structured mentorship programs, reasonable workload expectations and consideration for the sociocultural and developmental adjustments being made by initial entry professionals be a part of any graduate nurse recruitment and employee retention strategy.

Heroes in their own story: New nursing graduates in acute care

The introduction of new nursing graduates (NGs) into professional practice most often occurs within the context of the acute-care institution. Evidence now confirms a demanding workload for hospital nurses that can be attributed to cost-cutting measures and delivery system changes that have prolonged the length of stay for the chronically ill and elderly, and increased the acuity of the remaining tertiary patient census (Buerhaus et al., 2007; Griffith, Pattullo, Alexander, Jelinek & Foster, 2006; Seifert, 2000; Upenieks, 2003). Inadequate staffing levels, an inefficient appropriation of the patient population (e.g., chronic care patients with extended hospital stays due to lack of access to long-term care beds) and a lack of support for the advancement of professional nursing roles (i.e., nursing decision-making autonomy and independent intervention enactment) is rendering the hospital environment an untenable workplace (Bowles & Candela, 2005; Canadian Health Services Research Foundation, 2006; Lin & Liang, 2007; May, Bazzoll & Gerland, 2006; Rogers, Hwang, Scott, Aiken & Dinges, 2004; Rowe & Sherlock, 2005; Sadovich, 2005; Shields & Wilkins, 2006). Ongoing reforms to the healthcare system that derive from this dysfunctional medically-driven model of healthcare delivery result in a workplace climate for nurses that is fraught with overwhelming workload intensities that force nurses to become organizational task masters rather than clinical case managers and direct-care providers (AbuAlRub, 2004; Blythe, Baumann & Giovanetti, 2001; Greenglass & Burke, 2001). Recently, it has been demonstrated that such a climate increases job stress, decreases job satisfaction and contributes to experiences of cognitive dissonance and moral distress as nurses find themselves increasingly unable to fully execute their professional roles (Ebright, Patterson, Chalko & Render, 2003; Kilstoff & Rochester, 2004; Squires, 2002). Decreasing morale and Registered Nurse (RN) attrition out of acute care are unsurprising consequences of this pervasive disenchantment (Callaghan, 2003; Cho, Laschinger & Wong, 2006; Coomber & Barriball, 2006; Manojlovich, 2007).

While evidence reveals that an exhausted and disillusioned senior nursing workforce is a serious cause of concern to the profession, of equal concern are the profound levels of dissatisfaction amongst NGs within the hospital setting (Casey, Fink, Krugman & Propst, 2004; Chang & Hancock, 2003; Duchscher, 2001; Kilstoff & Rochester, 2004; Sadovich, 2005). Considered to be a source of rejuvenation to the existing nursing workforce, these new recruits are struggling to adjust to work expectations that are often unrealistic and unachievable. New graduates who work in the hospital setting consistently express frustration and a sense of demoralization as a direct result of the incongruence between their perceptions of nursing and what they find nursing to "really" be. Further, they describe a prescriptive and intellectually oppressive practice environment that impedes the delivery of quality nursing care (Duchscher, 2001, 2003). Subsequently, these NGs develop a growing resentment which they direct inward toward themselves for failing to actualize the quality of care they were prepared to provide (Glasberg, Eriksson & Norberg, 2007; Lin & Liang, 2007; Sadovich; Smith, 2007). As well, they come to resent the educators, seasoned nurses, managers and hospital administrations who they perceive as continuing to allow them to be put in such a compromising position (Charnley, 1999; Hanna, 2004; Hardingham, 2004; Jasper, 1996; Kelly, 1998). As a response to unmanageable workloads and a perceived lack of support for the enactment of their practice capabilities and professional values, these millennial graduates may simply elect to exit the hospital environment or nursing altogether in pursuit of a context that is more congruent with their socially inspired career aspirations (Buerhaus, Needleman, Mattke & Stewart, 2002; Cumbey & Alexander, 1998; Duchscher & Cowin, 2004; Hardingham; Lovern, 2001; Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002; Quine, 1999; Turnbull, 1995; Wheeler, 1998). The research presented here chronicles the emotional, intellectual, physical and sociodevelopmental adjustments made by 14 NGs on their journey through the initial 12 months of their practice career. The "story" of challenge and triumph shared by these novice practitioners offers insight into the experience of making a professional role transition into a contemporary acute-care nursing environment.

Research Background

This qualitative study was conducted as part of a doctoral program at a large midwestern Canadian university. The purpose of the study was a theoretical sampling of a specific context of transition within the framework of the author's grounded theory program of research seeking to illuminate an evolving substantive theory of professional role transition for the NG. Upon receipt of ethics approval from two provincial university ethics boards and two regional health authority ethics committees, fourteen female graduates from a four-year baccalaureate undergraduate nursing program were purposefully selected to participate in the study. All participants who were ultimately chosen had established a minimum of casual status as Graduate Nurses and were working at least 20 hours per week in a nursing role; these criteria ensured a consistent and reasonable exposure to the acute-care working environment. No age or gender limits were placed on the selection process, though all participants who volunteered were female, ranged in age from 19 to 28 years, and were entering the professional workforce for the first time. Only English speaking participants were selected to reduce the variable of language as a barrier to narrative interpretation.

The study occurred over an 18 month period and utilized the following data collection strategies: a demographic information form completed at the start of the research process; preinterview questionnaires; in-depth interviews and followup focus groups at 1-3-6-9-12-18 month periods; monthly reflective journals; letters, collages and pictures; and email exchanges by participants at various points to illustrate their experiences. A generic qualitative approach to the collection of data was employed with the intent to explore and build upon particulate aspects of the NG transition experience into acute care studied by this author over the past 10 years (Caelli, Ray & Mill, 2003; Silverman, 2000). While the researcher used a grounded theory process to guide and record the evolving thematic emergence (Glaser & Strauss, 1997), it became evident that a "plotline" (Creswell, Hanson, Clark & Morales, 2007, p. 243) was emerging that uncovered

a "whole" story, the parts of which were compellingly represented by different participants over the course of the 18 months (Chase, 2005). Polkinghorne (2005) claimed that data acquired through the process of reflective discourse requires connecting and relating such that the words and their meanings can be integrated and coalesced into a more coherent whole. The use of the term *narrative inquiry* figures prominently in many versions of qualitative research and has been interpreted broadly here to mean any written and spoken data that relates the personal reconstruction of an event, personal experience or period of time in the life of the participant (Polkinghorne, 1988). While it is not the intent of the author to claim the presentation of this data as *narrative analysis* in its purest form, it is reasonable to suggest that the story presented here is a composite of "narratives that combine a succession of incidents into a unified episode" (Polkinghorne, p. 7), with the episode being the initial professional role transition experience of the NG into acute care.

