

NEW GRADUATE REGISTERED NURSE TRANSITION TO CRITICAL CARE

TRANSITIONING TO CRITICAL CARE: AN EXPLORATION OF THE NEW
GRADUATE REGISTERED NURSE EXPERIENCE

By

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ABSTRACT

With the increasing demand on the health-care system and increasing human resource shortages, the delivery of critical care services is facing a crisis. Although funding is being provided to increase the number of critical care beds to meet the physical demands, the supply of qualified registered nurses (RNs) is decreasing. To increase the required staff, new graduate RNs are being hired into critical care units more than ever before. The influx of newly graduated RNs has been deemed controversial as it is viewed that new graduates are unable to engage in complex decision-making or complete the technical skills required in critical care.

The research objective of this study was to explore the experiences of new graduate RNs entering a critical care unit and to gain an understanding of the barriers and facilitators present when transitioning to the unit. Semi-structured interviews with eleven participants were conducted with new graduates from four critical care units within two major teaching hospitals in Southwestern Ontario. A qualitative descriptive design described by Sandelowski (2000) was used for this research study. The findings describe the experiences of new graduates including the emotional experience, the times of transition, becoming a professional, embracing team support and learning to feel comfortable within the unit.

These findings will be of interest to a broad audience including nursing students, new graduates, hospital managers and administrators, educators and policy makers. It is anticipated that these results will help inform organizational policy and programs and will direct further research on this topic.

*To my family, for their endless love and support
To Andrew, for your love, patience and for always
reminding me to believe in myself*

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CHAPTER 1: INTRODUCTION

The nursing profession in Ontario is facing impending pressures due to the increased acuity of patients, increased number of patients accessing the health care system and an impending projected shortfall of Registered Nurses (RNs) (Chernomas, Care, Lapointe McKenzie, Guse & Currie, 2010; Morrow, 2009). One of the clinical areas in Ontario that is feeling this pressure the most is critical care units. (Baumann, Hunsberger, Idress-Wheeler & Crea-Arsenio, 2009). One of the strategies to counteract the nursing shortage in this area is to hire new graduate RNs into critical care units, as new graduate RNs are the primary source for staffing in acute care (Hillman & Foster 2011; Ihlenfeld, 2005).

Hiring new graduate RNs into critical care has traditionally been seen as controversial as Ihlenfeld (2005) describes that new graduates lack the critical thinking and complex decision-making skills required to practice in this highly acute area. However, little is known in the literature on how new graduates transition to practice in critical care, and how they experience this transition. This thesis explored the transition experiences of new graduate RNs to critical care and sought to understand the barriers and facilitators to the transition experience. In this chapter, the significance of this current issue as well as a statement of purpose for the study and the research questions is further explained below.

Significance of Issue

The delivery of critical care services in Ontario is facing a crisis due to increasing demands on the health-care system and worsening human resource shortages. This situation will only worsen as it is estimated that the number of critically ill, mechanically ventilated patients will double by 2026 (Fisher, Baumann, Hunsberger, Blythe & Fitzpatrick, 2008). As the demand for critical care services increases, the supply of qualified health care professionals is decreasing as baby-boomers retire and leave the healthcare workforce (Fisher et al, 2008).

Critical care nursing is a specialty that deals with human responses to life-threatening problems (American Association of Critical Care Nurses, 2010). Important to providing this specialized care are RNs. Yet, it is estimated that by 2016, Canada will be 115 000 RNs short of the anticipated 363 000 RNs required to meet the needs of the population (Chernomas et al., 2010; Morrow, 2009). Demographic data reveals that critical care areas often experience the highest rate of RN attrition (Baumann et al., 2009). For the purposes of this thesis, critical care is defined as the specialized interdisciplinary care provided to clients with life threatening or potentially life-threatening conditions (Accreditation Canada, 2010).

The primary employer of RNs in Ontario is the acute-care hospital sector (Baumann et al, 2009). A significant decline in the number of RNs working in Ontario occurred between the years of 1993 and 1999 when there was a loss of 5765 RNs from the Ontario labour market due to an economic downturn within the province (Baumann et al, 2009). Baumann and colleagues (2009) report that during the early 2000s although the

College of Nurses of Ontario (CNO) reported a gain of RNs, additional acute care nursing shortages appeared, prominently in intensive care, cardiac care and emergency units in large urban hospitals. This was tied to the aging workforce of RNs within Ontario.

To fill these nursing vacancies, organizations are, more than ever, hiring new graduate RNs into these critical care positions (Duvall, 2009; Seago & Barr, 2003). A new graduate RN is defined as a person who has graduated from an accredited nursing program, passed their licensing exam, and is within their first year of practice.

Historically, new graduate RNs would commence their professional practice on a medical or surgical floor for at least one year to develop the knowledge, skills and confidence necessary to engage in specialized practice (Duvall, 2009; Reddish & Kaplan, 2007).

Integrating new graduates into critical care areas is a controversial issue. Critical care and emergency departments are dynamic environments for new graduates. It presents them with complex care, experienced staff who have high patient care delivery expectations, limited clinical supervision (Patterson, Bayley, Burnell & Rhoads, 2010), complex decision-making and frequent stressful situations (Ihlenfeld, 2005). Ihlenfeld (2005) suggests that new graduates bring with them inexperience, a lack of confidence in their abilities, and the need for professional reassurance. New graduates who are recruited into critical care units are at risk of not abiding by professional standards due to the high stress and workload expectations (Duchscher, 2006). Some of these standards outlined by the Critical Care Secretariat for Ontario include: professional behaviour/ethics, continuing competence and research, client and nurse safety/risk prevention, therapeutic

and professional relationships/caring and clinical skills, knowledge, integration and critical thinking (Critical Care Secretariat, 2005). However, supporters of new graduate RNs in critical care units argue that RNs who enter into this environment do so without any preconceptions about nursing, and are enthusiastic to learn new skills (Ihlenfeld, 2005). Demonstrating the trend towards hiring new graduates in critical care, in 2009, 10.4% of new graduates began their practice in critical care (Baumann, Hunsberger & Crea-Arsenio, 2010).

Not only are new graduate RNs being hired at an increased rate in critical care units, but it is also a preferred clinical area to begin their professional practice. When asked where they would prefer to begin their professional practice, new graduates stated that they preferred acute care settings in urban hospitals, as they perceived these settings to be faster paced environments that provided more opportunity for hands-on technical skills than other settings (Fenush & Hupcey, 2008; Hayes et al., 2006). In a study conducted in Pennsylvania by Fenush and Hupcey, focus groups with 55 final year nursing students were completed. They found that critical care was chosen over general medical and surgical units because of the high patient acuity, the pace of the clinical unit, the smaller nurse-patient ratio, perceived independence and the idea of making a difference in the care of a patient.

An appropriate supply of critical care RNs is needed in the workforce as the Ontario Ministry of Health and Long-Term Care (MOHLTC) has recognized the anticipated demand for critical care services by proposing to add 130 critical care beds by 2015/2016 (Fisher et al., 2008). However, with the projected attrition rates, there will not

be the critical care nursing workforce necessary to support this growth (Fisher et al., 2008). With the current trend of new graduate RNs being hired into these areas, investigation needs to be done on how this group of RNs transition into a critical care environment.

However, not only is it controversial to hire new graduates into critical care, but there is also the risk of hiring new graduates, and having them subsequently leave the clinical unit, which presents significant costs for an organization. Duchscher (2009) stated that current attrition rates for all new graduates in North America is noted to be between 33% and 61%, while the Canadian Nurses Association (CNA) estimates that two out of ten new graduates will leave the profession within three years of graduation (CNA, 2002). A study of new graduate RNs in Quebec noted that 61.5% intended to leave their current position (Rheaume, Clement, & LeBel, 2011). The economic cost of RN turnover cannot be ignored as Buffum and Brandon (2009) suggest that training an RN in critical care can cost up to \$64 000 US. Based on the reported attrition rates, it can be hypothesized that not enough is being done to facilitate the transition into practice for new graduate RNs. Understanding new graduate RN experiences in critical care is imperative to provide and retain the workforce necessary to care for the most critically ill patients in Ontario (Laschinger, Finegan & Wilk, 2009).

Statement of Purpose

The purpose of this qualitative descriptive study was to describe the experiences of new graduate RNs beginning their practice in a critical care unit and to better understand the barriers and facilitators associated with their transition. This information

can be used to direct planning of programs and policies related to the employment of new graduates in critical care units at both the organizational and provincial levels.

Research Questions

The primary research question addressed in this study was “What are the experiences of new graduate RNs transitioning to a critical care unit?” A sub-question was “What are the barriers and facilitators to transitioning to a critical care unit for a new graduate RN?”

CHAPTER 2: LITERATURE REVIEW

The purpose of this literature review is to examine what is known about the experiences of new graduate RNs transitioning to practice, including the transition to critical care units. Transition is defined as an alteration in role relationships, expectations or abilities (Meleis, 1991). Transition requires the person to integrate new knowledge to alter behaviour, and therefore to change the definition of self in a social context (Meleis).

The electronic databases that were searched included: Cumulative Index to Nursing & Allied Health Literature (CINAHL), Cochrane Database, ERIC, Ovid MedLine, PsychInfo, PubMed, Sociological Abstracts and Web of Science. Key terms included: 'new graduate nurse', 'graduate nurse', 'novice nurse', 'critical care', 'intensive care unit', 'cardiac care unit', 'pediatric intensive care unit', 'neonatal intensive care unit', 'specialty areas' and 'transition to practice'. Key words were searched individually and in combination with the other search terms, as appropriate. Limits applied to the search included publication years 1990-July 2011, and English language only. A Google search using the key words was used to search the grey literature. Hand searching of reference lists was completed which yielded four additional articles. A total number of 59 articles were included in the literature review, including: qualitative and quantitative research studies, organizational reports, literature reviews, theoretical literature and descriptive reports. The breakdown of the studies include: 16 qualitative studies, 11 quantitative studies, 3 systematic reviews, 3 non-systematic literature reviews, 8 theoretical papers, 1 provincial website, 1 book, 1 report from a

university research institute and 14 published articles (program descriptions, program evaluations etc.). Literature included in this review was from Canada, United States of America, United Kingdom and Australia.

The literature review is structured to first explain professional role transition, and then to explain the theoretical transition to practice for new graduate RNs. The review then describes new graduate RN's readiness to practice and the barriers and facilitators for RNs transitioning into medical, surgical and community settings. The review then focuses on the current state of knowledge related to new graduate RNs transitioning to critical care units.

Professional Role Transition

Role transition to any profession can be a time when one experiences a great deal of change. During this time one may face challenges that could include, but not be limited to having to socialize to a new environment, understand professional standards and change behaviours. When examining the transition, sociological literature contributes a number of theoretical approaches to professional role transition (Turner, 1956; Nicholson, 1984). Examining professional role transition is important, as the transition into a new work role has been shown to have a significant impact on the future development of individuals in any profession (Nicholson). New professionals search for occupational identity during their professional role transition (Taylor, Evans & Behrans, 2000). Role transition can lead to a change in self-concept, values, skills and life styles. Having support from colleagues during these stages is often cited as essential to successful professional adjustment (Gibson, 2003; Nicholson).

Nicholson (1984) outlines a theory for a work role transition encountered by any professional: he defined work role transition as a change in employment status and any major change in job content (Nicholson). Nicholson's theory discusses two adaptation processes that occur during a role transition: personal development and role transition (Nicholson). Nicholson highlights that personal development entails adapting oneself to fit the role, while role transition entails adapting the role to fit oneself (Ashforth & Saks, 1995). He states that successful role transition relies on the relationship between organizational socialization processes, requirements demanded by the role and motivational orientation (Nicholson). This suggests that work roles evolve as individuals adjust to the role, based on the dynamic changes in both the individual and the environment (Nicholson).

Nicholson's theory highlights how key variables such as prior occupational socialization, motivational orientation and role requirements can be part of the role transition for any professional (Nicholson, 1984). Although not specifically based in nursing, the theory highlights precipitating factors that can have an influence on the role transition for professionals. This theory has been mentioned in a nursing context examining role development and transition to practice. This includes studies examining role orientation for novice nurses in homecare (Murray, 1998) and exploring licensed practical nurses (Goodwin-Esola & Gallagher- Ford, 2009) or enrolled nurses (Cubit & Lopez, 2011) transitioning to become registered nurses.

Turner (1956) explored professional role adaptation from another sociological approach. Turner's description of role taking is not specifically directed to professions,

but can be easily applied. Role taking in its simplest definition is “relating the acts of the individual to the social contexts of his actions” (Turner, 1956, p. 316). By applying role taking to a professional context, it describes how one person in a new profession examines others behaviours in the social or situational context of the role being taken (Turner). Turner describes role as a collection of behaviours that are appropriate to a person occupying a particular status in society. This theoretical approach relates to Nicholson’s work as Turner discusses how one changes oneself to fit into a role, and that socialization with other people within that context assists with professional role development. However, role taking should not be used interchangeably with role performance as role performance refers to the enactment of the role, rather than the period of learning a role as with role taking (Turner). Clearly both of these theoretical models suggest a behavioural transition. The role transition, and role taking often occurs after the professional has been hired into the role, and it is his/her transition in the beginning of his/her work context that transforms behaviour.

Overall, the sociological literature highlights the complexities of professional role transition. Nicholson’s (1984) and Turner’s (1956) theoretical work highlights the impact socialization and context can have as individuals undergo behaviour and personal change when entering a new profession.

Theoretical Perspectives of New Graduate Transition

In addition to the professional role transition theories in the sociological literature there are multiple theoretical perspectives specific to the new graduate RN transition in the nursing literature (Benner, 1982; Duchscher, 2008; Duchscher, 2009). These

theoretical models describe the transition process for new graduate RNs into practice. The models described here each focus on different aspects of the transition process. Benner (1982) explains the skill proficiency development for nurses throughout their career, while Duchscher (2008, 2009) seeks to explain the transition process for new graduates only. This includes expanding on Benner's (1982) work by describing the initial novice stages in more depth, and to further explain the initial stages of transition in her transition shock model. The three theoretical perspectives are further described below.

Benner's (1982) novice to expert work adapted the Dreyfus' Model of Skill Acquisition into a nursing context and this work is frequently cited when examining the new graduate transition (Chestnutt & Everhart, 2007; Duchscher, 2008; Ellerton & Gregor; 2003; Halfer & Graf, 2006; Ihlenfeld, 2005; Morrow, 2009; Reddish & Kaplan, 2007; Reising, 2002). Benner describes five levels of proficiency within the model: novice, advanced beginner, competent, proficient and expert, which reflect the progression a nurse makes throughout his/her career (Benner, 1982). Benner classifies the new graduate RN as a novice in the early stages of his/her professional practice. Her theoretical adaptation highlights that the novice nurse has little to no experience with situations or tasks that are learned in the clinical environment. Benner describes that the novice nurse focuses solely on task behaviour because he/she lacks discretionary judgment (Benner, 1982). There are no clear indicators that would suggest when a novice nurse has transitioned to an advanced beginner, but it has been suggested that this

transition occurs within the first six months of professional practice (Benner, 1982; Duchscher, 2008; Ellerton & Gregor, 2003).

In Duchscher's (2008) stages of transition theory, she outlines three stages of new graduate RN transition: doing, being and knowing. According to Duchscher, new graduate RNs move through these stages during their first year of professional practice. This theory could be examined as one that builds upon the work of Benner (1982), by describing the novice and advanced beginner stages in greater depth, as Duchscher describes movement from task behaviour to being more comfortable in unit routines. Both Benner and Duchscher (2008) state that nurses become more comfortable and competent as time passes, and Duchscher (2008) states that new graduates need time to adjust to their new profession to develop necessary thinking and practice expertise. According to this theory at six months new graduates are ready to be introduced into a setting with more unstable patient populations (Duchscher, 2008).

Building on her previous work, in 2009, Duchscher developed a transition shock model, which was based on a ten-year qualitative research program that utilized multiple qualitative methodological approaches. This model examines the roles, responsibilities, relationships and knowledge that balance the transition experience in the initial three to four months of professional role transition (Duchscher, 2009). This model contributes a unique perspective to the previous theoretical models as it discusses the internal feelings experienced by new graduate RNs as they transition into their position. Transition shock differs from her previous work on the stages of transition by describing transition shock

as the most “immediate, acute and dramatic stage in the process of professional role adaptation for the new nurse.” (Duchscher, 2009, p. 1111)

In summary, these three theoretical perspectives highlight the complexities and idiosyncrasies of the transition experience for new graduate RNs. Benner’s (1982) model has been applied and tested in numerous new graduate transition settings increasing its credibility. The disadvantage with both of the models proposed by Duchscher (2008; 2009) is that neither has been tested; however, both provide foundational knowledge related to new graduate RN transition. All models demonstrate that the new graduate transition is a complex internal process that requires support from the clinical environment for at least the first six months to year of practice.

Readiness to Practice

When examining the literature on new graduate RN transition, there is a common theme regarding new graduate readiness to practice in their new environment. Some of the key issues facing new graduate readiness to practice in the literature are dealing with role changes (Casey et al., 2009; Duchscher & Cowin, 2004), having low self-confidence and fear in the workplace (Duchscher, 2009; Hartigan, Murphy, Flynn & Walshe, 2010), and learning new skills in their workplace (Ellerton & Gregor, 2003).

When examining readiness to practice in the new graduate, current literature suggests that baccalaureate prepared nurses are ready to manage the skills and knowledge required for today’s healthcare system. The expectation placed on new graduates to ‘hit the ground running’ may be unrealistic as demonstrated by what some call, ‘reality shock’ (Casey et al., 2004; Duchscher, 2008; Duchscher & Cowin, 2004; Dyess &

Sherman, 2009; Ellerton & Gregor, 2003; Kramer, 1974). This reality shock represents the beginning of the role change for any new graduate RN. Reality shock has been defined as a shock-like reaction of entering a profession which one individual feels prepared for and then realizes they are not (Kramer, 1974). It also occurs when the new employee recognizes that there is a disparity between academic and work values (Duchscher & Cowin, 2004). The impact of reality shock may be attrition from the current place of employment or from the nursing workforce altogether.

In Duchscher and Cowin's (2004) article seeking to understand the causes for attrition in the workplace, they describe that today's generation of new graduate RNs are highly motivated and well-educated and often place high expectations on themselves when entering the workplace. However, stress arises when they enter a workplace with very little clinical experience and face an intimidating work environment and an organizational culture that often contradicts what they learned during their university education (Duchscher & Cowin, 2004). During this tumultuous time, new graduates also have to learn new skills, meet role expectations, form a professional identity and socialize into their new workplace (Duchscher & Cowin, 2004).