As lived experience becomes a narrative description of a particular phenomenon, the researcher takes on specific responsibilities in transforming the received data (van Manen, 2003). Each set of data from this study was subjected to a constant comparative analysis method developed by the researcher through the modification of techniques used by Glaser (1992, 1998), Glaser and Strauss (1997), and Strauss and Corbin (1998). Throughout the research process, emerging concepts and categories were compared against the original data and through the dynamic and fluid processes of induction and deduction, the story of transition unfolded (Milliken & Schreiber, 2001). Concurrently, the researcher recognized early on that both the nuances and the patterns hidden in this voluminous data (more than 3500 pages of transcription) that could contribute to the story of transition were not always easily reducible. There was a creative and personal process inherent in the researcher's interpretive analysis that May (1994) described as mystical. As such, "technique and rigor...cannot entirely explain what moves the analyst from confusion to insight, from chaos to order, and from simple description to understanding. The

product [story] is shaped, but *not completely defined* [original emphasis] by the process through which it was created" (May, p. 14).

Study Limitations

The nature of qualitative study is such that the researcher must intentionally institute internal measures that can assure an acceptable level of rigor while at once recognizing the "uncompromising harshness and rigidity implied in the term [rigor]...that threatens to take us too far from the artfulness versatility, and sensitivity to meaning and context that mark qualitative works of distinction" (Sandelowski, 1993, p. 1). It has been argued that small sample sizes, such as the one used in this isolated study, and the embeddedness of the researcher within the narrative have the potential to infuse a narrow, superficial and biased interpretive process into the analysis (Creswell, 2007). It could be otherwise argued that any telling of one's story assumes a relative subjectivity on the part of the teller that biases all "truths" by virtue of what is recounted and how this is done (Caelli et al., 2003; Sandelowski). While these unavoidable variables of qualitative research have the potential to limit the trustworthiness and usability of the end-product by others, they are also the hallmark of qualitative research and provide the rich grounding that facilitates a discovery and deep understanding of complex phenomena, processes or perspectives (Merriam, 1998). It should be noted that possible additional sources of bias within this study include the interviewer's previous interactions with some of the subjects when she taught them nursing, use of the researcher as the primary instrument for interpretation and data analysis, the demographically homogeneous sample population, and the limitation of data collection and analysis to a qualitative, narratively interpretive research approach. Significant effort was made to introduce rigorous processes that would counterbalance the challenges to exacting an authentic and honest portrayal of the story that arose out of this data. For example, participants were used to verify and clarify the plotline and evolving story, experts in both research process and transition content were asked to read and provide interpretive commentary related to the

transcripts, and a detailed set of researcher field-notes, theoretical memos and audit notes were recorded throughout the research period and used to ground the content and sequencing of the story.

Situating the Story-Telling Approach

Few researchers overtly present their data in the context of a story-building process (Sandelowski, 1994). More commonly, by infusing techniques such as member-checking, peer-debriefing and bracketing there is a significant attempt, and some might say even an obligation on the part of the researcher, to dilute the subjective voice or at least minimize the appearance of a personally biased representation of the data (Morse, Barrett, Mayan, Olson & Spiers, 2002). Conversely, noteworthy qualitative researchers have suggested that the suspension of a researcher's bias, informed perspective or uniquely embedded knowledge of the voice they represent is not only theoretically impractical and unnecessary, but may interfere with the iterative process of knowledge development (Sandelowski, 1993).

The idea of "telling the story" of the NGs' initial professional role transition into acute-care nursing originated out of the author's long and familiar history with this demographic, ongoing and deep immersion in the data and the serendipitous use of an interview summation technique during the course of this study. The researcher has spent the last 10 years working with, mentoring, guiding, coaching, consoling, admiring, supporting, researching, teaching and learning from NGs. As a direct-care practitioner, an undergraduate nursing faculty member, a researcher, and currently as the Executive Director of *Nursing The Future* ©, a new Canadian nursing organization aimed at identifying and addressing issues related to professional role transition for new nursing graduates, the researcher has a long-standing commitment to this topic. The privilege of spending significant time with this captivating group of young professionals has afforded the researcher the vantage points of observation, interaction, dialectic and reflection which in turn lend credibility to both the construction and narration of this story. During the course of this

research, each interview was summarized in the voice of the graduate being interviewed and then returned to them to contribute to a more rigorous re-iteration of the experience. Consistent affirmative responses to the research interpretation was understood as an indicator that the researcher had accurately and astutely captured the nuances of their journey.

By interspersing authentic text from my doctoral research with my own narrative interpretation, I have sought to unfold the journey of transition by sharing the lived experience of those involved. The italicized narrative represents verbatim text taken directly from official transcripts, while the non italicized text represents my interpretation of the collective account of the experience of transition as it unfolded over the 18 months of this research. For the purposes of fluidity and bridging, I chose to assume a first person stance in the writing of this paper. By personalizing the presentation of the stages as they were revealed to me it is hoped that this chronicle will fracture the walls of isolation that prevent NGs from entering a space of shared professional development with each other and with those who seek to support them through this difficult process (Hay & White, 2005).

The Story

A Shocking Experience (1 Month)

As I reflect back on that first month of my career as a nurse, I am struck by the shock I experienced. *Like there's just so many "firsts" all in that one month.* I remember feeling quite good as I finished school, though I wonder now *if all those teachers who told me I was doing so well and that I would make a great nurse, have any idea what it is like out there! I also wonder if they knew what they were doing when they gave me all those great marks, because it almost feels as though I didn't learn anything during my entire four years of school.* But I am getting ahead of myself.....let's go back to that first month of orientation. I know I got what I thought was a decent orientation. I was in the classroom for about four days where they taught us about the hospital routines like fire and safety and informed us about things like flexible shift schedules and employment benefits. Then I was buddied with a couple of senior nurses on the ward where I was

going to be working. It was a bit frustrating that I didn't have one person to go to; instead, there were about 3 different nurses I spent time with and while one of them was really great, the others didn't seem too interested in teaching. I had two buddy days and two buddy nights working with an experienced nurse before I was completely on my own. I thought it was kind of strange that after my first two days of buddying they called me in to work as a regular staff member. I told them I was still orientating, but they said they were short staffed and needed a nurse, and that it was OK because I would gain more experience. It didn't seem right, but what do I know; I'm just a grad.

To be honest, being a new graduate (NG) is a time of unbelievably *mixed emotions*. You start out nervous and excited, but *those feelings quickly turn to overwhelming stress when you realize you are out there on your own. My feelings of comfortableness with the staff and the unit soon changed. I was feeling overwhelmed, stressed and doubtful of my choice of becoming a nurse. It was almost as though at times I was actually feeling signs of what is an anxiety attack, where my heart would race, my head would ache and I had feelings of nausea. I can say that probably the majority of my shifts I feel like I'm not safe because I'm not always aware of what's going on.* There are other nurses around me, but either I feel like I should be able to do this by myself (after all, *they have left me alone so they must think I am capable*), or *I feel like I am a burden* to those other nurses who look just as busy as I am. Don't get me wrong, *I couldn't ask for more supportive colleagues to work with; they have helped me manage my workload and they made me feel welcome.* The manager seems like a nice lady, but then again *I never see her and I am not really sure how she thinks I am doing.* Once, in the hallway, she asked me how things were going and *it put me on the spot. There's staff around so of course I'm not going to say "I'm scared, I'm scared. Scared out of my mind." On my last buddy shift I had a minor breakdown. That's when it really hit me that I'm on my own.* I wish someone would sit down with me and tell me honestly what I am doing right and what I need to improve on.

I have to say that I was really grateful when *the manager buddied me with one of the Licenced Practical Nurses (LPNs) and then with a unit clerk* because that really helped me to understand the differences between my role and theirs. *As a student, you are so used to doing everything and so it is quite confusing when you first come out. It's strange having them come to me with information* about the patients and then asking me what they should do. I am not sure I feel confident enough to tell them anything because so many of them are older than me and have so much more experience. Sometimes I feel like it is *easier to just do it myself* rather than approach them. Oftentimes that means *I don't get my morning break because I am a bit slower right now and I just want to make sure I have everything done and that I have everything done right.* I just accept it as part of being new.

The responsibility I have for these patients is huge. I'm always worried about giving the wrong med or missing something that would hurt the patient. I've made medication errors that really shouldn't have been made. If I would have been paying attention, I wouldn't have made them, but I think that you're overwhelmed and don't do the things that you learned in school. Even the senior nurses make mistakes and they have been doing this for years. *I saw one nurse grabbing the wrong antibiotic and giving it but I didn't do anything about it. And I thought "Oh God," you know, because then I was missing my dose. I said "Do you know what happened?" and she's like "Oh God, I think I might have given it to this other patient" and sure enough it was the wrong patient. She's like "Oh, I'll just phone pharmacy and get another dose for you." I just thought she's an older nurse and I'm not going to say anything. And I know that's bad. It was tough, it was tough. I just had to walk away from it though because she was more experienced than me and I was new on that floor so I didn't want to be the rat who ratted her out.*

I must say I feel very lucky because a girlfriend that I went to school with said she was ready to quit because of an experience she had with one of the older nurses. She asked that nurse a question that seemed reasonable to me and her nurse said *"You mean you don't know that? What did they teach you anyway?" She said it made her feel really stupid. She says it makes her*

hate going to work and wrecks her confidence. She says she doesn't even look at the schedule ahead of time anymore because if she did, she'd be tempted to call in sick. The *morale on some of the units is really low* because of the shortages in staffing and it makes things even more tense. I cannot tell you how grateful I am that I have someone I would call a mentor on my unit. When I first started orientation, I was working a lot of my shifts with her and just got to know her. Even though she was never really "assigned" to me, I remember a couple of times *she came over and told me how well she thought I was doing; I mean she actually asked me how things were going! I said "You have no idea how much that means to me right now."* I couldn't believe it but *I will never forget it. I had been having such a terrible day and I felt like I hadn't done anything right, but when she said those things to me I knew that I could go to her if I had any problems.*

Night shifts are still difficult for me. I'm not thinking as clearly basically because I can't sleep! *I dream about starting IV's (intravenous), I dream about handing out pills, I dream about machines beeping, I dream about everything.* There are so many things that I have to do on nights that I am not used to, like putting my chart together if I get an admission, checking all the meds against the medication administration record and calling the doctors with problems. That is absolutely the thing *that scares me the most. I get really nervous around them, especially the Attendings* [senior staff physicians], *and feel like I'm almost being belittled by them.* Sometimes I feel like what I am telling them is not important. Like I have been told *"Why are you wasting my time with such trivial information?" As a student, you're not allowed to take telephone orders and usually you don't talk with physicians much so when you finally do have to do that, you feel kind of thrown in there.*

In terms of my general life, *I've been in school for so long and now that I'm out, I find myself at a loss. My boyfriend was asking me the other day "What do you want to do? Like, what are your hobbies?" And I don't know anymore. I don't have any hobbies you know, school was my hobby.* I am glad to know that my hard work has paid off and I am enjoying the freedoms of not having to study all the time. Of course, I couldn't even if I wanted to because *I am too*

exhausted when I get home! And yet, at the same time I can hardly believe that I am done my education and that I have to work for a living. I feel like it all happened too fast and that *I am too young to have all this responsibility. I just wasn't ever really made for the real world. I really liked school and living at home. It's a big change and it's really overwhelming; you're happy about it one minute and bawling about it the next. Other people in my life don't understand exactly what I'm going through. They think it's just a new job and "you'll get over it" kind of thing*. In fact, my Dad told me to work as much overtime as I possibly can and pay off all those student loans. *He just doesn't understand* what it's like to carry all this incredible responsibility. Everyday there is something different at work and no shift seems to be the same as another. You have to be prepared for whatever is thrown at you and a lot of these situations are completely new to me. I feel like I can hardly muster up the courage to go back every day and *each time I feel "new," it's like my confidence is being eaten away*. I go for coffee a lot with my NG friends and we talk constantly about everything; thank goodness I have them to talk to because they really are the only people who can truly appreciate my situation. *Right now I feel like I am not going to get through this and that this is not the profession for me. I am beyond stressed and overwhelmed to the point where it's not healthy. To me it feels like being a NG is sink or swim; and right now I feel like I'm drowning.* If my parents, friends, or worst of all if the other nurses around me had any idea what I was going through, they might think I couldn't cope with being a nurse. *All I want is to know that they think I am a good nurse.*

Learning As I Go (1-4 Months)

I can say this – I struggle. I struggle to get familiar with everything while at the same time *I am struggling to learn everything. I struggle to find purpose and meaning in a system that I don't believe in. I struggle to find a foothold, someone to turn to when I am walking on new terrain. I struggle to come to terms with the disappointment of realizing I have worked four years towards something and as it turns out, it's just a job, like every other job I had before it. Some days I struggle to swallow down the anxiety and do it all one more time. As I sit here now, I can*

feel the anxiety dancing on the edges of words and my memories. Until you're out there on your own, I don't think you really know. Strange as it sounds, *nursing is everything I thought it wasn't going to be: communicating with physicians, taking orders, the paper work. Like I never knew the legalities that are in nursing and the importance of documenting. You can sit at the phone and at the desk for most of your shift sometimes just trying to get things organized and you see how many holes that a patient can fall through in the system. I've never really understood the politics and I'm starting to get a bit more insight on that.* When we are students, *we are never really taught to work as a team* with the other members. We care completely for our small group of patients and that allows us to get the full picture of our patients, but not of our role in a multidisciplinary team.