Duchscher and Cowin's (2004) findings are consistent with Morrow (2009) who published a non-systematic literature review exploring the lived experiences of the transition to practice by new graduate RNs in Canada. In this review, databases, grey literature and recommendations from colleagues were utilized in the search strategy. The review highlights that acute care hospitals are the most stressful for the new graduate RN, due to high patient acuity (Morrow, 2009). Morrow (2009) confirms throughout the

review that new graduates experience a great deal of stress and lack self-confidence in the clinical setting because of the role change. Limitations with Morrow's study are the exclusion of information on how articles were selected, how many articles were included in the review and the quality of the references included in the review.

In addition to having difficulty adapting to their new role, new graduates lack self-confidence and have a great deal of fear in the clinical setting. Hartigan and colleagues (2010), after interviewing 28 registered nurses in Ireland found that episodes that challenged new graduates confidence focused around whether or not they had a grasp of patient assessment and technical skills. However, the registered nurses they interviewed had a mean of 11.8 years of experience. The reader is left to wonder why such an experienced group of nurses was asked to comment on the new graduate experience rather than new graduates. Due to time in practice, the results may reflect recall bias thereby negatively impacting the findings (Hartigan et al., 2010).

Some researchers have discovered that new graduates have a fear of interacting with the interdisciplinary team, patients and families (Duchscher, 2009; Ellerton & Gregor, 2003; Morrow, 2009). Duchscher (2001), in a phenomenological study explored new graduate RNs transition to practice in acute care settings and found that participants reported a fear of physicians, staff members and an overall anxiety with completing written orders. Some participants reported feeling verbally abused and were in constant fear during the first six months of their professional practice (Duchscher, 2001). This is supported by views focused around the current environment and culture in an acute care setting. Duchscher and Cowin (2004) state that some new graduate RNs have not only

described the working environment as un-welcoming, but also antagonistic, and filled with negativity towards the nursing profession and health-care.

In addition to fearing interactions with other team members, literature discusses the new graduates' fear and frustration when working with patients and their families.

In their study, Ellerton and Gregor (2003) used an interpretive social science approach, and conducted eleven open-ended interviews with new graduate nurses three months into their practice. They found that new graduates were often fearful and frustrated when dealing with patients and families because they lacked the ability to communicate meaningfully with them. However, Duchscher and Cowin (2004) and Ellerton and Gregor's (2003) findings are not consistent throughout the literature. Using a quantitative descriptive design, Casey and colleagues (2004) discovered that 99% of their participants who were new graduates (n=209) reported feeling completely comfortable communicating with families and their family members. These contrasting findings could be attributed to the different data collection strategies, the types of nursing education programs that participants had experienced, or the clinical areas that were represented (eight out of eleven participants in the Ellerton and Gregor study were from pediatric areas, where as the Casey et al. study was more representative of all clinical units).

When examining all the fears experienced by the new graduates, the literature is varied with the overall impact that fear has on new graduate RNs transition. Some authors state that fear can be stressful and debilitating to their self-confidence (Duchscher, 2009), while some authors express that the fear is mixed with excitement

and is part of the balance of emotions (Dyess & Sherman, 2009). Therefore, the literature is not clear on whether fear is negative to their transition or more representative of a threat versus challenge model (Lazarus, 1993). Lazarus (1993) described that, when a stressful event is seen as providing some benefit of self-growth, it becomes more of a challenge, rather than a threat.

In addition to experiencing role changes, fear and low self-confidence, new graduates also express difficulty learning new skills in the clinical environment. Casey and colleagues (2008) found that the main stressors for new graduates were related to the expectations of the work environment. This finding was consistent with Wolff and colleagues (2010), who conducted focus groups with 150 nurses regarding readiness for practice. Participants in this study were not solely new graduates, but rather a combination of fourth year nursing students, new graduates and participants who had experiences with new graduates. Findings from this study attributed the lack of readiness to practice to the shift to baccalaureate preparation in nursing education. It was traditionally viewed that diploma nurses were more technically skilled, and that the degree programs place more focus on critical thinking than technical skills, which contributes to technical deficiencies amongst new graduate RNs (Wolff et al., 2010). The findings also described that new graduates crave technical skills, and as time progresses, usually after the three months, their self-concept begins to improve in regards to task completion (Casey et al., 2004; Duchscher, 2008; Ellerton & Gregor, 2003; Halfer & Graf, 2006).

In summary, new nursing graduates enter nursing, and often face a ‘reality shock’ while struggling to adapt to their new role, new skills and new expectations (Price, 2008; Winfield et al, 2009). During this critical period, the new graduates require support from their clinical unit so they can be successful in enacting their new role. (Duchscher, 2008; Ellerton & Gregor, 2003; Morrow, 2009).

Facilitators of Transition

When examining the literature, a number of facilitators to the transition experience for new graduate RNs are discussed. One of the key facilitators is providing the new graduate with an appropriate orientation program. An appropriate orientation program generally includes a preceptorship or mentorship program for the new graduates (Halfer & Graf, 2006; Hayes & Scott, 2007; Lavoie-Tremblay et al., 2008). Secondly, it is clearly shown that a successful transition often stems out of a supportive work environment (Zinsmeister & Schafer, 2009).

Orientation programs have been noted to be a key facilitator to the new graduate transition, and numerous studies have examined the success of orientation programs to facilitate the role transition for new graduate RNs (Berkow, Virkstis, Stewart & Conway, 2009; Chernomas et al., 2010; Halfer & Graf, 2006; Hayes & Scott, 2007; Lavoie-Tremblay et al., 2008; McKenna & Green, 2004; Owens et al., 2001). However, the orientation structure is dependent on the individual organization in Ontario as there is no current standardization of orientation programs across Ontario (Baxter, 2007). This subjects new graduates to a variety of organizational programs and experiences.

The literature clearly suggests a lengthened, standardized orientation program to adequately support the new graduate in his/her transition experience (Baxter, 2010; Casey et al., 2004; Dyess & Sherman, 2009; Duchscher, 2008; Lavoie-Tremblay et al., 2008; Winfield et al., 2009). The literature is varied on what length of time is required for the new graduate to orientate to his/her new role. The recommended ranges for all clinical settings appears to be anywhere from eight to eighteen weeks (Baxter, 2010). However, in a systematic review examining retention interventions by organizations, offering an orientation for three to six months had a positive impact on new graduate RN retention (Salt, Cummings & Profetto-McGrath, 2008). Traditionally, specialized areas offer longer orientations. Baxter (2010) described that some organizations offer 12-week orientations for areas such as emergency, burn units and obstetrics, while others describe programs up to 26 weeks.

In addition to providing an appropriate length of orientation, the content of the orientation must be appropriate. The literature is clear in the importance of keeping a new graduate in a supernumerary position and having preceptors and mentors for the new graduate (Allin & Smith, 2009; Baxter 2010; Chernomas et al., 2010). Placing a new graduate in a supernumerary position during their transition is essential (Chernomas et al., 2010). Supernumerary refers to the new graduate not being included in the scheduled clinical workforce, rather being an additional member of the healthcare team (Allin & Smith, 2009). Chernomas et al. (2010) describe that by placing new graduates in supernumerary positions, it allows them time to feel comfortable in their new environment.

The idea that the new graduates can be used as supernumerary staff members for a period of time at the beginning of their nursing position is not new in Ontario. In 2007, the Ontario Ministry of Health and Long-Term Care (MOHLTC) created the New Graduate Initiative, which was an investment used to stimulate full-time employment for new graduate RNs (Baumann et al., 2010). The MOHLTC provides funding to health-care organizations to pay for new graduate RN salaries for the first six months of employment. During this period of time employers are to provide adequate orientation to the new graduate and must consider the new graduate as a supernumerary staff member rather than a regular staff member (MOHLTC, 2009). Since 2007, over 8000 new graduate RNs and 250 employers have been involved with this provincial initiative, with the majority being in acute care settings (Baumann et al., 2010). This was shown to be an effective way to introduce nurses into clinical practice with respect to new graduate satisfaction, and has shown an increase in full-time RN employment (Baumann et al., 2010). However, this program requires further evaluation on overall new graduate RN retention (Beaty, Young, Slepko, Isaac & Matthews, 2009). The program has limitations, as the organization must provide six weeks of supernumerary funding, if it is unable to provide a full-time position for a new graduate at the end of 26 weeks, therefore increasing the overall costs to an organization (Baumann et al., 2010).

In addition to prolonged orientation periods, inclusion of preceptorship programs for new graduate RNs has been shown to help facilitate the transition to practice (Ellerton & Gregor, 2003; Kelly & Ahern, 2009; Laschinger et al., 2009; Morrow, 2009; Zinsmeister & Schafer, 2009). Preceptorship refers to experienced nurses on a clinical

unit who orient new nurses to the practice environment (Forneris & Peden-McAlpine, 2009). Ellerton and Gregor (2003) found that the new graduates who were the most satisfied had access to competent preceptors for a prolonged period of time. These preceptors spent time with the new graduates explaining policies as well as modeling professional behaviours (Ellerton & Gregor, 2003). The positive influence of preceptors is further supported by Gallonardo, Wong and Iwasiw (2010) who, using a survey sent to all RNs with less than three years of experience and working in an acute care setting in Ontario, found new graduates who were paired with preceptors who exhibited strong leadership capabilities were more engaged in their transition experience, and ultimately more satisfied in their new position.

In a literature review examining the effectiveness of orientation programs (Winfield et al., 2009) preceptorship was shown to increase the satisfaction of new graduates during their transition experience and to increase long-term retention of new graduate RNs. However, this review did not indicate how the review was compiled, thereby leaving the reader with uncertainty regarding the reliability of the findings. In addition, none of the reviewed studies provided information about the retention of RNs past one year of employment, which would be necessary to get further results on retention. The lack of follow-up is critical as it is stated that during the first year of practice nurses remain undecided whether or not they will remain in nursing or leave the profession regardless of their transition experience (Cowin & Hengstberger-Sims, 2006). Higgins and colleagues (2010) presented similar findings, highlighting that a supportive

environment helps facilitate post-registration development for nursing practice and helps retain newly graduated nurses, which will ultimately improve patient care.

One of the key responsibilities of a preceptor is to ensure that the new graduate is socialized into the clinical unit. Socialization within peer groups in the unit is essential in making new graduates feel a part of the organization (Buffum & Brandon, 2009). A meta-study of ten qualitative studies examining the socialization of new graduate RNs highlights that a positive socialization experience early on in their work experience has a strong influence on an individual's view of nursing (Price, 2008). However, this meta-synthesis was limited by the absence of a rigorous search strategy and critique of the included literature by two people. Price's (2008) findings are consistent with a qualitative descriptive study of new nursing graduates and nurse managers (Chernomas et al., 2010). The new graduates sampled recognized they needed guidance and support from co-workers. They listed their preceptor, nurse manager and co-workers as transition facilitators (Chernomas et al., 2010). Although the new graduates expressed the need for mentorship from senior staff members, these individuals were seldom available thereby, hindering their transition (Chernomas et al., 2010).

In addition to having an extended orientation period with a preceptorship program, a mentorship program during or after the preceptored period ended has also been shown to assist with the socialization, and to ease the transition to clinical practice for new graduate RNs. A mentor is defined as someone who takes on the role to assist someone to grow and learn through the transference of experience (Buffum & Brandon, 2009). A mentor continues to assist the new graduate with socialization, and can further

assist in his/her role development (Baxter, 2010). They can provide informal support, be a resource within the clinical unit, and can provide much needed feedback to the new graduate (Baxter).

In summary, the facilitators to transition clearly stem from the characteristics of healthy work environments. Orientation programs have a great benefit to assisting the new graduate with their transition as they can promote retention of new graduate RNs in units (Salt et al., 2008). Preceptorship and mentorship have also been shown to be necessary and valuable to the transition experience. Not only do they assist with the technical aspects of transition but also new graduates who feel accepted and supported by their new colleagues and preceptor consistently rated their transition experience positively (Ellerton & Gregor, 2003; Kelly & Ahern, 2009).

Barriers to Transition

A number of barriers to the transition of new graduates have also been identified in the literature. The literature is clear that the barriers to the transition experience result from unsupportive work environments. This includes the direction of negative language by staff to new graduates, inappropriate power structures and unwillingness by staff to assist the new graduates with their transitions.

As new graduate RNs often enter into the profession with a low self-concept, they require support from their clinical environment. If this is absent from their transition experience, it can lead to burnout and attrition from the clinical unit (Cowin & Hengstberger-Sims, 2005; De Bellis, Longson, Glover & Hutton, 2001; Laschinger et al., 2009). Using a phenomenological approach, Kelly and Ahern (2009) examined the

expectations of the socialization process that new graduate RNs had in Australia. This methodologically rigorous study identified a number of barriers experienced by the new graduate RN. One of the key barriers described was the use of negative language by staff on the unit. The participants in this study discussed how the use of silence, and term 'new grad' hindered their development, and led them to feel unwelcome in the clinical environment (Kelly & Ahern, 2009). When labels such as 'novice', 'kids' and 'new graduate' are used new graduates often feel stigmatized and unwelcome (Casey et al., 2004; Chernomas et al, 2010; Duchscher & Cowin, 2004; Kelly & Ahern, 2009).

In addition, new graduates can experience barriers to socializing due to pre-existing power structures within the unit environment. Lavoie-Tremblay and colleagues (2009) discovered that 43.4% of the new graduates in their study had experienced psychological distress because of an unsupportive clinical unit. This finding was echoed by Kelly and Ahern (2009), where their participants described an inherent 'bitchiness' directed towards them by other staff RNs. This type of behaviour was also echoed in a qualitative descriptive study by Dyess and Sherman (2009) where they found that participants frequently experienced horizontal violence in the workplace. Horizontal violence is defined as any act of aggression demonstrated by a colleague, inclusive of emotional, physical and verbal threats (Dyess & Sherman, 2009). Unsupportive clinical units can lead the new graduate to perceive power inequities and artificial hierarchical structures within the clinical unit. This situates the new graduate at the bottom of the structure, subsequently promoting the notion of nurses 'eating their young' (Kelly & Ahern, 2009).

The degradation of new graduate RNs can have a negative impact not only on the transition experience but also on the retention of the new graduate in the clinical unit. Laschinger et al. (2009) highlighted that nurses' perception of incivility are related to how supported they feel within their work environment, and found that higher workplace incivility led to burnout, which, then lead to attrition.

When examining the attrition of new graduates, Rheume and colleagues (2011) examined intentions to leave the workplace among Canadian new graduate RNs. Utilizing a cross-sectional design, they collected data over a 5-year period, surveying 348 new graduate RNs. The majority of the respondents (92%) were from an acute-care setting. The study concluded that 49.6% of new graduate RNs did not intend to leave their employer, 4.9% stated they would leave and the remaining 45% expressed uncertainty (Rheume et al., 2011). This study also highlighted the factors that contributed the most towards staying in their unit, which were, the work environment, the ability to provide quality nursing care and psychological empowerment (Rheume et al., 2011). However, the response rate of the survey was only 27%, which can decrease the external generalizability of the study findings.

In summary, it is imperative for a healthy work environment to support new graduate transition. Feelings of incivility and decreased self-concept increase the dissatisfaction of new graduate RNs in the clinical environment and may lead to new graduate attrition from the clinical unit (Duchscher & Cowin, 2004; Kelly & Ahern, 2008; Laschinger et al., 2009; Lavoie-Tremblay et al., 2008).

New Graduates In Critical Care

The aforementioned literature presented what is known about the new graduate RN transition to practice. Although encompassing acute care hospitals, critical care units were overwhelmingly absent from the studies examining transition to practice. An exception includes the cumulative work completed by Duchscher (2008; 2009) and Casey and colleagues (2004) where critical care and specialized units were included within the sampled clinical units, but not separated during the analysis phase.

Although it is becoming more common for new graduate RNs to enter critical care areas upon entry into the nursing profession, there are still those who believe that new graduate RNs do not belong in this highly acute and unpredictable setting.

Duchscher (2009) clearly stated in her summary on the new graduate RN transition that hiring new graduate RNs into critical care areas should be undertaken with caution and that ideally, this novice practitioner should start in a relatively consistent and stable setting before moving to a highly acute and unpredictable clinical setting (Duchscher, 2009).

Regardless of the on-going debate whether or not new graduates should enter critical care areas, due to the shortages of RNs in all clinical settings, new graduates are anticipated to be a sizeable part of the nursing demographic in critical care. Interestingly, when examining clinical unit choice amongst baccalaureate nursing students, over half of the participants identified wanting to enter critical care due to the favourable nurse-patient ratios, acuity and pace (Baumann et al., 2009; Fenush & Hupcey, 2008).

Literature on new graduate RNs in critical care units is sparse; the majority of studies are focused on the evaluation of critical care orientation programs within individual organizations (Ballard & Trowbridge, 2004; Chesnutt & Everhart, 2007; Dunn, 1992; Dunn & Fought, 1994; Duvall, 2009; Kollman et al., 2007; Patterson et al., 2010; Seago & Barr, 2003). Published literature on new graduates in critical care focuses on the description and evaluation of various organizations' orientation programs.

Literature from these published descriptions of orientation programs highlight that the orientation process for a new graduate in critical care should be intensive, although program design can be variable (Boyle, Popkess-Vawter & Taunton, 1996; Ihlenfeld, 2005; Kollman et al., 2007; Reddish & Kaplan, 2007). Most critical care orientation programs consist of in-class instruction, practical skill demonstration and prolonged preceptorship (Kollman et al., 2007; Reddish & Kaplan, 2007). The preceptor relationship is vital, with preceptors preferably having at least three years of experience in a critical care setting (Kollman et al., 2007). Additional qualities that have been examined as predictors of success in a critical care unit are: previous critical care placements as a student, strong academic performance, and an employment history in an acute care setting (Kolman et al., 2007).

Four additional studies were located in the literature that discussed new graduate RNs entering critical care. These studies examined the technical abilities of new graduates in comparison to more experienced nurses (Whyte, Ward & Eccles, 1996), the experiences with a critical care orientation program (Davenport, 2000), and the

socialization of new RNs entering critical care, regardless of previous years of experience (Boyle et al., 1996; Reising, 2005).