Delegation is one thing that I felt we really didn't have a chance to do in nursing school. Now that you're out there, you need to delegate. There's no way you can do everything on your own and I think that's really hard to accept. I think the trust you develop between your co-workers is very important. You have to trust that the LPN is doing the assessment and so on. I saw a few senior nurses go in behind the LPN and do the assessments again. I don't do that – I right away trust them and I don't know if that's the right thing but you have to start somewhere and I always believe that you give that person the trust. Once, the LPN even asked me to go listen because she said his lung sounds are just crazy and so I did go listen for myself because it's a learning experience. I've never doubted my LPNs. I've never doubted them. It's a bit different working with the RNs. Maybe that's because the LPN does more like what I am used to doing. *For me to tell an RN to do something is tough. I kind of look up to them and I don't want them to think that I'm lazy and not wanting to do my job.* I want to be respected by them as a nurse. *You hear them talk about NGs and some of them are like "Oh, she just doesn't get it" and I hope they don't talk about me like that. I've heard other wards talking about the people I went to school with. I really just want to go over there and say, "You know what, why don't you just help her rather than talking about her. Why don't you just say 'You know, it might help if you do it this*

way' because you're the one who knows how to do it." Or they *come and just take over everything that you're doing rather than saying "Okay, this is how I would do it" and show you. I think that's why NGs are all so uptight about what's going on because they are worried that someone is going to say something about them and not tell them so they can fix it. They are walking on pins and needles all the time trying to impress and please everyone.*

I am not exactly sure when it happened and I can't really pinpoint what is different, but things changed for me about 3 months after orientation. *I think the worst part of it is over. I've noticed a huge change just in the way I'm feeling. My emotions are a lot different because I'm not as overwhelmed as I was at the start. I am enjoying it a lot more now and feeling like I actually fit in to the profession; maybe I just needed to adapt. When I heard that I passed my exams* [Federal Licensing Examination], *it was kind of a bittersweet feeling for me. On one hand I was glad that I was no longer a NG and that I didn't have to explain this to anyone anymore, but on the other hand I felt as though the expectations of me were much higher and that the benefit of the doubt was slipping away. Maybe this is a fear I have within myself as my practice evolves into ever-more independence.* As much as I feel like I am *gaining my legs* in this profession, I do feel like my confidence is still very fragile. It seems that the slightest thing can set me off. For instance, being put in an unfamiliar situation, dealing with upset families or unstable patients, or getting negative responses or comments from other nurses or physicians *breaks down the confidence I've struggled so hard to build up.* Whether or not the other nurses are supportive *is crucial to my ego and my learning experience.*

Although I think things are getting easier, I am still finding it difficult to maintain a healthy balance between my life at work and my life at home. I sometimes wonder how long it will take before I feel less afraid before I start my shift. *I see those other nurses and they come in and talk about their family and what they did this weekend. I wish I was like that. I come in and I'm "Oh, so how is this person and how's this person and what happened with that person" and they don't want to hear about it. They're like "Who cares? Like just forget about it right now. We're not*

working yet." I've been more active with sports and going out for coffee with friends, but I'm still finding it hard to meet up with people. Some of my closest friends and family I haven't seen in weeks, which is partly because I'm pushing myself away right now; I feel like I need time to myself. I need time to enjoy the things that I like to do by myself, like just reflecting. I am glad I chose to take part in this research because it's good to be able to debrief and not keep it all bottled up inside. I am still quite tired, *but initially it was more emotionally related. Now it's the physical part of managing my workload and it's all the thinking about what I'm doing and why. This whole experience has affected my overall health. I'm too tired to go to the gym and I'm not eating as well as I was. Oh yeah, did I mention the gravol addiction in June?*

I find that I am on one extreme or another. *When I have good days it's completely fine and I'm thankful I'm there. Then, when you have bad days it's like "What am I going to do with my life? I can't do this forever." There have been days when things haven't gone well - days where I think I wasn't cut out for this type of nursing. When I have those moments, I feel like a failure. But I couldn't leave even if I wanted to because I would feel like I would be disappointing myself. Even now, the day before a shift I am not at ease, even though I do not have to work until the following morning. Because I know that for the next three days my life will entail working, coming home, unwinding, going to bed with that nervous feeling in the pit of my stomach, getting up and doing it all over again. The night before a shift I pray that I will have a good day but always run through things in my mind....what if someone codes, what if I have a patient with a condition I am absolutely unfamiliar with and end up being a terrible nurse, what if I feel so stressed I have to walk off the ward? On days I'm fine because we get a patient load of eight but on nights that goes up to sixteen and that's quite a bit for an LPN and an RN.* I don't feel comfortable saying anything because I don't want anyone to think that I can't handle it or that I'm incompetent.

I think *people are probably getting tired of me because I ask questions all the time. The kinds of questions I am asking have changed though; I'm not asking the dumb questions anymore.*

I can process things in my head to a little higher level so I guess you could say that my questions are more pertinent. I'm sure after the six month mark that my questioning will change because when I started I had a more senior nurse say "I'd rather have you ask these questions now than six months from now," so I sort of took that as "OK, I guess I better know everything by six months." I think that makes me a bit nervous because I wonder what I'll do if I come across something later that I haven't seen before. *I think NGs are always looking for feedback and I think that's the only way a person really knows exactly what they need to work on. Feedback is a big deal but managers are not good at giving it to you. I don't know what I'm supposed to be able to do and not do at this point in my career and I want to know if I'm progressing at the rate I should be.*

One of the biggest things is my organization; it's not even as much a concern as the patient care at this point (four months). *I have no problem going into the patient's room, conversing with them, doing their assessment. No problems at all doing dressing changes* or any of the other nursing routine tasks. *I remember* recently I had this patient who was *experiencing chest pain and ended up being in a-fib* [atrial fibrillation] *and I panicked because I didn't know what to do. So at that point, I was like "please do as much as you can for me because this is a situation where I want to help and do stuff but I can't make the calls on exactly what needs to be done here." I can sit and think through it and figure it out,* but if I need to do something quickly, it's just too much for me. I don't always see it coming because I am too focused on what I am doing. *I'm like in this private little bubble with my six little patients and things are going on all around me and I cannot hear them, I cannot see them.* It's like the more experienced nurses can predict what's going to happen, while all I can do is react to what has happened. I can't seem to *get my mind around the connections.*

I think part of the problem for me in my transition was that I took a float pool position so I didn't have consistency or familiarity in where I was working, who I was working with, and what was expected of me as a nurse on a particular ward. I would get orientated to one unit and spend

very little time working there before I was moved to another unit and orientated there. *My floating situation contributed a lot to my struggles with organizing myself because when you go onto a new ward, you're dealing with new routines, different staff and roles of the staff. I am not picking it all up as quickly as my friends who are not floating. I think that they just have more of that same experience to know, "Okay last time I went this way and it didn't work so I'm going to do it this way this time" and I just haven't had as much of that* because I am always in different places seeing different things.

Another struggle I am having right now is that the way I was taught to do things in nursing school is not always the way they are done in the real world. I am finding that the standards of care aren't what I thought they would be. I think my greatest fear continues to be hurting someone because I don't know enough about where my boundaries are. I don't know what shortcuts I can take without being unsafe so I don't take any shortcuts at all. While I am getting a bit better I still take twice as long to do anything as some of the senior nurses. *I don't feel confident enough in my knowledge base or in my nursing tasks* to modify what I am doing to each situation. But I *would definitely say that I am more efficient* than I was when I first started. At least now I know normal, so that when something happens that is not normal I know to ask about it. *I am comfortable with the basics. I still fret before I go to work and I'm still waiting for my first CODE. One of my friends already had it and she called me right away and she's like "You're not going to believe this. I was on his chest and I could feel the bones crack. Oh my God, it was so good. I ran for papers like they tell us to do. If you just stay out of the way and do the papers you're fine." And I thought "Would I do that? Would I know what to do?" I dread it.*

I have definitely gained a perspective on the differences between learning something in school and seeing it in a patient. I mean *putting a catheter into that little plastic whatever doesn't teach you about the guy that does not want that catheter and is trying to kick you.* Like you know you heard about compartment syndrome, but *when I started working I'm like "What am I looking for? Numbness, tingling, what?" But now I know what they mean and I know what I would do*

right away. I know to cut the cast. I wouldn't have known that before. You can read and hear whatever you want, but it'll go in one ear and out the other. Once you actually see it, you don't forget it. I'm getting used to the patients, getting used to the ward, getting used to the protocols and routines and that gives me a little more confidence. As the song goes, "Life's a dance you learn as you go. Sometimes you lead, sometimes you follow. Don't worry about what you don't know; life's a dance you learn as you go."

Post-Stress Shock Dys-Order (4-8 Months)

I know it sounds strange, but I'm finding this part of the transition to be the most difficult because the excitement about being done and the shock that I was in has worn off. Now I feel as though I'm on a raft that is drifting farther and farther away from "shore" (the safety net I had of being a student or a new grad). It's nice though that while I am still usually one of the youngest, I'm not always the newest anymore. *I feel like the staff members have accepted me, which is great, but I feel as though they forget that I am still a new grad. There are many things which I have still not done and many others that I have very limited experience with.* Some of my struggles right now might lie in the fact that even if I wanted to, *I cannot escape just by saying "I'm a new grad." I don't think I've earned that title* [RN] *yet.* I know I'm not alone, which is so great, because I have *had the opportunity to talk and debrief with other people that I graduated with. It turns out that they are going through the same stages I am. It's nice to know that I am not alone with these feelings and* being able to have a peer group to talk to *has been a really critical support for me. As I compare myself to others at the same stage as me, I feel I am adapting at the expected rate.*

Even though things have started to come together for me, I think that the workload is just too much, even for those nurses around me with lots of experience. Because we are so focused on tasks, the nursing part isn't as big and that leaves me feeling dissatisfied. I can see how this would not be enough for me and I think I see it more *as a stepping stone. I'm disappointed that the nursing role seems to encompass a lot of different professional roles. We do some pharmacy stuff,*

dietary, housekeeping, portering and so forth. *It would just be nice to do the nursing role. The nurse that's kind of my mentor has worked all over and she said "This is too many people. This is not right." There's not really any talk of changing it. We just kind of accept it.*

I have been asked to go to the observation unit (obs) a couple of times and so have several of my friends who are also new grads. *I tell staffing that I am not orientated there and so I think they will find someone else. I get a phone call and they say "Here are your options: You can either go into the obs unit or take a unit on the floor and you can fill out an unsafe work report." Why would you send me somewhere knowing it is unsafe? I am a brand new grad and I barely know my ass from my elbow. I am not comfortable with this and keep hearing one of my teachers saying "A nurse is not a nurse is not a nurse – don't let them send you somewhere just to be a body. You have to protect yourself and your patients." I turn to my charge nurse looking for some advice from her about what she felt was appropriate to do in this situation. She said bluntly, "I am staying out of it." I wanted to cry but I knew if I cried in front of this woman I could spend the rest of my life trying to gain her respect back. I am scared and would really much rather just go home, but I am stuck here. I choose not to confront the charge nurse about how I felt she had abandoned me. I really feel like this isn't what I want to do anymore. If they are worried about retention of NGs, I can see why they have trouble. I feel like I have had to be much more assertive than I ever imagined I would have to be and I have only been doing this for five months.*

My body still isn't used to shift work and I find that when I work nights I am a lot more emotional and worn down and it is harder for me to handle certain situations. I know that my girlfriend doesn't even take her breaks on nights; it's understood that if you don't leave, you won't be left. *I feel leery about being the only RN on the ward when the other one is on break. It makes me feel uneasy never knowing what could happen. There's another grad on that unit and she's ready to quit. She said it's almost like the staff that have been there forever are too scared to do something about it. They won't write up an incident report. Like the one night they each had about 16 patients and they brought it to the attention of the manager and the manager just*

laughed it off. I don't remember the quote but, "well you made it through didn't you?" sort of thing. I don't think that's fair at all. Everyone there is tired, everyone's burned out. I know one thing I've noticed is that if the manager is supportive of the staff, it's a whole different place.

October [5th-6th month] *has been frustrating. Because of the nature of the temporary full-time relief position I'm in I get stuck with all of the shifts that no-one else wants. I also got stuck working nights over Christmas, which I know everyone has to do but it just feels like another blow. About once a week I get a note in my mail box informing me that a few shifts have been changed. I'm finding it very difficult to plan my life around work and becoming increasingly frustrated by this. I feel like I have no control over work and I'm losing control over other parts of my life.* Several of my friends have either gone part-time or taken a casual position, just so they can have a bit more control over their schedules and their lives. *I don't want to become one of those crabby nurses who hate their job and complain every day. That's not who I am but I can see how easily you would get sucked into it. If your working conditions are always bad and if you didn't like it, you didn't like the patients, you didn't like the people you worked with, how could you ever enjoy that? I want to love my job.*

As I pass my seventh month mark, I feel like I am actually doing quite well; *it's like a whole different job, a whole different place, a whole different me. I'm feeling much more confident that I'm getting everything done properly. I don't lose sleep after my shifts anymore, though I still lose some before shifts, and I don't go home dwelling on what I could have missed or should have done. It feels like I have adapted to my schedule and routine and my social life has meshed in.* I think my stress now is more *related to job security and job positions.* I have become more vocal about how I'm feeling and I share this with *the staff in my unit when they ask me how things are going. I'm more decisive at work and I've learned to stand up for myself. The calm and confidence that people think I have, I'm starting to feel it. I feel I am becoming more of a critical thinker as opposed to doing my job with blinders on and focusing on doing the tasks as I did previously.* I seem much more interested in learning new things and I've noticed that *whereas*

before I could never look ahead, now I can plan for this patient for the next few hours. I am still not 100% comfortable in all that I do but I am not ashamed of this. I feel that it is a normal process. While I feel more comfortable all the time with what I've seen before, *the situations where I do feel overwhelmed are where there are a lot of things happening with one particular patient that's very complex. Having students is a good example.* We have a lot of students on our ward, and although it is so neat to see how much I have grown since I was a student, having the responsibility of watching over them is still too much for me at this point. *I remember having a couple of students this one time and thinking to myself "I hope they don't ask me too many questions, because in my mind we were still on the same knowledge level, only I have more responsibility." I was thinking that if the students or their faculty knew how insecure I was, or how little I felt I knew, they wouldn't allow the student to work with me.* I know by talking with some of my coworkers that they are finding themselves even more frustrated by feelings of incompetence. As new grads I think we tend to think that we should be able to function by now and that if we don't feel that way, that there is something wrong with us. I'm not sure where we get that – if that is from school or if we get the subtle hints from other nurses that not knowing means we weren't taught properly or that we are not very bright. It takes so long to gain the trust and respect of some of these senior nurses. I do know that it doesn't feel good to always think like you're not up to standard, and after awhile it starts to get old.