Summary

The literature presented in this review is clear on a number of key issues related to the transition of new graduate RNs into clinical practice. There is a wealth of literature that discusses the transition to practice in medical, surgical and community settings. This literature highlights that the transition can be stressful, and new graduates are not able to 'hit the ground running' when they enter the clinical environment. What new graduate RNs do need is an appropriate length of orientation with supportive preceptors and mentors. When new graduates are faced with unsupportive work environments it leads them to feel marginalized, degraded and could lead to attrition from the clinical unit.

Although there is an abundance of literature on the new graduate transition to medical, surgical and community settings, there is very little known about the transition to practice in critical care for new graduates. What the literature does tell us is that a lengthened orientation, up to twenty-four weeks is recommended, as new graduates often feel uncomfortable and unsure of their new environment.

What is missing from the literature is an accurate and complete description of the transition experience to critical care for new graduate RNs. It is important to know specifically what the transition to critical care is, as these units demand a great deal of technical skill, decision making and critical thinking. It is also important to explore the abilities of new graduates to enter these highly acute units, as they have traditionally not been available to new graduates. This gap in the literature demonstrates the need to

further explore the transition experience for these new graduate RNs, and to highlight if there are any similarities and differences to what is already known about the transition experience.

CHAPTER 3: METHODS

Methodology

A qualitative descriptive approach (Sandelowski, 2000) was selected to explore and describe new graduate RNs' experiences of transitioning to a critical care unit. This approach aims to provide a comprehensive summary of an experience within the confines of the experience while enabling the researcher to obtain answers to questions that are often of special relevance to practitioners and policy makers (Sandelowski).

A qualitative descriptive design seeks to achieve two important goals: first to achieve descriptive validity, which requires that an accurate account of the events be explored and second, to achieve interpretative validity (Sandelowski, 2000). This requires an accurate presentation of the meanings that participants attribute to the studied phenomenon (Sandelowski). Qualitative descriptive studies are composed of a reasonable collection of sampling, data collection, analysis and re-presentation techniques (Sandelowski).

Reflexivity

As the primary researcher in this study I am an RN, and a recent new graduate, therefore reflexivity throughout this study was important. Reflexivity refers to the researcher being conscious of the biases, values and experiences that one brings to a qualitative study (Creswell, 2007). I entered an emergency department as a new graduate RN; therefore, I brought a number of personal feelings and experiences to the study. I have continued to work in this environment for four years. I am no longer considered a

new graduate but I am influenced by my experiences as a staff RN as well as my past experience being a preceptor to new graduate RNs. I am also an MScN student, studying the topic of new graduate RN transition. I was a student at one of the sites being sampled, so I bring the experiences that I had transitioning to that department as a student. I also brought to the study knowledge of current literature and theories on the topic, and was aware of the influence that these may have had when analyzing the data. I am someone who survived the transition experience as a new graduate and remained in the nursing profession. As an MScN student, I was new to the research process and was insecure at times when navigating through it.

During the research project, I continually journaled personal feelings, biases, presuppositions, and propositions to ensure that I was aware of what elements of my life that may have influenced my interpretation and reporting of the data. In order to ensure that the participants' stories truly reflected their experiences and not my own, I shared the data with members of my supervisory committee. This included seeking and receiving input and feedback during all phases of the study, which increased the credibility of the study findings. I also summarized the content of the interview with each participant, ensuring the appropriate and accurate messages were gathered.

Setting

This study was based in two urban tertiary care organizations within Southwestern Ontario. Critical care units sampled included an adult Intensive Care Unit (ICU), Coronary Care Unit (CCU), a Neonatal Intensive Care Unit (NICU) and Pediatric Critical Care Unit (PCCU). All units sampled in this study operated as a closed ICU

system. A closed ICU refers to an ICU-based team of critical care physicians, nurses, pharmacists, respiratory therapists, and other health professionals that are responsible for the management of patient care (Joint Commission Resources, 2004).

Sampling and Recruitment

As this study sought to explore a particular group in depth, a purposeful sampling approach was employed (Sandelowski, 2000). Purposeful sampling involved sampling information-rich cases in order to understand the issues of central importance to the study, in this case, the new graduate RN transition to a critical care unit (Patton, 2002). More specifically, homogenous and criterion sampling strategies were employed (Patton, 2002). Homogenous sampling refers to selecting a small, similar group, and is used when the purpose of the study is to describe a particular group in great detail (Patton, 2002). Criterion sampling refers to studying participants that meet specific criteria (Patton, 2002). The homogenous criterion sample included all new graduate RNs within a critical care environment with the criteria of having graduated in 2009 or 2010 from an accredited nursing program, practicing within the ICU, CCU, NICU or PCCU of the organizations sampled (Patton, 2002). Additional inclusion criteria for the study included: being able to speak English; registered to practice nursing with the College of Nurses of Ontario; and working in one or more critical care areas full-time or part-time. Although the definition for a new graduate for this study is a person within his/her first year of practice, new graduates were selected within their first two years of experience to maximize the number of participants available for recruitment. It was felt that eligible participants may have just finished their transition experience, or be able to recall the

experience being so new to their professional practice. This enriched the overall content of the study by having new graduate RNs in various stages of their transition.

Sampling and recruitment began in October 2010 and ended in February 2011. A sample size of eight to ten participants was sought, as a sample size of up to ten is often cited when utilizing homogenous sampling. However the study was not completed until data saturation was achieved (Sandelowski, 1995a). Data saturation refers to sampling participants until new information obtained does not provide any further insight into the issue under study (Creswell, 2007). Data were saturated after eleven interviews, and subsequently recruitment and data collection ceased at that time.

Two different types of recruitment techniques were used. At one site, participants were recruited using REB-approved flyers (Appendix A). These flyers were placed in various places around the unit such as the bathroom, staff lounges and staff locker rooms. The second recruitment strategy employed in the second organization was to send out recruitment emails via a gatekeeper within the organization that had access to the names of all the new graduate RNs working in the critical care areas.

Recruitment Challenges

During the initial phase of this study, a number of recruitment challenges presented themselves. Initially only one organization was included, as it had been determined that the number of new graduate RNs hired within the last two years was sufficient for the study. After gaining research ethics board approval, recruitment was initiated. However, there was no response after three weeks of advertising. One recruitment barrier occurred when the orientation classes for new graduate RNs were not

being offered at the same time as recruitment so presentations to introduce the study were not an option. A second barrier was an outbreak of clostridium difficile within the organization, which further increased the difficulty of recruiting eligible participants. After little response (two participants) within one month, an additional organization was added. Upon recommendation of an employee within the second organization who served as a gatekeeper for the study, a second recruitment strategy was used. An REB-approved recruitment email was sent to participants by the REB- approved gatekeeper who had knowledge of the new graduates in critical care units. This recruitment strategy was successful and lead to an increase in response from participants.

Both recruitment methods included contact information for myself. Upon contact, I would screen the participant for eligibility and if eligible would send them a letter of introduction regarding the study (Appendix B). If the participant expressed that he/she wanted to continue on, a date for the interview was set, and the consent form (Appendix C) was sent to them to read and sign prior to the interview.

Data Collection

Data were collected from participants by way of a semi-structured interview, either face-to-face or over the telephone. An interview guide was developed and pilot tested to ensure that relevant data were collected.

Interview Guide.

An interview guide ensured that appropriate questions were posed to the participants within the time constraints, and made the interviewing of participants more

systematic and comprehensive (Patton, 2002). The initial interview guide was informed by Duchscher's (2009) Transition Shock Model (Appendix D), reviewed literature and the study's research questions. Utilizing a theory to inform data collection corresponded to the qualitative descriptive approach, which created congruency within the study (Sandelowski, 2010).

Pilot Testing.

The initial interview guide was pilot tested with three new graduate RNs who began their professional practice in an emergency department where I worked. This was done as Creswell (2007) states, that pilot cases should be selected on the basis of convenience, access and geographical proximity, which was the motive when selecting this department. The goal of testing the interview guide was to assess for any degree of observer bias, test the framing of the questions and to highlight any additional information that should be included (Creswell, 2007). The guide was tested with three new graduates at different points in their professional practice. One new graduate RN was within his/her first year of practice, and two between one and two years of practice. Each time the guide was tested, the responses were examined and the guide was changed as necessary. Changes made to the interview guide included: re-wording the initial question and adding or re-wording probing statements. The model used to set up the interview guide, Duchscher's (2009) Transition Shock model was consulted during the pilot testing process to ensure that the responses being obtained fit within the description of the four categories outlined by Duchscher (2009). All of the data collected from the pilot test were not included within the data collection and subsequent data analysis.

Interviews.

Prior to each interview, all participants were asked a number of demographic questions, which were used to help describe the participants backgrounds. Collecting information to provide a rich context is essential in qualitative descriptive research, as the collection of as much data related to the research question will allow one to capture all of the elements of an event to describe it appropriately (Sandelowski, 2000).

Data were collected using semi-structured interviews. Interviews are used in qualitative research when the purpose of the study is to obtain a rich, in-depth experiential account of an event or episode in the life of a participant (Fontana & Frey, 2000). Semi-structured interviews also help discover the ‘who’ ‘what’ and ‘where’ of the experience (Sandelowski, 2009). A semi-structured interview also allowed the researcher to control the process of obtaining information and provided the researcher with enough flexibility to explore participant responses and to pose questions in greater depth on certain issues (Patton, 2002; Pardington, 2001; Stake, 2010).

All interviews were scheduled outside of work at a mutually determined location, either in person or over the telephone. Interviews lasted between 45 and 60 minutes. Each interview was audio-recorded and transcribed verbatim by a professional transcriptionist; two digital recorders were used in case the first one malfunctioned (Creswell, 2007). I took short notes during the interview to be able to summarize at the end of the interview, and to be able to ask the participants further questions based on their responses.

Upon completion of the interview, participants were given a \$20.00 Second Cup™ gift card to thank them for their time and participation. Participants also received a certificate of participation in research for their College of Nurses of Ontario Professional Profile. The honoraria were provided to show appreciation for their participation and to recognize that participating in the study may have created a burden for them and may have led to an invasion of personal privacy (Stake, 1995).

Data Management and Analysis

Data were collected and analyzed concurrently in order to highlight any emerging themes in the data, to inform future interviews, and to determine when the data had been saturated (Sandelowski, 2000). To manage the data throughout the study, NVivo 8® was used. In qualitative descriptive studies, content analysis is used to analyze the collected data (Sandelowski, 2000). Qualitative content analysis examines the language of the collected data with the goal of compounding data into informational categories that represent similar meanings (Hsieh & Shannon, 2005; Sandelowski, 2000). This type of analysis is the least interpretative of the qualitative approaches; instead, there is an effort to understand the latent content of the data (Sandelowski, 2000). As the focus of the study was to understand the experiences of new graduate RNs, there was a focus on understanding what the text said in order to describe the experiences, also known as exploring manifest content (Graneheim & Lundman, 2003).

There are a number of ways to complete content analysis. In Sandelowski's (2000) description of the qualitative descriptive research method, she states that researchers can begin the analysis process with pre-existing coding systems, which are

then continually modified in the course of analysis, by adding more codes to the initial list.

For the purposes of this study, directed content analysis was utilized (Hsieh & Shannon, 2005). The entire analysis process is visible in Appendix E. Directed content analysis is used when there has been some knowledge or theory used to inform the research question (Hsieh & Shannon, 2005). In addition, directed content analysis is beneficial when there is a wealth of information on a topic, but a gap still remains, which was the case examining new graduate RN transition to critical care (Hsieh & Shannon, 2005). In this more structured approach, key concepts (based on research questions, literature etc) were identified as initial codes. More specifically, initial codes used in the analysis were based on the transition shock model and the research questions that were posed. Codes are labels used to assign meaning to information collected from a study and were applied to sections of the text (Miles & Huberman, 1994). Every code was defined throughout the analysis process to promote consistency across coders (Miles & Huberman, 1994). This was essential as my supervisor coded three transcripts and members of the supervisory team coded portions of one transcript and commented on the emerging codebook to ensure rigor throughout the analysis process. Throughout the entire analysis process, any code that could not be categorized with the initial codelist was given a new code (Hsieh & Shannon, 2005).

My supervisor and I decided upon the initial codes. Each initial code was defined and formed the initial codelist, which contained nine codes. To begin analysis, my supervisor and I coded the initial transcript independently. A consensus meeting was

then held to discuss the coding and determine consensus. After the initial consensus meeting I continued to code all of the transcripts independently using the emerging codelist, while continuing to add codes as needed. Approximately halfway through the analysis, my supervisor and I held a second consensus meeting after independently coding an additional three transcripts. At this point, consensus was again reached on the emerging codebook, and the codes being assigned to the sections of text.

After all of the transcripts were initially coded by myself, and after the two consensus meetings, the codebook and a transcript were sent to the rest of the supervisory committee. At a meeting, the codebook was reviewed, along with a transcript, and a discussion about the codes and emerging themes was completed. At this meeting, consensus of the codes applied was achieved and emerging themes were discussed. The final step of analysis involved me re-coding all eleven transcripts with the final codebook to ensure coding consistency across all transcripts.

After all the transcripts were coded with the final codelist, I chunked the data into themes. Creating themes is the core feature of qualitative content analysis (Graneheim & Lundman, 2003). A theme is a group of content that shares a commonality and must be both internally homogenous, and externally heterogeneous. It should be exhaustive and mutually exclusive, meaning anything related to the study purpose; in this case the experience of a new graduate RN was included (Graneheim & Lundman, 2003).

I formed the themes from the codes and all data reduction and analysis decisions were documented. I then discussed the emerging themes and sub-themes and provided exemplars to the members of my supervisory committee in order to achieve consensus,

which increased the interpretative validity of this study (Law & MacDermid, 2009; Sandelowski, 2000).

Rigor

The overall rigor of a qualitative study is judged in terms of its trustworthiness. Guba and Lincoln (1989) state that in order for a qualitative study to be trustworthy, it must be credible, transferable and dependable. The researcher ensured credibility by journaling during the entire research project. Additionally, at the conclusion of the interviews, key points from the interview were clarified with the participants (Guba & Lincoln, 1989). This served as the member checking for the study. Additionally, all design and analysis decisions were discussed, and agreed on by a supervisory committee, increasing the trustworthiness of the study.

Dependability refers to taking into account factors of instability and design induced changes that affect the quality of the study (Graneheim & Lundman, 2003). Dependability was strengthened through the use of a semi-structured interview guide, which ensured that the same questions were asked of all participants. In addition, defining all of the codes created congruency amongst coders during the analysis phase. An audit trail of all study design and analysis decisions was recorded throughout the entire length of the study. The audit trail included raw transcript data, data reduction and analysis products, such as the emerging and final codebook, process notes and data reconstruction products such as emerging and final themes and sub-themes (Morse, 1994).

Transferability refers to the extent that the findings can be transferred to another setting (Graneheim & Lundman, 2003). Transferability of the findings was confirmed by providing a clear and distinct description of the units, description of the participants, data collection and analysis, in addition to providing direct quotes from the data to provide a rich context for the readers (Graneheim & Lundman, 2003).

Ethics

Ethical approval was obtained from the first organization on October 5, 2010 (Appendix F). Once the study was expanded, an application was submitted to the research ethics board for reciprocal review. This ethical approval was granted on December 1, 2010 (Appendix G).

The initial organization was chosen, because I did not have any affiliation with the organization, which reduced the ethical risks of sampling my own workplace (Creswell, 2007; Morse, 1994). Although I was an employee of the second organization, there was no affiliation with the units sampled in this study. Additionally, I was not a faculty member at any School of Nursing during the period of the participants' education, thereby, eliminating the chances of being a past educator of any of the participants, which could have represented a power imbalance in the study.

Upon contacting myself, all participants received a letter of introduction and a consent form for the study. Once they had agreed to further participate in the study a mutual date and time was set up between the participant and myself. Participants were given ample opportunity to ask any questions related to the study. At the initial meeting

before the interview, participants signed the consent form, and were given a signed copy for their records.

All interviews were digitally recorded and sent to a professional transcriptionist for transcription. Prior to beginning the transcription, the transcriptionist signed a statement of confidentiality, as some identifiers were present in the audiotape. Electronic files were securely sent via an FTP website to the transcriptionist. All transcripts were stored on a password-protected computer in my home office. During the analysis developing a code ensured process anonymity of the participants and pseudonyms for all participants, with original codes and consent forms stored in a locked filing cabinet my home office. In addition, any identifying information from the consent forms, recruitment flyers and ethics documents included in this manuscript have been blocked out.

Additional physical data such as transcripts, demographic data, codes and research templates were stored in a locked file cabinet, and/or a password protected computer file with access restricted to solely the research team. The raw data will be stored for ten years as required by the research ethics boards. After ten years the electronic files will be deleted while the hard copies will be shredded and destroyed.

CHAPTER 4: FINDINGS

Findings from this study describe the experiences of 11 new graduate RNs hired into one of the following critical care settings: a neonatal intensive care unit (NICU), a pediatric critical care unit (PCCU), an adult intensive care unit (ICU) and an adult coronary care unit (CCU). These participants eloquently described their transition experience as well as the perceived barriers and facilitators to their transition.

Demographic data were collected from each of the participants in this study. All eleven participants were female, employed full-time, in their first career and were given some unit-specific critical care education. Additionally, four of the participants took a formal critical care course through a local college. The work experience of the participants ranged from 5-20 months and of these 11 participants, 7 had previous critical care experience, either as a summer job or a student placement.

This chapter describes each of the main themes that emerged from the data: times of transition, the emotional experience, becoming a professional, the unit environment and the unit team. A glossary of definitions for each theme and sub-theme is listed in Appendix H.

Throughout this chapter, pseudonyms were used rather than actual participant names in order to protect participant anonymity. To enhance the readability of direct quotations, extraneous words have been removed.

Schematic Model

A schematic model was created to demonstrate the relationships between the themes (Fig. 1). The schematic model displays the transition experience of the participants, starting with them as new graduate RNs and ending as critical care RNs. The central portion of the schematic model displays the themes described by the participants and illustrates how the themes form the overall transition experience.

The entire transition experience was grounded by time, which is represented by the red arrow at the bottom of the model. It moves from the beginning to the end of the transition, as the end-point was variable depending on the participant. The entire transition experience for the participants was also influenced by emotions, which is represented by the blue line of the emotional experience following them through their transition experience. The entire transition experience took place within the unit environment, which is reflected in the model. Through this model, one can ascertain where the participants went through their realizations and role-taking as well as when nursing and team support was most prevalent. Finally, the red line in the model represents the two times of transition. The two lower portions of the line represent fear and anxiety in the participants, while the higher points of the line represent feelings of comfort in their transition experience.