More Questions Than Answers (8-12 Months)

As I head into January [8th-9th month], I feel like I am starting to seriously question whether or not I want to do this for much longer and I know that when I get together with my other NG friends, the sentiment is "*If this does not start getting better soon, I'm leaving.*" Having said that, someone said "What if *that just comes with being in a career?" I don't know if I was spoiled in nursing school when instructors are always telling us we did such a good job. But we don't get that anymore and you just leave work kind of empty.* I have heard from more than one of my friends that they are thinking about going back to school. But for me, I wonder if the answer

lies in *furthering my education in a profession I am not particularly loving? What's the point if you're going to end up in the same spot at the end of it all? Do I just need to get out of acute care? Why do I feel like I'm failing in my profession by taking another route? What is it about my job that makes me feel so bad? What is the answer to getting up in the morning and looking forward to going to work?*

I feel like I am back at square one wondering where those nine months of experience have disappeared to. I was feeling so good a couple of months ago and it's like I don't even remember that feeling. I am a pretty even-keel kind of person, but I have been wondering lately, "*Could I be experiencing burnout?" I was intrigued by an article that reported 66% of new grads were experiencing symptoms of burnout, including emotional exhaustion and depression! In other similar studies the reason for this burnout was a perceived lack of fairness in the workplace, workload, poor interpersonal relationships, and a lack of empowerment. The more I thought about this, the less shocking it became. I can relate to a lot of what the article is saying. It said that they* [NGs] *tend to make sure their work gets done but they lose interest in what they're doing. That's what I found really hit me the most. I thought "That's it!" Honestly, like it's hard for me to get out of bed but I always get there on time. I'm always tired – oh, I can't believe how tired I am. I get up and want to go back to bed and I've lost like about fifteen pounds since I started. I certainly feel stress about coming to work, I work irregular shifts and come in on short notice, I do quick turnarounds and some days the work is so depressing. Like do you know that now we have patients in the hallways in our units? I had a patient in the TV room the other day. Like this is the real world and welcome to it, you know? We're full to the max, mostly with medicine patients on a surgical unit and the surgeons don't want to cancel so we take our least sick patient and put them in the equipment room or the TV room. You nurse them there and hope nothing goes bad because you don't have any suction, you don't have any oxygen. We put a note on the door saying "Patient Room. Please Don't Enter." I just couldn't believe it when they were asking us to do this. I thought, "Are you nuts?" A lot of our hospital is filled with patients that*

long-term care won't take. We call them "the screamers" because they scream and yell all day. I'm trying to concentrate and do something and all I hear is yelling and screaming. Nothing will stop it. They've tried everything. They've been there screaming for months. It's a really bad work environment and they call it "the pit." When I'm down in the pit, I'm out of my mind sometimes. On a general day, I take care of 10 patients. If one patient has a lot going on, the others really suffer and whoever is making these decisions obviously has no idea what goes on in a nursing unit. I think it comes down to money and keeping those surgical wait lists down. I feel like the hospital is being run more like a business than a caring community. It's disheartening to think that this is what it's become. I find the whole nursing thing a bit disheartening and that's so sad because I love nursing. I never thought that as a NG I would have 16 patients on nights and when I do, I find I can barely even say hello to them. I feel bad for the patients and I feel bad as a nurse that I'm representing this. Lots of times I ignore it and just think "Well, that's the way it is." I admire the dedication of the senior nurses. I do think we respect one another as nurses; we have this unspeakable bond I think. But as nurses, we don't speak up about the working conditions enough. I tried to speak to a senior nurse about a staffing issue that concerned me. The three nurses that were scheduled to work nights were myself and two of my classmates. The most senior nurse had just over one year experience! Apparently, when the manager was asked what she considered senior staff she replied, "Anyone that has worked on the ward for 6 months." Anyways, the nurse that I was speaking to about that staffing situation *replied, "That's just the way it happens sometimes," as if to say "Suck it up – deal with it." To me this is jeopardizing patient safety. Not to say that we aren't capable or competent, but only on a novice level. This is huge stress to place on these staff. It's not really fulfilling knowing that you're leaving something out or you're missing something. No wonder nursing grad burnout rates are so high.*

I am feeling more and more comfortable with the clinical situations I deal with and I have noticed my thinking is *faster,* I see *more of a bigger picture and* I can *consider more pieces of the puzzle.* Before, *it was just getting the tasks done. Now, instead of pushing the families away, I'm*

pushing the tasks aside and getting them done when I get a chance. I do feel *like it's coming together a bit now. I feel like people don't look at me like a NG anymore and they see me as a colleague – they see me as an RN.* I'm starting to get that "feeling" about my patients and *even though I don't know exactly what is going on with them I have that feeling.* I remember thinking the other day that *I am ready for my mentor to let go of my hand a little. When she is in charge she dotes on me and though I shouldn't complain about all the help she gives me, I need to prove to myself I can do it.* But I guess it's one of those "be careful what you wish for kind of things." They do leave me pretty much on my own now *and that's good, but let's say you're taking care of a post-op patient and something's kind of off. That's where that lack of experience is a bit scary because it could be very important but the NG's thinking "Hhhmm, is this really important? I don't know." No one's around or you're working with another new grad. It's like you don't have time to go through the patient's history or go through the chart and find everything else out so maybe it's not always the best decision.* So, I guess I still appreciate having someone there, just maybe not as close as they were before.

I think about some of my friends who went to the intensive care unit [ICU] or emergency [ER] and *I absolutely think that new grads should not be working in those places. I think that would be a huge, almost unsafe responsibility to take for a couple of reasons. You have to be quite confident with your skills and I don't think anybody has that kind of confidence when you're first out. Like if you've never even been in a CODE in your life, how do you throw yourself into ER? I also think it's really beneficial to gain some general bedside experience for at least a year with the most stable patients because those places* [ICU and ER] *don't really give you a broad scope of what nursing is really like. If you're going to be in ER or ICU you need to know the signs to look for when people are going down or you need to know why they're going down and even now I don't always know.* Just even for me on the ward, *they started putting me in charge in the obs unit and one day I was with a nurse from ER for the last eight hours with two transfers from ICU within fifteen minutes and by the end of the day I was ready to throw in the towel. Two*

days in a row of just being completely overwhelmed and I was out of my element. I didn't have anyone to help me out and I felt so isolated in there. They're pushing me to a different level now so it's another challenge I guess. Then again, I was in obs yesterday and it was a fantastic day and I felt really good about where I am but I just feel that at this point it can go either way.