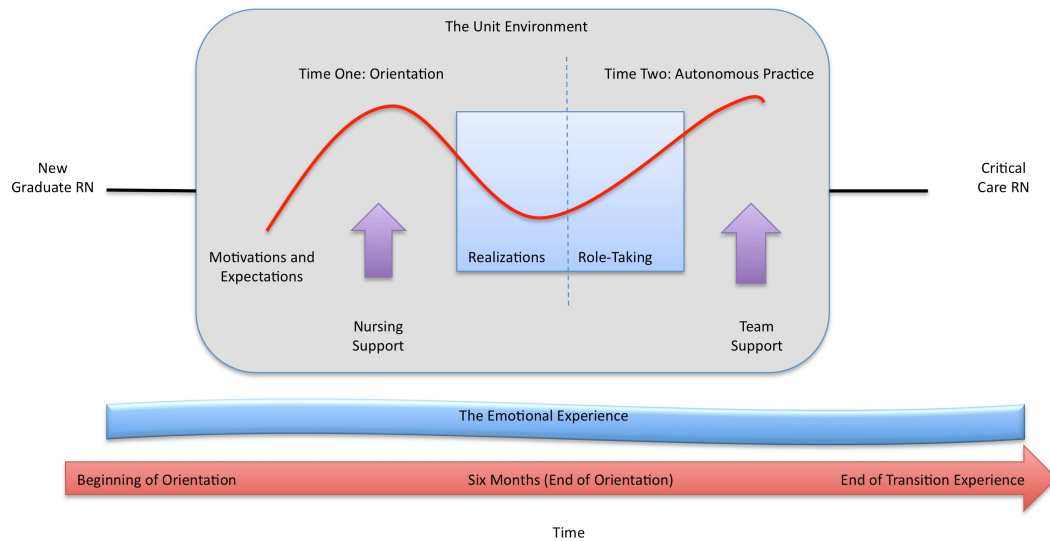


Figure 1. The Times of Transition Schematic Model

Times of Transition

What is unique in these findings was the participant's description of an experience that reflected two distinct periods of time in their transition experience. For the purposes of this study, times of transition refer to the varied levels of comfort based upon the part of the transition experience that they were in. These times of transition were impacted by a number of supports that were available to them. The times of transition are so important to the overall transition experience because they determined how the new graduates felt and adapted to the clinical unit. These two distinct times almost served as a 'roadmap' to

the transition experience. The times of transition have been broken down into time one: orientation and time two: autonomous practice.

Time One: Orientation

For the purposes of this study, the orientation period, or time one of a new graduate RN refers to the time where the participant was preceptored and receiving formal education in their respective units. As the participants were navigating through their formal orientation period they used words such as ‘protected’ and ‘supported’. New graduates still had their preceptor as a main support and were receiving formal education within their unit.

I think it is when you come on to orientation ... you were still protected in a sense...you were accountable you were writing your name next to the meds and you were doing the assessments and you were doing the charting. You were accountable but I still felt that... when I went in and checked pupil reactions when I ... asked questions, and when I listened to a chest, I knew my preceptor was going to come in right after me and be there anyways. So if you heard no breath sounds, I knew she was going to come in and hear no breath sounds. We would figure it out together, and so it was really easy to learn that way, because I knew that if I had a question or if I was unsure, you had someone telling you what to do. (Sarah)

During this period of time, new graduates began to ‘settle’ into their units, and began to understand their roles as well as feel more ‘comfortable’ within their units. The orientation period allowed the participants to begin to form relationships with staff, their individual preceptor and unit leaders. However, as their orientation period drew to an end, the preceptor began to ‘back off’ thereby providing more opportunities for the new graduate to work independently.

Yeah. For sure. When she would kind of back off [near the end of my preceptorship], that was kind of my time to deal with the patient, and she kind of

sat back. That was kind of my time to figure out how I am going to manage things in a timely manner. (Leanne)

When the preceptor began to back off the level of comfort for the participant decreased. The participants began to feel more uncomfortable as they knew they were now becoming responsible for the patient care, and could no longer rely on being in a supernumerary position; learning and working side-by-side with a preceptor on the preceptor's patient assignment. This period of the preceptor backing away culminated with their formal orientation period ending. This led the participants in the study to begin experiencing the second time in their transition.

Time Two: Autonomous Practice

The time two, or autonomous practice refers to the ending of the orientation period when the preceptor stepped away, formal orientation programs ended and the participant moved into working alone. This time was described by participants as highly stressful and overwhelming, as their previous supports were no longer readily accessible. They were now the primary RNs for their patients; no longer sharing a patient assignment with their preceptor. This often made the new graduates feel very uncomfortable and anxious. Kathryn stated:

Yeah, during my orientation I felt comfortable going into work maybe a few months after I started, and then again right after I got off orientation, I didn't feel very well going in. I was always wondering what I would get, and wishing that I had the most stable patient on the unit, but I feel like now, maybe a couple of months after being on my own, I feel a lot more comfortable going into work.

The participants in this study clearly identified how overwhelmed and stressed they were during this second wave. Some participants described it as more frightening

then when they began on the unit. Leanne stated “ [the transition] was almost the same, it was almost the same honestly in terms of nerves. It was scary when I first started, and it was scary when I was on my own.” This period was critical for participants, as they had to be independent RNs for the very first time. They no longer had the comfort of the preceptor to make sure they didn’t “miss anything” (Sarah). Colleen compared it to going from a “team of two” to a “team of one.” This latter phase was critical to them as they were trying to enact the role of the RN and to succeed independently in a highly acute environment.

Oh yeah, I was scared, nervous all the time. I would walk in and see my assignment, and shake sometimes. I was like how am I even going to, I remember walking in one day, and my assignment was heavy...I was literally shaking.
(Leanne)

...being on my own it has brought back that whole I am brand new again, and I need to re-learn everything again, and I need to do it for myself, and I need to ask for help and ask questions, and do that because I don’t want to miss anything.
(Sarah)

Once the participants transitioned to working on their own, and had some time to work independently with the support of their colleagues, they gradually started to feel more comfortable. However, this was different from the first time of transition, where the participants had felt comfortable due to the guidance and supervision of their preceptor, where now, they had to seek out and rely on other colleagues to support them in their independent practice. This was important as for the second time in their transition experience the participants had to work hard to feel comfortable in their new role as an independent RN.

[Was I ready?] Yes and no. Honestly I think it depends on the day, like, no I wouldn’t say I felt comfortable to start... I think I would always have that nervous

feeling, but no it is fine. It just depends on the day. I think I have learned that I have to just stay on top of things more, and it is all in the organization...[but] there was still people there if I needed to ask questions about anything, which I still ask questions if I need help. (Michelle)

[I am more confident and comfortable] because of my knowledge, and I have made friends in the unit...other people are...pretty good friends now. Being able to work in level two and level three, and being able to do my stuff, and then also if it is not too busy on my assignment, you can go around and ask other people if they need help and to be able to help them out. I feel more comfortable with the fact, and just knowing that sometimes we are just so busy, it is not because you are new, it is just because it is a busy place. If people offer help, just say yes. (Kathryn)

Some participants took longer to feel comfortable than others. Some participants described that it took a 'set' (four twelve-hour shifts) to feel comfortable or some described that they were still searching for that comfort over a year and a half into their practice. Leanne described her experience as:

...and so six months orientation, and then a good six months before I felt like, okay, I can do this, and then another six months has gone by, and I got a really sick patient, and I was a bucket of nerves again.

Elizabeth found her own comfort a bit earlier, and stated, "...not too long after my four sets were done really. I think maybe my first two sets after my orientation, I was a little nervous going in, but now I am totally comfortable going in."

It was near the end of the second time of transition when participants described that they really felt like they had 'hit their stride' and were a valued and important member of the team. It was during this time that they were more comfortable, and could describe how they felt in their new independent role as a critical care RN. Elizabeth described:

The best thing is feeling accomplished. I would say, because you come in and even now I have been working there a little over six months, there are new people

coming in, and it is nice to be like oh I used to be there, and I used to know what it felt like, and I used to, I remember having those same questions, and then I know the answers to those questions, and I can help them, and it is really nice to see how much growth I have had. I like the growing process well, so, which is wonderful.

I think being on my own that is like after preceptorship that kind of when that started, and when you were giving report, like to the big team and everything, that is when you feel like you are part of the team, like the information if valuable, and you are needed to help with the patient's care and everything, and I felt like I was really part of the team. (Jessica)

The culmination of the second time of transition reflected comfort and contentment in the participant's individual practice. The participants, when describing this part of the transition experience, opened up and started discussing staying in the department and further developing their practice because of the support they had received from everyone in their unit. Elizabeth described:

Yes. [Because of my experience I am going to stay], and it is funny because all the older nurses will come to me, and they will be like, oh so do you like it here? And I am like, I love it. And then I am like I think I am a lifer. I will probably be there for like thirty years kind of thing.

The Emotional Experience

As the times of transition served as a 'road map' to their transition experience, the participants also had a multitude of emotions that followed them through their transition experience. The emotional experience refers to all the feelings described by the participant during his/her transition experience. The emotions described by the participants in this study were: fear and anxiety, exhaustion, being overwhelmed, excitement, enthusiasm, privilege and feeling valued. These emotions were impacted by

the level and type of support the new graduates received, how long the new graduates had been in their units, and how the new graduates were personally coping.

Fear and Anxiety

Participants described feeling fearful and anxious as they began their transition into practice. For the purposes of this study, fear and anxiety refers to: feelings of being scared and nervous about being in a transition experience. They were anxious due to the nature of their new environment and the amount of knowledge required to successfully work in it. Elizabeth commented that she was scared she wasn't going to be able to "handle it." Leanne highlighted, "Nervous. I am a nervous person as it is. I am very shy. I am very nervous, and yeah going into work I was always nervous..."

Being fearful and anxious was primarily anticipatory for the new graduates as they anticipated how dangerous care provision could be due to their lack of experience and knowledge. Michelle clearly highlighted the dilemma of feeling scared by stating:

[The beginning was] scary...it is quite enjoyable...it is very rewarding, but it is also very nerve-wracking just because patients are just not overnight patients...most of them are really sick, so it is quite nerve-wracking to have those types of patients where you are so inexperienced.

Sarah commented on her fear of being inexperienced, "...you don't want to kill anyone. I know it sounds bad but when you are in ICU and your kids can die any minute...you don't want to miss something because you are new..." The participants also stated they believed all their patients would be medically unstable, and it would be difficult to provide care for them. They knew how quickly a patient's status could

change, but were unaware of what the signs of a patient's changing status were, which increased their fear.

I think it is [being] scared of missing something, because, it's not routine at all... it is not like you [go and do] vitals and then do this, that and the other things...you are just worried about getting your meds on time, I go in worried that like my kid is going to be crashing...because of the sickness...they get sick really quickly and it is just not necessarily noticing the signs, because I have never seen them before. I think that is probably the worst part. (Sarah)

Exhaustion

Exhaustion refers to being emotionally drained of energy or effectiveness (Merriam-Webster, 2011). These feelings exhaustion were mostly prevalent during the first two to six months of practice, but for some it extended to one year.

During this period of time, new graduates described feeling emotionally exhausted as they tried to deal with shift work, the constant learning, worrying about patient care, reflecting on patient care decisions, and thinking about work long after the shift was over. When asked to describe what was most exhausting Colleen stated, "I think just the intensity of everything and...being on the edge all the time. It leaves you drained, definitely drained." Participants noted that they were unaware of how much work 'would consume' their lives.

Often it would keep you up at night, after you come home from work just thinking about things, or time management was an issue...usually before a night shift [it would keep me up]. It would keep me up thinking about the next day or what I had done that day, just kind of evaluating or reflecting on whether I should have done something differently or something like that. (Jessica)

This emotional exhaustion also had an effect on their overall self-care. Some participants stated they lost weight during their transition while some gained weight.

Kathryn described:

I think I lost some weight like right away when I started...I wouldn't get many breaks to eat, and then I would be sleeping a lot. I felt that when I was working, I pretty much just worked and slept.

Most participants lost sleep due to constant worrying, which made them more emotionally exhausted. Kristen stated "before my day shifts, I don't sleep, because I am constantly thinking about what I am going to walk into...so all this shift work messes up my sleeping pattern for the next few days [so I am emotionally exhausted]."

Participants were also exhausted trying to balance their personal life with their professional life, especially with the demands of their orientation. Participants always felt like they were at work and now had to juggle relationships and social commitments with their full-time work schedule.

There is a lot of happy moments, but there is also... those relationships... you are just thinking about what is going on, when maybe you should be thinking about what is going on at home in your own life, but you are thinking about people that are basically strangers instead. Yeah that was emotionally draining for sure.
(Kristen)

...My family is from Muskoka, and my fiancé lives in Sarnia, so on my days off, I would have to be travelling, and doing other things, so I didn't really have time, or it was hard to be motivated to do the work [that was expected during orientation] outside of work. (Kathryn)

Finally, participants described how much they thought about work when they were away from it. Colleen reflected that, "You dream about it...you hear alarm bells when you are at home." Some participants noted that they thought about their patients

outside of work, and would worry about how they were doing, something that they had never previously done as a student; ultimately making them feel more exhausted.

I live and breathe nursing, more so than when I was a student. People think that, oh you are so lucky; you work four days, and then have five off. No I am always thinking about work. Always. (Kristen)

Overwhelmed

In addition to feeling exhausted and struggling to balance work and life, new graduates felt overwhelmed trying to learn a new routine, time management, and new clinical skills. In this current study, overwhelmed refers to being overcome by tasks, emotions and knowledge required to work in critical care.

So four weeks of in-class was completely... overwhelming, because they are introducing ventilators, and they are going through it, and I am like numbers and words are just mumbo, jumbo in my head. I didn't even get it, and I think it was one of those things you had to see and you had to deal with in order to actually understand. (Leanne)

Jessica commented on how overwhelming it was to manage the routine:

I think the most challenging, I think was getting the routine down... the systems aspect of it down, and then also just the medical side of things, like values and different disease processes, especially I think in critical care, where you see a little bit of everything and you are not really getting good at one anything.

The participants felt overwhelmed by all of the new knowledge that was given to them during their respective orientations. They discussed how all the different patient presentations as well as the tasks they had to complete were overwhelming. Some new graduates discussed being overwhelmed with 'handling' the patients, and navigating the many complex devices the patients were dependent on and organizing everything that had to be done for their patients.

I felt like I didn't know anything, but then once you got going you knew things, and it is so much information all at once. You are like, how am I ever going to remember everything, and how else did I feel? Incompetent, like, you really do...those first couple of shifts... everything is everywhere, and I remember sometimes I just felt overwhelmed with the amount of work that you had to do...Sometimes you have four babies all due to be fed and changed, and give the meds all at the same time. It's like how am I going to organize my time? So definitely overwhelming sometimes, but also rewarding, because it is what I wanted to do my entire life. (Elizabeth)

Excitement

In addition to being fearful, exhausted and overwhelmed, the participants also experienced a number of positive emotions. Firstly, participants in this study were very excited about beginning in their new profession, their new job, and were excited about the experiences that lay ahead for them. In this study, I defined excitement as being happy and joyful about the transition experience.

Participants in this study described being excited about having finally completed school and getting a pay cheque. Michelle said it felt "amazing" to have a "title" and to be able to "write RN next to your name." Leanne stated: "It felt good... just to finally have a role as an RN. I was scared about the transition from student to RN, and I was relieved and excited to finally have a secure nursing position, and a steady income."

Participants were also excited to share their new designation with others. Participants commented that it was exciting to say to a patient's family that they were the RN taking care of their family member, rather than a student nurse. This period of excitement always highlighted the participant's sheer joy of joining the nursing profession.

Excitement remained a part of the emotional experience for the new graduates as they moved forward with their transition. As they moved through their transition, they were excited about becoming their own ‘person’ in the unit, becoming part of the team and feeling like they were *nurses*, capable of making their own clinical decisions.

I feel like it was just such a thrill to get my first pay cheque, and I feel a lot more independent, and I can decide what I want to do...in my practice, instead of always following someone else how they think I should practice. (Kathryn)

Five participants commented on how exciting it was to focus all of their energy on their job. This was a positive change from their undergraduate degree where they felt like they were being pulled in multiple directions. The participants now felt they were investing all this time on learning and studying outside of their work on one area and it was beneficial to their career. Elizabeth stated:

You just have your work...You can focus on your work, and it is nice that you can have your work and you home life and it is not like where you are working and you are in school and you have [your] home life [to balance].

Enthusiasm

Another key positive emotion described by the participants in this study was enthusiasm. Enthusiasm is defined as an excited interest in beginning one’s professional practice in critical care (Merriam-Webster, 2011). Participants described a great deal of enthusiasm to dive into a critical care unit as their first job. Colleen described it as, “... something that I really wanted to do. I didn’t really want to do the couple years in peds, then make my way there.” The participants wanted to take on the challenges that a critical care setting presented, and were not willing to settle with starting their practice in a more general area. They also described that they knew they had been given an

opportunity that some of their peers may have desired. This made the participants even more motivated to succeed in that unit. Sarah related it back to her personal abilities and stated:

...I find that is definitely a personal thing... you get those people who are, like I want this, get their hands in there...and want to be a part of the action... it is definitely appealing to work in an ICU if you are one of those people who is constantly on the go, and wanting to go there...

Elizabeth described:

...I have always wanted to work in the NICU, but going into it, pretty much the opinion of everybody else was like how are you going to do it. It is going to be so intense and scary and things like that, but I was ready for it, and I really wanted to do it, and it was my dream to work with babies.

Privilege and Pride

Not only were the participants in this study excited and enthusiastic about being RNs working in the critical care unit, but they also felt very proud to be there. Participants described feeling privileged and proud to have been hired into a critical care unit and felt that this put them in a 'special' class of nurses. Privileged refers as feeling special because of the opportunity one had been given. The participants recognized that they had been given an opportunity that majority of new graduate RNs had not. Elizabeth stated:

I just feel privileged...(pause)...yeah, because not too many people get the opportunity to work in the NICU...a lot of my friends would die to work here, and so I feel very privileged and lucky and blessed to be able to do that.