I feel like I'm on the edge of finding out who I am, where I need to be and where my place is in this world. I see what I'm doing as a job for right now and I hope that eventually I'll find somewhere that I really want to work. I'm not really where I want to be. I've learned a lot and gained a lot of experience and I've settled my life. I realize that nursing is wonderful but it is just one aspect of my life. Maybe part of it for me is that *I graduated and I had this degree and I thought "I'm going to be this Registered Nurse" and then you get in the huge system of healthcare and you realize you're at the bottom; it's like you're kind of insignificant even though you're the frontline worker. I'm just like "Wow! What am I? I'm just this little nurse." I guess when I was a student, I thought that nurses had a little more autonomy than they do because when you're a student, you go to the RN constantly but as an RN you're going to the doctor all the time. Even the patients always want to see the doctor. "When is my doctor coming? When is my doctor coming?" and then after, "Well, the doctor said this. The doctor said I should have a Tylenol tonight. The doctor said...." so they just listen to any little thing the doctor said but if the nurse says "You need to get up out of bed today. You need to be moving around," nobody listens. Of the young nurses, probably half of them either are leaving or want to leave. A lot of the older nurses have cut back to half-time or gone to straight nights. Something's going to change or something's going to break. I mean, it's physically, emotionally and mentally draining and then you compound that by understaffing and a lack of beds, too many patients and you're going to break. Things like fatigue that doesn't seem to be relieved by sleep are familiar. I get a week off and I don't go anywhere. I just relax, watch TV and read a book. I just want to be at home and I want to be resting and catching up on things at home and keeping to myself more because you're*

with people all the time and putting yourself out there all the time and it's nice to be at home and just kind of refuel for the next go.

When I think back, *I can't believe I've been doing this for a year now. I have decided that I will go back to school to get my Master's. Maybe then I can apply for another job that has more to do with policies and procedures* and make change that way. Some of my friends have gone, or are planning to go to other provinces and several of the people from your study are even going to the United States. I think it's good to try other places to see if they are any better. Or *maybe it's acute care* that's just not for me. *I'm feeling more like I'm at a plateau right now and not as passionate about nursing as I once was.* Not all my friends think like that though, in fact one of them recently said to me that she feels good every day now about what she has done at work. She's like *"C'mon just give me anything. You know, like bring it on! I can take it." Maybe it's because I went to work for a year straight and it's all I thought about and it was stressful. I'm just not as excited about going to work.* Several of my friends are out there applying for public health or community jobs where they can *work with people to help themselves and improve their own situation, improve their own health instead of in the hospital where we dictate that you're going to take these pills, your going to do this and this and this and this and they're not necessarily encouraged to take responsibility for themselves. They come in and we fix them and they go home. They come back, we fix them, they go home – "frequent flyers" we call them. Acute care sometimes feels like it's just a cycle; we see the same people coming back over and over and over again.* So for me, it's like *I feel excited to get to where I want to be in nursing, but I don't feel excited about where I am in nursing right now. Maybe in my mind I'd built up nursing to be this wonderful, glorious career where I saved lives and everything was coming up roses. Some days it is wonderful but other days it's just a job. I think the ultimate failure though would be to not be a nurse anymore – you know, to quit.* So right at this moment *I'm happy to hang because it's taken all I've got just to get to this spot. I'm not quite ready to go anywhere else because I'm finally a little bit comfortable and I don't want to go back into the discomfort just yet. I like the*

fact that I'm paying off student loans and that I am able to have a nice lifestyle for a little while. I'm still developing a relationship with my husband and I'm not prepared to give up my time. It would be interesting to go back and see when I was eager and excited to go to work. I don't know because even this feeling is new to me, even not liking it is new. I don't know what the answer is – is that OK?

Reflections

The professional role transition for the NGs in this study was clearly disruptive to both their personal and professional lives. Physical, intellectual, emotional and spiritual fatigue was apparent by about 3-4 months, with an even deeper level of exhaustion beginning to wear thin their motivation as they neared the 12-month mark of their first year of practice. Despite functioning in what was an overwhelming state of role disorientation and confusion these novice professionals were provided with minimal time to acclimatize to their new culturally saturated, skill-based and knowledge dependent responsibilities. There was an inherent expectation that they would be able to manage an advanced clinical workload, one which was equal to or even inappropriately advanced in relation to the senior nurses with whom they were working, almost immediately upon the completion of an abbreviated workplace introduction and with nominal access to, or receptivity from seasoned colleagues. Further to this, these inexperienced nurses were placed in positions of leadership early in their transition and expected to take responsibility for decisions and clinical judgments about situations to which they had had little or no exposure during their undergraduate education or professional orientation. All of this was occurring at a time when the NGs' overall development dictated a degree of self-focus that could accommodate the scope of change they were experiencing in their lives and the intensity of the responsibility they were feeling in their new life-roles.

Regardless of the level of discouragement they expressed during this isolating time in their professional socialization, the overwhelming majority of these graduates repeatedly espoused a commitment to the underlying values, philosophies and ideals of the nursing profession. It is

important to note that the drain on the NGs' coping resources identified here, though in some ways an expected outcome of such a significant life transformation, was made worse by the absence of preparatory knowledge about the adjustment inherent in a professional role transition and the inadequate allowance for supportive networks that could assist the NG to navigate the complex dynamics of an institutional culture. Insufficient feedback on progress and performance by managers and educators, a lack of accessibility to devoted mentoring by clinical experts, and little acknowledgement of the impact this developmental process was having on all other aspects of their lives resulted in both a loss of energy and a minimal repletion of that energy, and served to terminally strain the professional motivations of the majority of these NGs by the end of one year.

The undergraduate education experience for nursing students is appropriately and necessarily controlled, limited and aimed at advancing a more ideal version of practice "as it should be." This intent takes on great relevance in light of knowledge that people make sense of their world by developing preconceived constructs that are often theoretically or conceptually derived, and then use these constructs to explain what they find in the "real" world (Howkins & Ewens, 1999). If the constructs being applied do not provide for consistent meaning in the world as it is experienced, individuals will either attempt to alter the reality (i.e., external change) or reconstruct their perceptions to match it (i.e., internal change). This interplay between theory and practice, or the balancing of the ideal with the real is considered to be an unavoidable compromise between undergraduate nursing education and the healthcare industry (Tabak, Adi & Eherenfeld, 2003). Schön (1996) depicted professionalization as an essential component of educational curricula, suggesting that undergraduate programs have an obligation to teach budding practitioners to deal with situations of uncertainty, uniqueness and conflict. Using the analogy of road building, Schön illustrated that the problems of real-world practice rarely present themselves as well-formed structures. In such a case as deciding on what road to build, the civil engineer's problem is not solvable by the strict application of technical knowledge related to soil

conditions, building materials, dimensions or surface grades. Instead, this professional faces a complex and ill-defined set of political, environmental and economic factors. If professional nursing conduct is to be similarly characterized as "wise judgment under conditions of considerable uncertainty" (Eraut, 1994, p. 17), it may be necessary to reframe the facilitation of clinical and classroom knowledge for nursing students into a form of "scaffolding." Such an approach would demand content and knowledge transfer processes that would both advance the profession and allow new practitioners to function within existing organizational frameworks with a sense of job satisfaction and role fulfillment.