With this feeling of privilege also came feelings of pride. Rebecca discussed this feeling after being hired into an NICU:

I think just the sense of pride that I felt, like I went to my graduation and being able to say like that I was going to be able to be working in an neonatal intensive care unit, and that I was taking a peri-natal intensive care course, I felt really proud...

Sarah described her initial feelings about beginning her professional practice in a critical care unit:

I think you get, it is going to sound bad, but you get a sense of pride in the fact that you work in ICU, and that you were good enough to get hired in ICU...

Not only were the participants in this study proud of themselves, but they also felt that their managers had trust in them. They felt this way, because they described that they were 'good enough' to be hired in a highly acute unit, and that they were now being trusted to care for highly unstable patients. Participants also described receiving admiration from friends and family for landing such a coveted position and described that they felt obligated to demonstrate their best performance to be respectful of honour given and privilege of starting out as a critical care RN.

Valued

Not only did the participants in this study feel privileged, but they also felt very valued, especially at the end of their transition experience. Feeling valued referred to the new graduate feeling respected and esteemed by his/her colleagues. Interestingly, it was not until the participants were working independently on the unit that they described this feeling. New graduates felt valued when a) they could contribute something to the team b) when they felt that they were organized in rounds, and c) were able to complete all tasks required, and still have time to 'care' for their patients. Kathryn reflected:

[I feel valued] when I can do my own work... get it done on time, and when I can help problem solve in rounds, and give... that information that might change their decisions or say I agree with that because... and the parents...they are really appreciative of the care, and [when you] are doing... steps more than you have to, and then just they acknowledge that, and even if they don't, but like just feeling like you are doing the best job you can.

The majority of the participants described feeling valued when they were specifically called by their first name, notably by the physicians. Participants indicated that they equated the use of their first name by physicians with doing something well.

Elizabeth noted:

[I feel valued] when the doctors know your first name, and when the nurse practitioners know your first name, and when they actually come up to you, and ask questions that they need to know, and you can actually tell them, that is when I feel important, and that is when I felt, they actually know, that I am helping my baby...

Rebecca described:

... You felt like they knew you and they trusted you, because they were using your name, and like we work with so many nurses. I am sure it is easy for physicians to not know us by name, but when they do it makes a big difference.

Feeling valued in the unit came at different points for each participant. For some, it was right at the commencement of working independently, while others described feeling more accepted and valued months into their individual practice. Leanne commented on her struggles during her transition experience and she described not feeling valued until one and a half years into her time employed in the unit. She described that:

Just recently actually, I think they have always respected me, and they never talked down to me, or anything like that, but I feel like recently they are starting to value my opinions more and value what I say more, especially the doctors.

Becoming a Professional

As the participants in this study moved through their times of transition and experienced a great deal of emotions, they were also internally sorting out how to be a professional RN. A significant amount of this transition experience for the participants was focused on managing their new role, and learning what it entailed. Becoming a professional is defined as learning and taking on the role of an RN during their transition experience. The participants' viewpoints on what being an actual professional RN were shifted as they moved through their individual transition experiences. Each of the participants began with their own expectations of what they thought being an RN was like. As they progressed through their transitions they experienced a number of realizations about what it was actually like to be a professional. Finally, the participants then progressed to describe how they felt adopting the witnessed behaviours they saw on the unit, and described how it *felt* to be RNs. The sub-themes listed below include: expectations of being an RN, realizations and role taking.

Expectations of Being an RN

Expectations refer to the new graduate belief about what it was going to be like to be an RN in a critical care unit. Participants in this study centered their expectations on a belief that the New Graduate Initiative offered by the MOHLTC, was a great way to orientate to their units. They felt that a six-month orientation period in critical care would alleviate any worries that they would have as new RNs. They noted that they expected the learning curve to be steep, but reassured themselves that they had six months to become comfortable in the unit. Leanne explained, "I think that I had the idea that after six

months I would probably be more comfortable than I was at the beginning...” Rebecca noted:

Well I did the new grad initiative program, so I had six months buddied, which for me was great. I felt at peace because I knew that I had six months to feel comfortable and ask questions.

Participants also discussed how they expected the unit to be highly acute at all times, almost like a “tv show” (Rebecca). Ten of the participants all switched between having patient assignments in a step-down section of the unit and a more highly acute area, providing a varied patient context for the participants.

I always envisioned like this crazy place where everyone is running around all the time, and we are for the most part, but there are times where there is a lull, and there isn't that much going on, so it is kind of nice, because you can ... sit and chat... (Katie)

I think I expected [the unit] to always [be full of] sick kids [and] always be intubated kids, and it is not, so it was a bit different than I expected it to be. (Colleen)

In addition to having expectations about the unit, the participants also placed expectations on themselves. These expectations focused on trying to be ‘good’ enough and be accepted by their nursing peers and the larger interdisciplinary team.

I am the type of person who I really care what people think, and you know I thought some crazy things, and I guess when I was... brand new, I had concerns that...my thoughts or my assessments of my patients may not have been taken one hundred percent seriously, and I felt that I needed to gain respect and trust of the physicians mainly. (Leanne)

The participants recognized that they wanted to go into the unit and have their new work colleagues feel like they would be a ‘good nurse’ from the beginning.

I knew there would be a learning curve, and I knew that I wouldn't be fully functioning and I think allowing myself to feel that way was good, because then I

didn't put that pressure on myself, but I did want to set a good impression...I wanted people to think, you know, she will be a good...she will be a good nurse, and she will you know get it together that kind of thing, so yeah. (Rebecca)

Kathryn viewed her expectations from a different standpoint, fearing that a poor impression would result in a lost opportunity:

Maybe like the first three months, and also knowing that... I was on probation... I could be fired any time. Not that I really felt threatened that I would be fired, or let go.... but I felt that they were maybe expecting me to know it all.

Realizations

As the participants in this study began their individual transition experience, their expectations of being an RN began to fade, and they began to realize what the critical care RN role entailed. Realizations referred to those instances when the new graduate had an 'aha' moment, and/or when preconceptions were affirmed or dismissed based on their experiences. These realizations focused around the realities of being an RN, having to be the primary caregiver and for the first time be solely accountable for their patient's safety.

A predominant realization for the participants focused on the reality of being an RN in a highly acute unit. They realized that, at times they were actually a 'middle-man' within the healthcare team. Colleen stated:

Biggest realization. I think just sort of really getting a grasp of that we're... the middle man for a patient, physician, social work, like we are like this middle hub, which I really had never had to deal with before.

For the participants, it was the beginning of having to coordinate and organize patient care, a realization that they had not known prior to becoming an RN, as they were

greatly protected in a student role. Some participants were surprised to learn how much ‘nurses actually did.’ Rebecca explained:

...being the middle person, who has to sort of... talk to everyone at every level, and try to...get messages from this person to that person, and from the patient to the doctor, and everything like that, so it is enjoyable. I like it. It is a challenge, but I do really enjoy it...

It was this realization that led the participants to see that RNs could take on a different role in the health care team. This realization highlighted to the participants how important it was to really know the status of their patients and to communicate any changes to the appropriate health care provider. Katie described her realization of the importance of the RN role:

...I feel that in critical care, I didn’t realize how important the role was, and how vitally important it was...just the information they pass on, or looking at a lab value when the doctors are not looking at lab values, and reporting critical results. You have to be able to recognize those things...

For the first time participants felt they could advocate for their own patients and change their patients plans of care, because of *their* observations. Rebecca explained this and stated:

[A realization] is that it is the nurses that bring things to [physicians] attention, and ... we see the whole picture and we say, we can say to them, you know, these little things are happening. I think something is wrong.

Not only did participants realize the impact they could personally have on their patient’s care, but they also began to realize the impact of larger system issues such as staffing could have on their individual practices and care provision. Michelle reflected that:

Yeah, that was a little bit of a surprise that they were often always short [staff], and that sometimes there is nothing anyone can do and you just have to work...[and at] times you are kind of on your own. If no one can help you, then you have to just do the best you can on your own.

Participants now realized that sometimes they would have to miss breaks and to work after hours if there was an emergency, or if the floor was short-staffed. Most participants commented on losing breaks, and feeling pressured to better organize their time in order to be deserving of a break. When working on her own, Kathryn realized that due to the acuity and workload most people do not get all of their breaks, subsequently she too, felt the pressure to do better so that she could go on break.

I realized in Level two [nursery] a lot of people don't or can't take a break, or as long of a break. Sometimes you can take a long break at night, and then sometimes in the day you can't take three breaks, you take two or whatever. But I remember one preceptor saying, gosh you are working so slowly, like you can go faster, you have to, and I would say yeah, I guess I do.

As they moved through their transition experiences, participants described how tiring it was to miss breaks and to have a heavy assignment due to short staffing, often contributing to their emotional exhaustion. Three participants described realizing the impact that short-staffing had on patient safety. This impact stood out for them, as they were the ones now directly responsible, and had more pressure placed on them as a result. One particular moment stood out for Laura who stated:

I had always heard about how there is a nursing shortage, but to actually see the impact that it has on patients' care was surprising. There is, one time I remember a little girl that was on cardiac resynchronization therapy [CRT] and there are only certain nurses that are trained on that and one nurse had to stay for twenty-four hours or else they would have had to take this patient off of CRT when she needed it. So that was a big realization that for one thing it is not safe for nurses to do that, stay for twenty-four hours, and that is kind of scary that we don't have the resources available to provide a treatment that a child needed.

In addition to having a number of realizations about patient care and safety, the participants had a number of realizations that impacted them personally. Participants discussed how working in a critical care unit began to alter both their personal values and beliefs and how they wanted to live their lives. Katie stated:

...I think it was a big wake up as to how much we do to people, and obviously depending on how sick they are to keep them alive I guess. It definitely made me realize how I do not want to live, possibly the end of my life.

Participants also realized that they had to make a concerted effort to remain true to themselves because for the first time they were in an environment where they were exposed to ongoing negative comments about the nursing profession and, at times, comments related to the integration of new graduates into critical care units.

I just think I had to be careful...to reflect on what I feel about nursing, and what my values and beliefs are about the profession, and not get caught up in what everybody else thinks, because I think it is really easy to do that, and everyone is never going to be happy with everything where they work. (Kathryn)

Although not described by all, five participants talked about the realization that fellow RNs were not always accepting of new graduates in critical care. Leanne recalled:

Sometimes I felt like some of the more experienced nurses kind of 'were like what are you doing here?' This is...and they will even say, they have said it to my face that you know, they felt that this wasn't the best unit for new grads to start in. So I mean it was put out there [by the nurses], and these people are my friends, but that is just what they thought.

Colleen described an interaction she had with a staff nurse and how it made her feel as a new graduate, "...like you don't deserve to be in that place, and maybe that is part of it. Maybe you are not ready to be in that work place. You just feel belittled, and ...not good [enough]." It was these opinions that served as 'road-blocks' that needed to

be overcome by the participants. Colleen went on to say that this encounter with the staff nurse “motivated” her to prove her wrong.

Another key realization experienced by the new graduates in their transition experience was the need to understand and accept the responsibilities of being an RN. The participants discussed how different being a real RN was from being a student, and that when they were preceptored in their unit; they felt ‘sheltered.’ It was not until each of the participants were working on his/her own that they finally assumed total responsibility for their patients nursing care.

I do feel sometimes like wow this is a big responsibility, because I know everything that I do I am accountable for, so I didn’t feel so much like a student. I felt like I was working under someone else, if I messed up, I could be really sorry, but it was kind of on him or her in a way, but now I feel more of a responsibility. Yeah, I really like the independence, and the respect, from other people that I am working with and from the families. (Kathryn)

Jessica also stated:

It was a huge power shift, and a huge responsibility, and so that was, it was awesome in one sense, but then in another, very challenging I think to see yourself in that role, and then to realize the responsibilities that came with it...because as a student you always had that person to answer the question for you, you know and you could rely on to cover your back in case of anything...

Not only did the new graduates identify a new sense of responsibility for their patients, but they also felt a new responsibility towards their own learning and to develop their own capabilities.

There is a lot more accountability on you. You don’t always have somebody to go to right beside you to ask for help. There is more of an onus on yourself to identify your learning needs and reflect on your practice on your own and not having somebody else guide that for you. ... I feel like you get a lot more, not so much power, but more say in things that you do and you see. (Laura)

Role-Taking

Throughout these realizations, the participants in this study began to understand the role and the behaviours associated with the RN role. It was during this time that the participants began to describe how it *felt* to take on the role of the RN. As noted earlier, role taking is a process of looking at or anticipating another's behaviour by viewing it in the context of a role attributed to that other (Turner, 1956). Interestingly, although the participants were licensed RNs at the beginning of their time working in the unit, it was not until the end of their transition experience that they began to describe themselves as RNs, rather than 'new grads'. They were feeling validated and more comfortable in their new role as a critical care RN.

When describing the transition experience the participants eloquently moved from describing the realizations that they had about their practice, to then describing how they felt as independent RNs working in their unit. Feeling that they had taken on the role of the RN elicited a great deal of pride for the participants. Michelle simply stated, "...I feel very proud, so much responsibility. Like I am not a doctor, but I feel like I am up there." Kathryn further described the behaviours she exhibited that made her feel like she had taken on the role:

...When your time management is better you have time to do other things, like look things up, or talk to families, and then you feel more like a complete nurse, as opposed to maybe just going in and just start doing the tasks at the beginning. You have the time to do the tasks and talk with families, or look up something or things like that. Help other nurses. You feel more like a team, like a nurse I guess.

After the participants had felt that they had taken on the role of the RN, they identified themselves as part of the profession and readily called themselves RNs. This meant they had passed their licensing exam, and now had an “actual career” (Michelle).

During the role-taking period participants began to notice the differences that they were making in their patient’s care. They commented on how rewarding it felt, and that they felt ‘important.’ Katie stated “[I’m] happy in a sense that I can help contribute to trying to make this one person or multiple depending, to make their life better.” Kristen further explained her feelings with working in an NICU and stated:

...Sometimes I feel...when the parents aren’t there that we get to be these substitute parents for those babies, and that kind of gives me this other feeling that you wouldn’t maybe get in other areas. It is also really gratifying when you see them break through, and all of a sudden they are kind of on the mend.

Seeing these outcomes contributed to the participants feeling like they were RNs.

Elizabeth stated:

I think what also helped my transition is when you finally get it... you call a doctor, and then they actually give you the orders... you actually do actions, because of what you have discovered kind of thing... you are like I did that for that baby, and I am making that baby’s life better... That helped my transition, because I am actually getting it.

The Unit Environment

The unit environment played a key role in the new graduates’ transition. The unit environment refers to the critical care unit that the participants were hired into. The unit environment was such an important factor to the transition experience because it contained elements that were very supportive for the participants, but also provided elements that made the transition experience even more challenging. The sub-themes

present here include: learning in the unit, barriers to transition and facilitators to transition.

Learning in the Unit

Learning in the unit refers to *what* new knowledge was provided by the unit as well as *how* the new graduates described they learned in the unit environment.

Participants discussed how challenging it was to learn in their new environment. The ever-changing nature of the critical care unit impacted the participants' ability to feel like they were developing the knowledge to become competent. Kathryn described how uncomfortable it was not knowing the names of "basic equipment" in critical care. She described an intense situation where she was asked to draw up medication and she had to reply, "I don't even know what that is, I have never heard of it before." Sarah even described this period as "a blow to her ego" as her unit intimidated her.

As they transitioned, participants highlighted that at times they would feel like they were developing knowledge, but then would get a highly acute patient, and feel like they were back at square one. This seesaw nature of feeling confident, or less confident in their knowledge continually depended on the complexity of the patient that they were assigned to. Kathryn stated it this way:

...There was points like you feel like you know even less. At one point...[at the] very beginning...maybe I know some things, and then half way through all of a sudden... I feel like I know nothing... this kid is here, and they are really sick, and I feel...I should know what is going on, and I have no idea what is going on...

The amount of knowledge required weighed heavily on the minds of the participants.

You need to know your basics really well, and then you need to know also your critical [care knowledge] really well, and I think it is always the thought there of not living up to what you are supposed to or not being able to provide the proper care...(Katie)

Yes, I feel like I had to know a lot more, and you are going to laugh at this, but the tags we have, like one side is blank, and one has Registered Nurse on it, and mine kept slipping back and forth, and I was almost happy when they couldn't tell I was an RN, because I felt like I didn't know enough. (Michelle)

When the participants were lacking the basic critical care skills, they felt less prepared to accept the situation as a learning environment where questions could be asked. This was escalated by: the patient presentations, the changing acuity of the patients and the critical thinking required.

...When I started, like I said, putting all those pieces together wasn't even like a thought, because there were so [many] more things. So much more going on that I just, I was so focused on you know why is this patient de-sating? (Leanne)

The new graduate RNs in this study described how much there was to learn, perhaps more than expected. Sarah stated "There is so much to learn, there is something to learn everyday, you know and you get to experience ten times more than I ever thought, with the vents and everything..." Participants felt pressure to know 'everything' and 'have it all together' and this was difficult for them.

The unit environment also influenced *how* the new graduates learned- it was a style of learning that was different from what they were used to. The fast-paced nature of learning 'on the fly' was a different approach to what they had experienced during their formal education. Participants no longer felt they could rely upon formal methods of learning such as searching on-line databases, or learning about a case over one to two

weeks. They were now engaged in more in-formal learning from their peers, often in the middle of a critical situation.

I feel like it is a big difference from being in school and learning to being in the unit and learning is that it is very fast paced, so I do a lot of my learning by like asking the nurses, and talking to doctors with my questions as opposed to looking things up, like in a journal article or things like that. (Kathryn)

Additionally, Elizabeth described the shift from critically thinking in isolation and in an unhurried fashion to critically thinking on the spot and in front of the patient.

[Knowing] was actually having to do it, and seeing all the pieces of the whole picture for your baby, and what is going on with your baby.... and actually having the real resources like real resources, not like when you are in [problem-based learning] and you have to pretend.

Facilitators to Transition

As the new graduates navigated through their new unit environments, there were several facilitators to their transition experience that emerged. Facilitators refer to people or programs within the unit that assisted the new graduate transition experience.

Facilitators included past clinical experiences for the new graduates and the formal orientation programs available to them.

Past Experiences.

One important facilitator described by some participants (n=7) was previous exposure to, or experience in, critical care. Past experiences refer to having a previous clinical placement as a nursing student, or a summer job as a clinical extern or as a health care aide. New graduates stated that past exposure to critical care was helpful in

promoting their transition by helping them to understand “patient flow” and gave them “a little bit of an edge” (Sarah). This prior experience allowed participants to feel more prepared coming into orientation than the other new graduates due to their previous experiences. Sarah, who had her last student placement on her current unit said, “Oh for sure, I do attribute that back to my two months of being a student. I don’t think I would have been prepared...” Laura drew on her previous summer job experience stating:

[Transitioning] would have been so much different if I wouldn’t have had that experience as a clinical extern, because I was pretty shocked at that point of time, and I felt like it was definitely different than what you see on TV, or what my perceptions were when I started working as a clinical extern, but since I knew what to expect in a way going into working here as a new grad, I didn’t really have any shock really.

Additionally, the knowledge they obtained from previous placements seemed to assist with their learning:

Yeah, it was helpful having the knowledge from level two in St. Catherines [student placement]...I remember in the classroom orientation, I was like, oh I remember that, but then other things [I remembered] when I had actually gone on the floor. (Elizabeth)

In contrast, for the participants in the study who did not have any previous critical care experience, the data highlighted how their experience was affected by their lack of exposure to critical care. Leanne described:

Just, it was all just so new, and I had never seen an intubated patient [before]. I have never and that honestly when you first see that, I don’t know what it was. It was so foreign to me, so I don’t know. I got butterflies. Oh it was very strange.

Michelle also reflected on her lack of experience and stated:

[I was overwhelmed] mainly just by the new environment, and new skills. There was a ton to learn. Basically everything that I had learned I had never dealt with

before, so it was all new, and I still am coming across more and more new things, but I do them, and I have help, and I get them done.

Programs Available.

In addition to having previous critical care experience, another facilitator to the transition experience was the orientation programs made available by the organization and individual units for the new graduate to utilize. The six participants in this study who completed their six-month orientation through the formal New Graduate Initiative program were very appreciative of the program. They felt that this MOHLTC-funded program helped them to be successful as a critical care RN.

If it hadn't been for the new grad [initiative], then I wouldn't have been able to have that confidence to go into a critical care, and I don't really think it would have been fair without that good like six-month period of time, so I think that definitely helped facilitate it. (Colleen)

I think that the new grad initiative was a huge... factor for me transitioning slowly and at the pace that I needed to and I really hope that they let new grads come in with that program again in the future. (Sarah)

One unit included in this study did not offer the New Graduate Initiative.

Participants from this unit described how they wished they had had the security of a six-month orientation rather than just a prolonged staggered orientation. Kristin described:

If I could plan my orientation, I would have made it more similar to the new grad [initiative]. Four sets [four repetitions of four twelve hour shifts] seems like a fair chunk to start off...but it is funny how like you won't see some things you need to do. We have an orientation binder, it is huge. We have to get things signed off, and do different readings and different tests. They expect you to hand it in three months after you start. None of us have handed ours in yet, because there are things that we haven't seen. My first four sets, I did as much as I can and got as much signed off. My first day alone, my kid needed a blood transfusion, I had never hung blood, so it is things like that, where you wish you had more of a six month orientation, you would see those things with your preceptor there, so when

it did come around, when you are on your own, you could do it smoothly. So yeah, I do wish it were longer. I wish it were similar to the new grad [initiative] for sure.

The participants were not only appreciative of the opportunity to orientate to their unit for six months thanks to the MOHLTC new graduate initiative, they were also appreciative of the actual individual orientation content designed by their units. Therefore, both the length of the orientation, and the content of the orientation was a significant facilitator to the transition experience. Participants highlighted that the orientation programs promoted the development of unit specific knowledge while allowing time for both in-class learning and preceptorship. However, nine participants suggested that in-class learning should be tailored to better fit their needs. Some suggested spacing the in-class learning throughout their six-month orientation to allow them to take in more of the information.

[I would have liked] maybe do some classroom, and then...do some [practice] in the unit, and then be able to go back to the classroom, because you are learning stuff in the classroom, you can kind of practice it before you, not that you would forget it, but ... so you can...get used to it, and then you can go back, and learn some new things, or ask more specific questions. (Katie)

...The in-class orientation could have been done a bit better. I felt... it was kind of rushed and I think a lot of nurses didn't have any experience in level two or if your experience needed a little more information...I found that they did come on the floor, and they really didn't know what they were doing sometimes... (Elizabeth)

Yes, definitely, but it would be helpful to have something like that again [the New Graduate Initiative]. I feel like maybe six months after you have been on your own. You can go back and refresh and ask more questions, and actually understand it, and apply it to the thinking pattern that you have been in. So it would be a lot more beneficial for learning. (Jessica)

Extra external courses provided or funded by the organization were also a contributing factor to knowledge development throughout the participants' transition. The units who offered these courses to the participants made it mandatory for them to complete them as part of their orientation program.

It was so great, to have done my George Brown [College] course, I just had more pieces of the puzzle, so I had a bigger knowledge base of neonates and how everything is related, so I think having that...was really helpful in developing my skills (Rebecca).

Barriers to Transition

In addition to the units providing a number of facilitators for the participants, there were also a number of unexpected barriers that that participants experienced in their unit environments. A barrier to transition refers to a difficulty present within the unit environment that made the transition experience more difficult. The barriers described in this study included patient assignments and a loss of orientation.

Assignments.

Assignments refer to the patients assigned to new graduates to care for during their clinical shifts. As staffing is a significant component in any unit environment, it is not surprising that short staffing negatively impacted the participants' transition experience specifically, their nursing assignment. Overall, short staffing detracted from their overall learning experience. Colleen noted:

Everyone was kind of fighting for assignments, and because we were orientating a lot, they kept, I don't want to say shafted, because it is not a good word to use but kind of got pushed to the back and you know were used as extra staff to take care of, you know where heavier assignments require like just chronic patients, and

doubled assignments, and we just kind of got stuck in that situation, where we were taking care of patients that weren't necessarily helping me learn.

Participants felt like they were not being given the opportunities to learn all the skills they needed in critical care due to a variety of reasons. "I think if anything it would have been that the educator was not really on the ball with getting the assignments that I needed in order to continue with my training. That probably would have been the biggest barrier..." (Rebecca). Sarah stated that she did not feel she got "a good mix of patient care" during her orientation. She also felt that when the unit was short-staffed when she was working independently, she was put with highly acute patients, which made her fearful because she felt that "[she] didn't get a lot of sick kids during her orientation." Being given an acute patient after their orientation period had ended made some participants uncomfortable due to their lack of assignment variability during their orientation period. When working autonomously, the complexity of their patients increased and it triggered fear and anxiety in the participants.

Colleen stated that she felt she "lucked out" with the preceptor she was assigned because she tended to get assigned "sicker patients." It was this constant 'fighting' for assignments that was a surprising challenge within the environment for the new graduates, as they described really wanting and needing the exposure to the highly acute patients.

Loss of Orientation.

Not only did short staffing impact the participants' patient assignments, but it also impacted the overall length of their orientation. Loss of orientation refers to the

premature termination of an orientation period by the unit leadership. In this study, short staffing within the unit caused the early termination of the formal orientation period.

Participants described pressure at times to finish orientation early due to staffing constraints, sometimes leaving them with an internal conflict of not feeling ready, but also too scared to say 'no' to those in leadership.

I felt like I would be letting people down if I said, that is how I originally felt. I will let them down if I say I am not ready to go yet, and but nothing, you know, so nothing bad happened, so it was okay...I just really felt pressured at first.
(Kathryn)

Michelle described her frustrations when she was encouraged to end her orientation early:

By the end of it all, they almost provided the full six months, by doing the transition, but I would have preferred if they didn't try to push me into my own in between, because I was probably like at least three times, where all of a sudden I showed up and I was on my own and no one really told me. At the time I would have liked some warning.

In addition, the on-off approach of being an orientee or a regular RN at the beginning of each shift caused Michelle to be wary of what her status was as each new shift began:

So I think it was two months in, just because someone was sick, usually they would call someone, because I am an extra person, because I am on orientation, but I would just show up, and they would say, okay, you have a full patient rotation today by yourself, out of nowhere...

The Unit Team

The team in the critical care unit provided a great deal of support for each of the participants in this study. Although the team was inherent within the unit environment, it has been extracted as a separate theme to further explore the experience with other members of the team, and to highlight the impact that the team had on the participants'

transition experiences. Participants in this study described feeling unsteady at times in their new environment and because of that, relied on members of the team in the unit for support during their transition. The members of the team that participants received support from changed as they progressed through their times of transition but each was significant in their overall impact on that participant's transition experience. The unit team in this study refers to people within the clinical environment that provided support throughout the participant's transition experience. The team members assisted the participants to feel connected to their new unit and to feel valued in their role. The main supports were separated into two main sub-themes: nursing support and team support.

Nursing Support

Nursing support was a vital part of the transition experience for the participants in this study. Participants described receiving support from a majority of nurses working within their respective unit environments. The support predominately came from RNs, but two participants also specifically commented on the assistance from Registered Practical Nurses (RPNs). The sub-themes of nursing team support include: preceptors, nursing peers, nursing leadership and charge nurses.

Preceptors.

The most important nursing support throughout the entire transition experience was described as the preceptor. Preceptors are experienced nurses on a clinical unit who are assigned to work one-on-one with new graduates. The preceptors share their workload with the new graduate while simultaneously orienting them to the practice

environment (Forneris & Peden-McAlpine, 2009). Participants in this study described that their preceptors welcomed them into the unit environment, taught them critical care skills, introduced them to unit routines, provided support, and helped them to move through their orientation periods. Participants used terms like ‘backbone’ and ‘go-to person’ to describe their preceptors. Laura stated:

I had a great preceptor...she was super supportive...having that made me not scared. I think it would be different if I didn't have a supportive preceptor to guide me along the way. I never felt scared to ask a question, or express any concerns with her, but it definitely, I am sure it would be different if it wasn't that way.

Elizabeth commented:

My preceptor was very accommodating, and she was a very, very good teacher, so she would go through things. If I didn't understand something I would ask her, and I felt so comfortable asking her, and she would be able to explain things, and also guide me during the day, like if I was stuck and she could tell when I was a little frustrated or not frustrated, but like flustered, like I was like, oh there is so much to do, I don't know where to go. Okay, this is what I would do, and she would explain it, and then I was okay, this is what I can do, you know?

Additional positive preceptor characteristics included a preceptor that had a similar way of approaching patient care. Lisa noted that:

We both thought in the same way, and we learned in the same way, so that was like a huge bonus. She also was one who wouldn't want to just sit back and not understand the situation, so it was helpful to have you know someone who also cared about finding the best evidence, and critically thinking and that kind of stuff.

Participants stated that preceptors who were similar in age were beneficial because they could recall their own transition to critical care. Colleen highlighted “It was so helpful, it is just her being younger and being able to sort of still go back to that

feeling of being new and having just been out of school that made a big impact for me.”

Elizabeth, whose preceptor had graduated eight years prior stated:

She would often say, ‘I know how you feel, I know what it was like, I did the same thing, like don’t worry about it’...always saying things like that. That was really nice. ...I felt... she remembered exactly what it was like, she knew and then did as much as she could to help me transition.

Although the majority of participants described very supportive preceptor, there were two participants who described struggles with their preceptor. Jessica and Kathryn described their frustrations, mostly stemming from differences in personalities. Jessica stated the following:

She had never had a student before...she was misguided to what it entailed...her personality was like an intense kind of personality... that probably played a factor, because my personality is not that intense. So I am sure it was a personality issue. Yea and certain things like that. Repetitive questions, and needing help with things at the beginning until you are comfortable with them. I don’t know... she wasn’t an ideal preceptor.

Kathryn recalled the first day she met her preceptor:

When I first met her, I remember it was ...seven in the morning, and I said... Hi ...thank you so much for agreeing to precept me, and then she just said, well I didn’t really have a choice...So...right away, I was like oh no, here we go.

Nursing Peers.

Not only did the participants in this study receive a great deal of support from their preceptors, but they also received a significant amount of support from the other nurses working in their units. Participants identified throughout the study the need to feel accepted by their nursing peers. With this acceptance, came the confidence to ask questions, the ability to seek clarification, and to establish friendships. Katie described

how she appreciated being put on different clinical rotation, or schedule of shifts to help her transition to her unit by getting to know a variety of the nurses on the floor:

I think I worked with every...set up, because we also have 3-2's (3 days on, 2 days off) there, so I got to work with everyone and then they also get a feel for me, so it was kind of nice, because I know everyone in the unit by...name.... so I think that kind of contributed because that creates a little bit of... friendship I guess too, because you know each other a little better.

Elizabeth described her experience of becoming more confident and comfortable using other RNs on her unit to help her transition:

I think at the beginning of my transition, I was a little bit nervous. I would only go to my mentor, but as the sets went on, like my second, third, fourth, that I started to get to know people and I knew who would be the ones that would be willing to help me... (Elizabeth)

Additionally participants in this study attributed building a social network with other RNs as a contributing factor in feeling supported. Kathryn stressed the importance of such a network outside of work and stated "I think...talking to the other staff, and...getting together outside for work, and just talking about you know funny things that have happened on the unit".

Three participants in the study specifically described being appreciative of having other new graduate RNs starting in their units with them. They commented on how beneficial it was to be able to pose questions to other new graduates who were in the same situation as them because they did not feel stupid about asking them questions. The participants also used these new peer connections to get to know other members of the nursing team. Elizabeth commented:

...That has really helped, because I was hired with... five other people, and they are all pretty young... like my age, so yeah, I started out with new friends and we

are staying friends...if you didn't have friends at work, it would be hard to get up and go, because you don't have anything in common if you don't have friends. It was this welcome and support that assisted the new graduates to feel a part of the unit.

Overall, participants described the nursing staff as helpful, encouraging and supportive as they moved through their orientation. Colleen said "I think just, yea working with such... great staff for me, really makes the experience...it just totally makes your experience what it is, so for me it was a lot about the people that I worked with." Leanne also commented: "I was with an amazing group of people. I learned a lot regardless, and if I went back into step down if we were having a slow night. My team was more than willing to take me on in another area to help me learn."

Nursing Leadership.

In addition to discussing their preceptors and other nurses as supports, participants also discussed the supportive role of nursing leaders on their units. Nursing leaders in this study were identified as managers, clinical educators and clinical leaders present within the critical care unit.

Managers were informal supports that many times were not present on the floor, but their 'check-ins' provided professional reassurance and a sense of being valued in their new workplace. Laura noted that "...my manager was pretty good at just letting you know that after six months we don't expect you to be an expert, we expect you to be starting, [we are] just sort of giving you an overall background on things..." Katie noted that quick meetings with the unit manager provided her with the opportunity to identify any concerns and to provide an update on her transition progress:

You know...if she felt like I needed a bit more work on something, it wasn't a negative thing. It is just I need a little bit more training, or a little bit more, you know one on one or even just hands on...you just need a little bit more work on it, which is fine.

The clinical educators on the units were helpful to the majority of the participants (n=8) in the study. Participants stated that they were the 'go-to' person to ask about specific learning needs on the unit. These educators would often be the ones leading the formal in-class orientations, and assisting the participants with the development of their learning plan. Participants described:

I would say the educator if there was something specific I needed, she would definitely help me. So if I said I wanted more information on art lines or I wasn't sure about something, she would probably provide information or come and explain it. She is pretty good like that. If someone is not sure how to use a machine or something she will come down and like running us through everything, and letting us know how to use it. So she is good. (Michelle)

We have an amazing nurse educator on the floor. It is actually a different one now, than it was when I was hired, but they are both fantastic. That was great, because they both made it, it has always been made very clear that they are there for us, and that if we have any questions, to go to them, and they organized everything in terms of orientation, and how things are going, and they are checking up on you, so I would for sure say they were number one, because if I every had a question or you know, couldn't find something, they would always be there to answer the question. (Kristen)

Interestingly, three participants indicated that they were surprised by the 'hands-off' nature of the clinical educator role at times, and how often they were occupied in meetings off the unit. This meant that the clinical educator was difficult to access when issues arose. Jessica stated:

The educator, she was like kind of around, but I guess I felt as though she wasn't helpful... she was there through the day, they were so busy anyways, so there are not ...many opportunities to go over skills... and they are always dressed in nice

clothes. You know what I mean. I just didn't feel appropriate. I don't know, so I didn't find the educator... I don't know if it is just the role, or the person itself. I am not really sure, but I just don't find them as useful as they could. I think they have a really, really great opportunity, and I don't think they maximize it.

Charge Nurses.

Another key nursing support for the participants was the unit charge nurse. The charge nurses provided most of their support to the participants when they had finished their orientation and were working independently. Charge nurses are defined as RNs on the floor who are the leader of the department for a 12-hour shift and whose responsibilities include controlling patient flow and RN assignments. They often do not carry a patient assignment; instead act as a resource to the other RNs on the floor.

Participants indicated that these individuals often became informal mentors to the participants, helping them with any problems that arose in the unit. Colleen stated that:

The charges nurses were super, super nice...they were very supportive, and they helped to make sure that I would get good assignments too so that I would do a lot of learning, and get to see a lot of neat things, so that was really, really nice too.

Leanne highlighted the importance of the charge nurses after she finished her orientation.

She described that:

My preceptor always told me, when you are on your own, they [charge nurses] will be around all the time for you. They will be here for you...as soon as she was gone; those charge nurses were all over it. You know, knowing we were new, and they still are. You know, they walk around. You need help with anything. I think they are a phenomenal resource, and I feel very comfortable with them and they know their stuff.

Team Support

As the participants moved away from their preceptors and became independent practitioners, the need for support from the larger health care team increased. Team

support refers to receiving guidance and knowledge from other health-care team members such as physicians, respiratory therapists and social workers in the critical care unit. All participants indicated that when they felt accepted by the physicians they felt more supported and a part of the health care team. Other members of the health care team (e.g. Occupational Therapists, Respiratory Therapists, Social workers etc.) were rarely, if at all mentioned by the participants interviewed. This highlights the importance that the participants placed on feeling ‘accepted’ by the physicians in their unit environment.

Sarah stated:

I felt like I was part of the interdisciplinary team when I was on my own, because it was my name on the board next to the patient. When they [physicians] had a question about the patient, they had no choice but to come and talk to me...I feel like I am getting a lot more respect from the health care team now that I am on my own.

Participants also indicated that they felt more support from their team later in their transition experience. Kathryn stated, “...I definitely started out with nurses, but as my confidence grew, I was able to talk to doctors, and nurse practitioners to ask them questions.”