In a review of the issues underlying the current nursing shortage, Cowin (2002) asked how an educational system could be expected to prepare a nursing recruit for a workplace that is "fundamentally at odds with nursing care philosophy" (p. 6). Cowin further claimed that it is the limited commitment of the work environment to the nurturing and developing of the practitioner that is at the heart of many losses of NGs. Studies have consistently shown that hospital nurses lack the autonomy and organizational influence necessary to fulfill their professional responsibilities (Cho et al., 2006; Kramer, 1966; Penticuff & Walden, 2000). As has been evidenced throughout this paper, NGs are motivated by an intrinsic sense of professional ethics and morals; they want to have the time and resources to provide quality patient care for their patients, be given the responsibility and autonomy to make decisions in the best interests of their patients, and work collaboratively to optimize the environment within which that care is provided. Applying Braskamp and Maehr's (1985) personal investment theory, one becomes acutely aware that the NGs' willingness to invest themselves in their workplace may well be directly related to the quality of the organizational culture within which they work.

Orientation programs are crucial to help the NG adjust to new roles and responsibilities (Ardoin & Pryor, 2006; Fey & Miltner, 2000; Lavoie-Tremblay et al., 2002; Marcum & West, 2004). In fact, Kramer (1966) found "that all but one of the respondents [in her study] who changed jobs during the first 3 months after graduation evaluated the orientation at their initial

place of employment negatively" (p. 242). Walker's (1998) study of five NGs in their first year of practice indicated that the longer and more structured the orientation, the more confident and less stressed the graduates were when taking responsibility for clients. Overall, NG orientation and transition facilitation programs should provide supernumerary staffing to accommodate the essential mentorship and socialization needs of the NG while gradually and progressively introducing content related to unit-specific tasks, unit routines, policies and procedures. A balanced sequencing of theory and practice enables the NG to immediately apply the content learned in the classroom to practice situations; a fundamental tenet of adult learning. While a focus on tasks and technical skills is most appropriate during the initial months of the orientation period, time should be spent in latter months facilitating critical thinking and helping NGs to manage their time, organize and prioritize their workload assignments and advance their decision-making and clinical judgment. Structured and frequent (i.e., every 1-2 weeks initially and tapered as mutually agreed upon by manager, mentor and NG) performance review sessions allow the NG to assess their relative progress and give management an opportunity to receive insights on professional issues that may exist within their units. Nursing unit managers are a fundamental link between NGs and their work environment, and have been reported to have a direct effect on the workplace satisfaction of newly employed nurses (Bircumshaw, 1989). McCloskey and McCain (1987) suggested that if initial expectations of NGs are not met, they may become less attached to their job, the organization and the profession. It is recommended that managers provide clear and realistic job interviews that include specific information related to job duties, tangible work benefits, leadership styles and nursing work routines, the social climate of the unit, evaluative expectations and opportunities for career advancement.

While the idea of assisting novices to make a smooth transition to a new job is not an unfamiliar concept in nursing (Benner et al., 1996; Vandenburg, 1997), NGs continue to describe relationships with senior nursing colleagues that are antagonistic, unsupportive and unsatisfying (Callaghan, 2003; Hardingham, 2004; Jackson, Clare & Mannix, 2002; McKenna, Smith, Poole

& Coverdale, 2003; Randle, 2003; Stevens, 2002). This takes on necessary significance in the context of role theory, which proposes that individuals perceive their own identity relative to those with whom they associate, those with related roles, or those who directly impact the individual's identity and performance (Simms & Lindberg, 1978). Seminal literature has demonstrated that the NGs initial work experience has a critical impact on the formation of their concept of nursing and their professional value system (Kramer, 1974). The critical nature of assisting NGs with their transition to professional practice is made more apparent by knowledge that NGs transfer their previous allegiance with an established nursing educational mentor to that of a senior nursing role-model in their clinical practice environment within 10-13 weeks of entering professional practice (Kramer). Mentoring and preceptoring programs that successfully utilize senior nursing staff to assist NGs in their transition to professional practice exist in a variety of forms (Billay & Yonge, 2004; Fagels, 1996; Greene & Puetzer, 2002; Hardyman & Hickey, 2001; öhrling & Hallberg, 2001; Stewart & Krueger, 1996; Vance & Olson, 1998). The needs of NGs relate to both the development of their psychomotor skills as well as the assimilation into the social and professional culture of the nursing unit and organization (Gazza & Shellenbarg, 2005; Thomka, 2007). Literature on the concept of nursing internships, externships, residencies or other programs related to NG transition facilitation identify periods of time ranging from 12 weeks to 12 months over which the concepts of mentoring and precepting are introduced and supported (Beecroft, Kunzman & Krozek, 2001; Blanzola, Lindeman & King, 2004; Cantrell & Browne, 2005; Cowin & Duchscher, 2007; Halfer, 2007; Murphy, Petryshen & Read, 2004; Olson et. al., 2001; Rosenfeld, Smith, Iervolino & Bowar-Ferres, 2004; Starr & Conley, 2006). Regardless of the time allotted to the program, guided support of the novice practitioner needs to be formally structured to include both theory and practice. Mentors and NGs need to work closely together, including the organization of corresponding shift schedules for the duration of the relationship and there should be a gradual shift of responsibility and accountability away from the mentor and onto the NG (Beecroft, Santner, Lacy, Kunzman & Dorey, 2006 ; Marcum & West,

2004; Pfeil, 1999). Further to this, the infusion of peer mentoring opportunities for NGs and the assurance that established mentorship programs provide a tangible return on investment for knowledge sharing (i.e., seasoned mentor compensation incentives) will go a long way to promoting a professionally collaborative and supportive workplace culture (Corlett, 2000; Lavoie-Tremblay et al., 2002; Squires, 2002).

Conclusion

It is difficult to deny the significance of the NG transition experience when witnessing the struggle of these participants as they made their way through the initial 12 months of professional practice. Issues related to changing knowledge, roles, relationships, and responsibilities coursed through the narrative, and participants' emotions were often labile, chaotic, intense and extreme in nature. These new nurses claimed they were unprepared for, and inadequately orientated to a level of practice that far exceeded that to which they had grown accustomed during their education. The novelty that characterized so many other facets of their new lives (i.e., young adults being held responsible for their lives in the "real" world for the first time) contributed to the high levels of stress incurred during the initial months of their introduction to practice but was not always acknowledged or addressed. The stress of the transition experience was further exacerbated by practice contexts that were unfamiliar, inconsistent and unpredictable, and where little to no feedback on performance, clinical competence or progress was forthcoming.

Ensuring that NGs are welcomed into, and then adequately supported by a work environment that is collaborative, progressive and flexible is a strategy likely to both attract and retain the newest generation of graduate nurses in the acute-care workplace. Planning for the integration of NGs into the contemporary workforce needs to be a collaborative venture between academic and industry stakeholders and would optimally engage seasoned nurses as practice partners much earlier in the process. Anticipatory socialization programs introduced into the latter years of undergraduate nursing education could establish critical links between the ideal and the real by reminding seasoned practitioners of the values and ideals to which they once aspired,

while introducing moderate challenges to practice standards that have, as yet, been only conceptually considered by the pending graduate. Finally, it is unreasonable to expect that a new practitioner will be able to "hit the ground running" in the dynamic and intense work environment that is contemporary acute-care nursing. Extended orientations, structured mentorship programs, reasonable workload expectations and consideration for the sociocultural and developmental adjustments being made by initial entry professionals must be a part of any graduate recruitment and employee retention strategy.

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