New graduates in this study placed great importance on feeling accepted by the physicians as the main factor of feeling a part of the larger health care team in the unit.

Laura highlighted how she felt included in the larger interdisciplinary team:

...Probably after I started working on my own. At the beginning of working on my own, it was just like I would have to use other people as my middle person, and I never thought I could talk to intensivists, so I didn’t feel like a part of the interdisciplinary team much. So probably after a couple of months after I started on my own, that I really started to feel like I can actually make a contribution to this team.

Participants described how being called an RN and having questions posed to them in front of other staff and family members by professional colleagues made them feel a part of the team as well as feel ‘welcomed’ and ‘accepted’ during their transition.

Rebecca described it as:

...It was great knowing that I had people who had my back, and who were going to encourage me in that like I was a nurse and that I had worked hard to become a nurse, and that was like my role, that was my title, and I deserved to be called that, so it was good to have support from my team...my colleagues.

CHAPTER 5: DISCUSSION

The findings from this study make a significant new contribution to our understanding of the experiences of new graduate RNs transitioning to critical care. Although challenges were present due to the participants inexperience and barriers present in their respective units, all participants described a successful transition to critical care. Findings from this study have value at a clinical practice and policy level, and will help to direct further research on this topic. Although the study produced a number of findings, this discussion is focused around the key findings and contributions in relation to the literature. The key findings from this study will be discussed in relation to the times of transition, the emotional experience, becoming a professional and the barriers and facilitators present in the transition experience. Finally, the discussion will focus on the overall viability of new graduates entering critical care units based on the findings from this study.

Discussion of Major Findings

The Times of Transition

This study revealed how new graduates in critical care areas transition in not one, but two sequential times. What was common to these times was that each one began with the participants feeling scared and anxious. They worked to feel comfortable, and feeling comfortable meant accessing support from those around them. This unique transition experience is different than the transition experience described by Duchscher (2009) in

her Transition Shock and Stages of Transition models (Duchscher, 2008) and instead the findings draw similarities to the Hobfoll's (1989) Conservation of Resources Stress model.

The times of transition represented varied levels of fear and comfort depending on what period of time of transition the participants were in. In her transition shock model, Duchscher (2009) describes transition shock as the initial months of practice where one doubts their career choice, and experiences a great deal of role stress and strain.

Transition shock encompasses the change in roles, relationships, responsibilities and knowledge in the new graduate. Participants in the current study certainly experienced some of the emotions described by Duchscher (2009) during their transition, but not in the same pattern. Duchscher (2009) described transition shock as happening at one point of time in a new graduate's transition, however, the findings from this study describe two distinct periods of time where they experience fear due to a change in roles, responsibilities, knowledge and relationships, almost implying two periods of transition shock. In addition to not reflecting the times of transition in this study, the findings from this current study certainly do not represent the negative stress and strain implied by Duchscher in her transition shock model.

In her second model, Duchscher (2008) presents three distinct stages in the transition process: doing, being and knowing. This model demonstrates that new graduates need time to adjust to becoming a professional. However, the fluctuation of fear and anxiety described in the current study's findings are not seen in this model either. Duchscher also states in this model that new graduates undergo a great deal of

stress, and because of this stress, they disengage from their unit at times. In this current study, the participants described wanting to be a part of their unit, and wanting to feel comfortable and accepted by their peers. The participants were always engaged in their unit, and were searching for resources to help make them feel more comfortable.

A key element that needs to be taken into account is that the majority of units studied in Duchscher's theoretical models were from medical and surgical units, and were reported to have orientations of seven to twelve weeks on average (Duchscher, 2009). The fluctuation of comfort based upon resources found in this current study could be related directly to critical care, as all participants had at least 24-weeks of orientation. This extended protected time of orientation may have made the transition experience less stressful and disengaging in comparison to the participants sampled in Duchscher's (2008; 2009) studies.

The idea that transitioning to critical care has two separate times of transition is further supported by a similar finding on the transition experience to critical care by Reising (2002). In a grounded theory study, Reising (2002) described how critical care RNs experienced an increase in stress when detaching from their preceptor and moving to independent practice. This finding by Reising represents the second time of transition in the current study's findings. Once working independently, the participants in Reising's study had to reconcile that it would take time to feel comfortable being on their own, much like the participants described in this study. However, Reising focused on new critical care nurses, not exclusively new graduate RNs, and only two were included in the sample size (n=10).

As reported, the variable stress levels reported by participants in this current study with respect to having or not having supports around them are clearly related to Hobfoll's (1989) Conservation of Resources Stress Model, rather than the current theoretical models on new graduate RN transition. Hobfoll (1989) ascertains that stress is a reaction to the environment where there is the threat of a net loss of resources or a lack of resource gain. Hobfoll describes resources as objects or personal characteristics that are valued by a person; they can be represented as mastery, self-esteem or learned resourcefulness. When a loss of resources is threatened or imminent, the stress response increases (Hobfoll).

In the current study, participants described a heightened feeling of stress at the beginning of their transition experience, due to a loss of familiarity. Stress decreased when resources were provided to them. These included, preceptors, fellow nurses, and critical care education courses. However, at the end of their orientation period as resources began to fall away again, the stress levels in the new graduate increased. As participants worked independently they began to build up their resources by searching out other members of the team and by becoming more self-directed when seeking out answers to clinical questions. This helped broaden their resourcefulness and provided them with more self-esteem, ultimately decreasing their stress. Hobfoll's model has also been widely applied examining job stress and burnout (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Halbslben, Wakefield, & Cooper, 2008; Van Den Tooren, 2008).

In summary, although this was not a process-focused study, the participants identified two distinct time periods in their transition experience. These times, which

produced fear and anxiety in the new graduates when they were not feeling like they had a number of supports around them has not been previously discussed in new graduate literature. The distinction between the current theoretical models and the current findings appear to be related to the critical care environment, and are more truly reflected in Hobfoll's Conservation of Resources Model.

The Emotional Experience

One of the clear findings from this current study was how emotional the transition experience was for the participants. The participants described a variety of emotions during their transition experience from being fearful, to feeling overwhelmed, exhausted, excited, valued and privileged. The unique contribution that this study makes is that the experience was not described as purely negative, rather, mostly positive. Previous works by Duchscher (2009) and Morrow (2009) have described the transition experience as being negative, degrading and stressful. However, in this current study, participants described both positive and negative emotions including: excitement, value, enthusiasm, privilege, fear, anxiety and lack of confidence when describing their personal transition experience. As Morrow (2009) called for better experiences for new graduate RNs transitioning to practice to retain them in the profession, this study clearly highlighted that the transition experience to professional practice for a new graduate RN can be positive, and when it is positive, they intended to remain in that clinical unit.

Instead of feeling stressed and disillusioned regarding their unit and career choice, participants described feelings related to the threat versus challenge model (Lazarus, 1993). As Lazarus (1993) described, when a stressful event is seen as providing some

benefit of self-growth, it becomes more of a challenge, rather than a threat. This was present for the participants in the current study, as the participants were never deterred by their feelings of fear and anxiety, instead felt excited about the experience that was about to begin. They described their fear, as something they felt would dissipate as they learned in the environment and deemed it more as a challenge, rather than a threat to their personal success.

The mix of fear and excitement described in the current study is not represented in the emotional portion of Duchscher's transition shock model (2009). In Duchscher's (2009) paper on transition shock she described the transition period as exhausting, isolating, disorientating, confusing and chaotic. Although, emotional exhaustion was seen in the findings from this current study, the participants never described not wanting to be in their clinical unit, nor did they indicate that they felt isolated as suggested by Duchscher. Duchscher (2009) further suggested that new graduates experienced high levels of stress during the first one to four months of post-orientation. This again was contrasted by the findings from the current study, which indicated that, although the participants experienced fear and anxiety, they were still able to function physically and emotionally on the unit. This mix of fear and excitement was also echoed by Dyess and Sherman (2009) in their qualitative study on new graduates in a community based setting. In this study, Dyess and Sherman (2009) attributed the confidence to recognition of everything they had learned in their respective nursing programs, and were hopeful that there would be organizational systems in place to support their transition to practice.

One of the key findings from this study is how privileged the participants felt during their transition experience. They viewed themselves as ‘better’ than other new graduates who were working in less critical clinical areas. Although the participants did not extrapolate on all the reasons why they felt privileged to work in this area, the literature provides some insight into why they may have stated this. First, it has been noted in a report published by Chelsea and Westminster Hospital (2009) that RNs working in critical care feel privileged in their role because of the position of trust they are given. Second, RNs as a professional group have described feeling privileged because of the opportunities to share in the most significant moments in a person’s life (Anderson, 1998). In the current study, participants indicated that they related the feelings of privilege to being the person given the opportunity to care for the highly acute patient, not the psychosocial nature of caring for patients. The study’s findings suggest that the feeling of privilege in the clinical setting could be exclusive to critical care, and how new graduates view their status of being hired into these highly acute areas.

In summary, the transition experience was overwhelmingly positive for the participants in the study. Participants had some fear, anxiety and exhaustion related to their transition experience, however, they always appeared to view it as a challenge to overcome, rather a direct threat to their ability to be successful in the unit. They also felt very privileged in their new role.

Becoming a Professional

Another key finding from this current study was that the participants internally struggled with figuring out what the role of the RN was. The participants brought with

them a number of expectations about what they thought the transition experience would be like which was often cultivated and shaped by their nursing education. Once working on the unit, participants described having a number of realizations about their individual role and the profession. Finally, near the end of their transition experience participants began to describe how it felt to be an RN and described how they felt adopting professional RN behaviours. The current study's findings clearly emphasize that, consistent with the current literature, new graduates spend part of their transition experience understanding their new professional role.

Navigating their personal expectations, realizations and role taking was evident by all participants in this study. This experience is well documented in the literature and demonstrates the complexities of the transition experience for new graduate RNs. Price (2008) in her meta-study of new graduate socialization describes the socialization process to be a period of time that involves realizing and re-defining role expectations. She describes that socializing is a "process of moving from previously held assumptions and expectations of nursing towards the reality of nursing in the practice setting and [culminates] with an individually-constructed reality." (Price, 2008, p.14-15). She further highlights that the early socialization period has the largest influence on the new graduates professional ideologies, and negative initial experiences can cause distress for new graduates. Casey and colleagues (2004) also support Price's (2008) findings stating that new graduates spend time in the beginning of their transition distinguishing what nursing 'actually is'. Other authors comment more specifically on the realizations that new graduates often experience during their transition. Some of these realizations include

new graduate RNs realizing the responsibilities and organization skills demanded of their respective clinical units (Kelly & Ahern, 2009; Higgins et al., 2010; Zinsmeister & Schafer, 2009). Some of these new responsibilities can involve having to take on more of a managerial role for the first time (Duchscher, 2009; Higgins et al., 2010; Morrow, 2009). As noted in the literature, some of these alterations in expectations can lead to a ‘reality shock’ in new graduates, but new graduate RNs can have a successful socialization experience by surrounding themselves with positive role models (Kramer, 1974; Price, 2008).

In summary, during the beginning of their transition experience new graduates not only have to socialize into their new unit but they also need to adapt to their professional role changes. This requires a great deal of internal focus for the new graduate RN. It further demonstrates that new graduates when entering their transition experience are still largely unaware of what the professional role entails.

Barriers and Facilitators to the Transition Experience

The findings from this study suggest several facilitators and barriers to the transition experience. The most important facilitators include support from people and adequate time for orientation. When these supports are not available barriers are created; both barriers and facilitators will be discussed.

Facilitators to the Transition Experience.

For participants, a key facilitator in the critical care unit was the support provided by the preceptor. In the literature, preceptors have been shown to have a positive effect on the new graduate transition (Baxter, 2010; Casey et al., 2004; Gill et al., 2010; Kelly

& Ahern, 2009; Hartigan et al., 2010; Higgins et al., 2010; Zinsmeister & Schafer, 2009). Preceptors assist new graduates with to develop clinical and organizational skills, while role modeling professional values (Zinsmeister & Schafer, 2009). Additionally, the quality of the preceptor has a positive effect on the new graduate RN's transition to practice (Higgins et al., 2010), work-related attitudes and job satisfaction (Giallonardo et al., 2010). Preceptors were the most supportive to the participants in this study, as they assisted them with acquiring new clinical skills and socializing them into their respective units.

Participants in this study described feeling welcomed and supported by most of the RNs in their respective units. Effective socialization into the clinical unit can have a positive effect on an individual's professional commitment (Hayes et al., 2006). Participants in the current study did not indicate a desire to leave their units because they felt supported, well integrated and felt that they were working in a positive work environment.

The participants in this study also discussed feeling supported by the larger interdisciplinary team. Interestingly, although this clinical area is highly interprofessional in nature, the participants spent little to no time discussing the other members of the interprofessional team. They singled out physicians and remember how it felt when they were called by their first name. The participants did not expand on why they singled out physicians, and the literature comments that physicians' interactions are traditionally a source of discomfort and anxiety for new graduates (Casey et al., 200).

It could be hypothesized that as physicians were historically viewed as the head of the health care team, these findings could represent how new graduates view the importance of the physician's role. In a critical care unit, nurses are seen to be primarily information providers, where medical staff has a high frequency of decision-making due to the authority they have to make medical decisions (Bucknell & Thomas, 1997). The attention placed upon the physicians by the participants may reflect the importance of the physician role as the decision maker, and the new graduate understanding how important it is to be an information provider. In addition, all participants in this study worked in a closed critical care unit. A closed critical care staffing model allows for an intensivist to be present in the unit at all times, increasing the proximity and exposure to physicians in comparison to working on a medical or surgical unit. A closed ICU requires effective collaboration between physicians and nurses as well matching responsibility with authority for decision-making (Burchardi & Moerer, 2001).

The second key facilitator identified by the participants in this study was time, or more specifically an appropriate length of time to be orientated to enable them to take on their new role. This finding is consistent with recommendations in the literature for a positive transition to practice for new graduate RNs. Reviews of the literature advocate for a lengthened orientation for any new graduate entering critical care (Baxter, 2010; Park & Jones, 2010). Park and Jones (2010) found that orientation programs given to new graduates in critical care had a positive impact on their confidence in the unit, competence with new skills and retention. This was seen in the current study's findings as the participants were all retained in their respective units, and became confident in

their new role. In a study examining the retention rates and financial impact of a year-long critical care orientation it was found that there was a higher rate of RN retention at three, nine and twelve months and because of the retention there was an annual financial savings related to decreased nursing turnover in the organization (Friedman, Cooper, Click, & Fitzpatrick, 2011).

Barriers to the Transition Experience.

As the two main findings for facilitators were support and time, barriers in the transition experience arose when support and time were threatened. The barriers described in this study were the loss of orientation and not receiving appropriate assignments.

Participants described being forced by unit leadership to end their orientation early due to short staffing. They also described episodes of being pulled from their supernumerary position during their orientation to act as a 'regular' staff member. This was frustrating for the participants in this study as they were often too scared to challenge authority figures in their unit when asked to work independently even if they were not prepared. Participants did not discuss any adverse patient outcomes related to this practice, but literature highlights that this type of practice places novice nurses in potentially unsafe situations, and can be a threat to patient safety (Morrow, 2009). Furthermore, inadequate orientation, less mentoring opportunities and fatigue are some system issues that have been noted to increase adverse events for patients (Morrow, 2009).

Participants also described inappropriate patient assignments as a barrier to their orientation. They expressed concern over the heavy assignments stating that they did not promote sufficient learning. The same outcome was evident when the new graduate failed to have variation in their patient assignments. This led the participants in the current study to feel ill prepared and uncomfortable when working independently. This finding is similar to the findings described by Boyle and colleagues (1996) who asserted that assignment congruence between orientation and independent practice resulted in lower anxiety and higher job satisfaction in new RNs entering critical care units. The findings from this current study provide further justification that a variety of patient assignments could assist with the transition from orientation to independent practice.

In summary, it is clear that barriers to the transition experience for new graduate RNs arise when support and time are threatened. The new graduates transition experience is not only affected negatively, but can also pose a serious risk to patient safety.

New Graduates in Critical Care

When examining the findings from this study from a broad perspective, this study makes an important new contribution to the understanding of the nursing staff mix in critical care units. The overall message noted from this experience, is that transitioning to critical care can be a positive experience for the new graduate RN. Traditionally, new graduates have not been hired directly into critical care, rather were hired into medical and surgical areas where they had the time to develop organizational and time-management skills (Ihlenfeld, 2005). It was the belief that new graduate RNs did not have

the capabilities to master the complex technical and decision-making skills required in critical care (Ihlenfeld). However, based on the findings from this study, the integration of new graduate RNs into the critical care is acceptable and can assist with maintaining safe staffing levels.

The findings from this study clearly illustrate that by providing proper orientation and support to new graduate RNs, they are able to be successful in this highly acute area. Based upon the experiences described by the participants in this study, participants were able to learn the skills necessary to be successful in critical care. They attributed their extended orientation program to their success and to ultimately feeling comfortable in the critical care environment. Furthermore, all participants in this study were still employed full-time at the time of their interview, and expressed the desire to continue to remain in that environment. The findings from this study refute the statement discussed by Duchscher (2009) where she advocates that new graduates should not be hired in highly-acute areas, rather be allowed to work in areas with highly stable patient populations for at least twelve months. She states that hiring new graduates into critical care areas must be undertaken with caution, as new graduates have limited cognitive processing ability in the first twelve months of practice (Duchscher, 2009).

As the projected shortage of RNs is expected to be 115 000 RNs by 2016, and there is a projected increase in demands for critical care beds looming, hiring and mentoring new graduates in critical care may be a viable answer to maintaining safe and appropriate staffing levels (Chernomas et al., 2010). In addition to being a viable

opportunity, new graduates view these highly acute setting as a desirable area to work (Fenush & Hupcey, 2008).

Study Limitations

As with any study, this study is not without its limitations. The new graduates in this study were at different points and times in their transition experience. To increase sample size, new graduates who had graduated in 2009 were included in this study, due to the limited number of new graduates hired into critical care. Interviewing participants later on in their transition may have resulted in recall bias when reflecting on the early portions of their transition experience. However, including participants with up to 20 months of practice may have enriched the study's findings, highlighting how the transition experience can extend up to that time period for some people. Participants were interviewed were between their 5th and 20th month of employment, which may have resulted in recall bias. All participants were still working in their originally employed units, which suggest that they were satisfied with their transition experience and therefore may have been more willing to share their experiences. Those who had left their unit within the first few months did not respond to the call for participants so their perspectives are not included in this study. Their perspective would have enriched the data and provided a broader range of experiences. New graduates in this study were also interviewed at one time-point in their experience. The depth and quality of the descriptions may have been improved if interviewed several times over a longer period of time to better capture their experiences and to avoid recall bias. In addition, all participants were female, white Anglo-Saxon, in there 20s and in their first profession.

This is a limitation as having different ethnicities and participants at different life stages may have impacted the findings.

Knowledge Translation & Exchange

Knowledge translation is defined by the Canadian Institutes of Health Research as “a dynamic and iterative process of synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians.” (Canadian Institutes of Health Research [CIHR], 2010) Knowledge translation is important, as new knowledge often does not lead to widespread implementation on its own (CIHR, 2010). This current study was completed as part of the thesis requirement for a Master’s of Science in Nursing degree. Once defended, the thesis will be housed in the McMaster University library system.

Knowledge translation includes dissemination, which involves identifying the appropriate audience for the research and tailoring the message to the audience (CIHR, 2010). This includes publication in scientific journal or at a conference. The results from this study have already been disseminated in the form of a poster at the Nursing Leadership Network of Ontario conference in Toronto in March 2011 and at the McMaster Faculty of Health Sciences Graduate Research plenary in May 2011. This study will also be presented in an oral presentation at the Workplace Integration of New Nurses conference in Halifax, Nova Scotia in December 2011. In addition, a one-page fact sheet will be created and submitted to the Nursing Health Services Research Unit at McMaster University for further dissemination. Knowledge will be further disseminated

through submission of a manuscript for a peer-reviewed journal publication such as the Journal for Nurses in Staff Development.

In addition to dissemination is the more active process of knowledge exchange. Knowledge exchange refers to the interaction between a researcher and knowledge user, which results in mutual learning (CIHR, 2010). As the purpose of this study was to explore the transition experience of new graduates, and identify the barriers and facilitators to that transition, interaction with decision-makers at an organizational and policy level is essential. Findings will be shared at both organizations that were included in this study. Communicating research findings to knowledge users is important, as knowledge users are individuals who are able to use the knowledge generated through research to make informed decisions regarding policy, programs and practices (CIHR, 2010).

Summary

Findings from this study are consistent with the new graduate literature, but also present new findings related to the new graduate transition experience as it relates to critical care. Participants clearly described how emotional the transition experience could be. However, the experience can be positive when supports and time are available. Participants described support from preceptors, charge RNs and other staff, and also contributed feeling supported from their lengthened orientation. Participants were very aware of feeling a part of the team, and navigated through their transition to feel that they had adequately taken on the role of an RN.

CHAPTER 6: IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

The study provides important insight into the transition experiences of new graduate RNs entering a critical care unit. Findings from this study present a number of implications for clinical practice, policy, research and nursing education, which are described below.

Implications for Clinical Practice

The findings provide support for a lengthened orientation for new graduates entering critical care. Based on the findings from this current study a twenty-four week orientation for new graduates entering critical care is recommended. Twenty-four weeks would allow for the new graduate to learn from their preceptor, receive formal critical care education and to become comfortable in their new environment. This period of time would assist new graduates to settle in their unit and to allow adequate time for collaborative relationships to be formed and nurtured.

Findings from this study suggest that new graduates should not have their formal orientation period cut short. Rather, they should remain supernumerary throughout the 24-week orientation period. Without this protected time participants in this study felt ill-prepared, frustrated, scared and too intimidated to advocate for themselves with a senior member of the unit. Furthermore, this time would allow the participants to fully socialize into their new role and clinical unit, which has been noted to be essential in the role-development of new graduate RNs.

Based on the findings from this study, there was a discontent regarding the patient assignments given to the participants in this study. Data shows that some assignments

limited the exposure to critically ill patients, which ultimately increased their fear when having to care for these patients independently. A recommendation of providing a progressive exposure to medically complex patients is made based on these findings.

New graduate RNs should be placed on the same schedule as their preceptor or mentor for a follow-up resource role once the orientation period has finished. A short transition period of at least one month is recommended after the 24-week period so working independently can be validated. Alternatively, managers could consider moving the new graduate to their new schedule to spend the last few shifts being preceptored by a nurse that would be working the same schedule with them to ease their transition. This will demonstrate continued support for the new graduate, increase their job satisfaction and comfort and broaden their social network in the clinical practice area.

Effective preceptors are essential to the transition experience of new graduates. However, it is clear that an extended orientation period may place additional strain on preceptors. Therefore, to avoid the typical stress and burnout experienced by this group, which can be exaggerated by an extended orientation period, it is recommended that various forms of support be made available through peers, the unit and organization.

Finally, providing professional development opportunities and preceptor training classes to preceptors, charge RNs and other staff members is essential so staff members are adequately aware of the transition experience of the new graduate.

Implications for Policy

Findings from this study reinforce current policy by the MOHLTC, which provides a 24-week funded orientation for new graduate RNs working in critical care.

This extended, protected time enables new graduates to receive formal education and to establish relationships within their units. All participants in this current study verbalized intent to stay in their unit, which demonstrates the positive impact a lengthened orientation period can have on retention.

Hiring policies are also needed at an organizational level to allow for the integration of new graduate RNs into critical care units. The findings from this study clearly identified that allowing new graduate RNs to enter critical care is a viable and sustainable option in critical care units. This investment can continue to build up the critical care workforce to allow for appropriate staffing levels in these highly acute units.

Implications for Research

The findings from this study have implications for future research in the area of new graduates in critical care units. This study demonstrated that the transition to critical care could be viable and successful but subsequently, further exploration is suggested to identify economic costs and patient outcomes associated with this hiring practice. Two research questions have flowed out of the current study.

Although a lengthened orientation creates a positive transition experience, it also requires a significant investment of financial and human resources. Because of the nature of this investment, the financial benefits of these orientation programs needs to be explored.

- 1) What is the impact of a lengthened orientation on new graduate job satisfaction, sick time and retention in the organization as compared to a standard 12-week orientation?

This proposed research question could be addressed using a quantitative research design, using standardized measurement tools for job satisfaction and unit data on retention and sick time. This could be done either with a cross-sectional, or a prospective cohort research design, following new graduate RNs for the first year of practice.

Additionally, an important research study would be to examine the patient outcomes associated with having a new graduate RN care for patients in a critical care unit. This would be important to further understand the viability of new graduate RNs entering such units.

- 2) What are the patient outcomes when being cared for by a new graduate RN in a critical care setting?

This question could be answered using a prospective cohort design, where new graduate RNs patient outcomes would be tracked and compared to outcomes of previous years with no new graduate RNs caring for them.

Implications for Nursing Education

Results from this current study demonstrate the value of continuing to provide clinical experiences for fourth year students in critical care units. Results indicated that prior exposure to these areas positively benefitted individuals' transition experience if they choose to seek employment in this area. Prior experience in a critical care area may decrease fear and anxiety for the new graduate due to previous relationships they established with staff and the familiarity that they would gain with unit routine, equipment, policies, procedures and unit norms.

The findings provide evidence for educators to broaden discussions about the transition period with senior year nursing students so that they can better understand the barriers and facilitators to working in a critical care area. Subsequently, students could begin thinking about how they would fit into this type of unit and what strategies they could employ to overcome potential barriers. Educators need to stress the importance of advocating for oneself during the transition period. Additionally, they can also discuss role development and socialization in the clinical workplace.

Conclusion

This study makes an important and new contribution to our understanding of new graduate RNs transitioning to critical care. While each participant had his or her own unique transition experience, five common themes were identified: the times of transition, the emotional experience, becoming a professional, the unit environment and the unit team. These themes highlight a number of key considerations to support new graduate RNs transitioning into critical care. New graduates need a 24- week orientation to begin their practice. Within these 24 weeks, extensive support from the preceptor, other RNs and those in leadership are required. Additionally, formal education will assist with the development of a positive experience for the new graduates. This current study demonstrated how emotional the transition experience could be, which members of the unit team need to be mindful of. Providing support in the first 24-weeks, and continuing up to the first year of practice will foster a positive unit environment for the new graduates to begin their professional practice. New graduates are a precious commodity to the nursing workforce, and placing them in a critical care unit, although some deem as

risky, can provide great reward to an organization. This was demonstrated in the current study when all eleven participants vocalized intent to remain in their unit.

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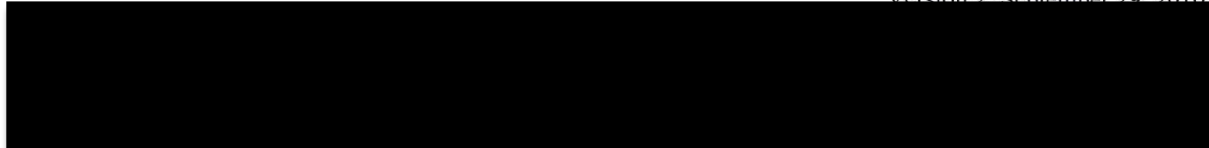
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APPENDIX A

Recruitment Flyer

Version 2, September 29, 2010



Are you a New Graduate RN in ICU or CCU?
If so, we want to hear from you!

For What?

A research study exploring the experiences of new graduate RNs entering critical care units at [redacted].

What Is Required?

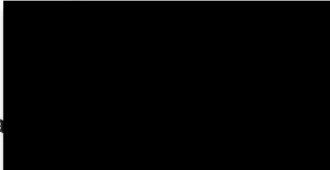
You are invited to participate in a 60-90 minute interview outside of work time at a mutually agreed upon time and location. A telephone interview can also be arranged for your convenience.

You Are Eligible To Participate If:

- You are a registered nurse
- You graduated with your BScN in 2009 or 2010
- You began your professional practice as an RN in the ICU or CCU [redacted]

Participants who complete an interview will receive at \$20.00 gift card for Second Cup[®], as well as a certificate of research participation for your CNO professional portfolio.

For more information, please contact:
Melissa Whitson, MScN student
(289) 389-5435 or whitson@mcmaster.ca



New Grad Study
(289) 389-5435
whitson@mcmaster.ca

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APPENDIX B

Letter of Introduction to Participants

**Letter of Introduction to Participants**

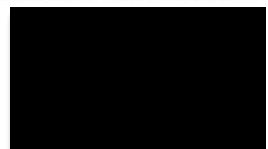
My name is Melissa Whitson. I am an MScN student in the School of Nursing at McMaster University. To complete the thesis requirements of this program, I am conducting a research project. You are being invited to participate in a research study to explore the experiences of new graduate RNs transitioning into a critical care unit. Sharing your experience is vital to the success of this project. By sharing your experience you provide information to further direct programs within organizations. Additionally, the results are anticipated to direct policy at a provincial level. Your experiences will provide us with information to further direct recruitment and retention efforts to assist with the improvement of nursing shortages.

Participation in this study will consist of participating in a 60-90 minute interview with myself. I will collect demographic data asking information regarding any previous experience in critical care or the health-care system, your work status (full-time or part-time) and the length of time you have been an RN.

Participation in this study is voluntary. You may refuse to answer any of the interview questions and/or withdraw from the study at any time. Interviews will be digitally recorded. You will not be identified by name in the thesis, or any other publications resulting from this project. Privacy and confidentiality will be maintained by storing all recordings in a locked cabinet for a period of ten years following the study. The recordings will be destroyed following this period. If you withdraw from the study, corresponding recordings and notes will be

Version 3, November 16, 2010

Whitson



destroyed if you wish. The results of this study will be shared with my thesis committee and my thesis supervisor, Dr. Pamela Baxter, Assistant Professor, School of Nursing, McMaster University.

Potential risks of participating in this study include the potential for emotional distress as you are sharing an experience that occurred during your transition onto the unit. Additionally, this study requires some time commitment, as it will take place outside of work time, at your convenience.

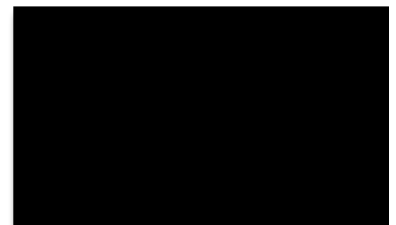
You will be given a \$20.00 gift card for Second Cup® as well as a certificate of participation in research for your CNO professional profile for your participation in the study. If you have any concerns about participating in this study, these concerns may be addressed to the Office of the Chair at [REDACTED]

[REDACTED]
Sciences Research Ethics Board at 905-521-2100, ext. 42013.

If you would like to participate in this research study or have any questions with respect to this research project please call or e-mail at: (289) 389-5435 or whitson@mcmaster.ca

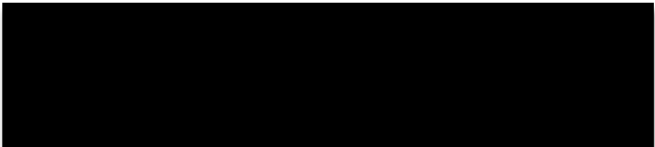
Thank you,

Melissa Whitson, BScN, RN



APPENDIX C

Participant Consent Form



Participant Information and Consent Form

An Exploration of the Experiences of New Graduate RNs Transitioning into a Critical Care Unit

Principal Investigator, Department/Agency/Institution

Melissa Whitson, MScN student, School of Nursing, McMaster University

Local Principal Investigators, Department/Agency/Institution



Co-Investigators

Dr. Jenny Ploeg, School of Nursing, McMaster University

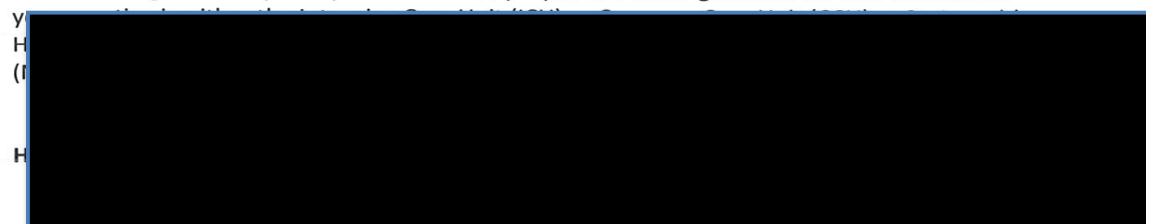
Prof. Charlotte Noesgaard, School of Nursing, McMaster University

You are being invited to participate in a study entitled: *An exploration of the experiences of new graduate RNs transitioning into a critical care unit*. This study is being conducted by Melissa Whitson. Melissa is a Master's student in the Master's of Science in Nursing Program at McMaster University. Melissa is being supervised by Dr. Pamela Baxter, Assistant Professor, School of Nursing, McMaster University.

WHY IS THIS RESEARCH BEING DONE?

The purpose of this project is to explore the experiences of new graduate RNs who enter into critical care units. As little is known about this transition, an understanding of the experience is being sought. The purpose of this study is to provide information to guide further policies on orientation and recruitment, and to help reduce attrition of new graduate RNs from critical care units.

You are being asked to participate in this study if you are a new graduate RN who has started




WHAT WILL BE MY RESPONSIBILITIES IF I TAKE PART IN THIS STUDY?

If you agree to voluntarily participate in this research, your participation will include a 1-1.5 hour interview that will be audio-recorded.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

Participation in this study may cause some inconvenience to you, as it will require some time commitment outside of work.

As this is an interview, there is always a risk of emotional distress as you describe an experience that you encountered during your new graduate experience. You may stop the interview at any point during the interview and/or you may refuse to answer any of the questions posed.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

The potential benefits of your participation include sharing your experience of transitioning to a critical care unit, which could have an impact on future policy, and programs within organizations (including orientations, mentorship) for new graduates entering critical care units.

WHAT INFORMATION WILL BE KEPT PRIVATE?

For all data collected, your name and other identifying characteristics will be removed or altered and the contents of quotes will not reveal your individual identity. In other words, no individuals will be identified in any reports or papers emerging from the project. The transcripts of the interviews will be shared with the thesis committee; however all identifiers will be removed prior to review.

It is anticipated that the results of this study will be published in the final thesis of Melissa Whitson, which will be housed in McMaster University Library. In addition, results may be shared through scholarly journal publications and presentations at conferences.

Data from this study will be secured for 10 years in Melissa Whitson's home office in a locked filing cabinet and/or on a password-protected computer after which time it will be destroyed.

WHAT HAPPENS IF I WANT TO END MY PARTICIPATION IN THE STUDY?

Your participation in this study is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences. If you do withdraw from the study, the information you provided up to the time of withdrawal cannot logistically be removed and will be included in the analysis. Withdrawal from the study will not have any bearing on your position at St. Joseph's Healthcare Hamilton or Hamilton Health Sciences.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

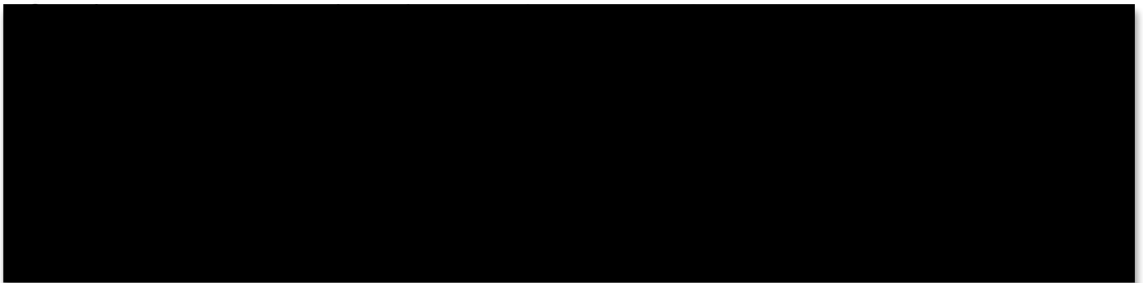
You will be provided with at \$20.00 gift certificate for Second Cup® at the time of the interview in appreciation for your participation in the study as well as a certificate for participation for your College of Nurses of Ontario Professional Profile.

WILL THERE BE ANY COSTS?

Your participation in this research project will involve your time.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?

If you have any questions about the research now or later, contact Melissa Whitson at (289) 389-5435 or by e-mail at whitsom@mcmaster.ca



My signature below indicates that I understand the above conditions of participation in the study and that I have had the opportunity to have my questions answered by the researchers. I have received a copy of this consent form for my records.



*Name of Participant
(Please print)*

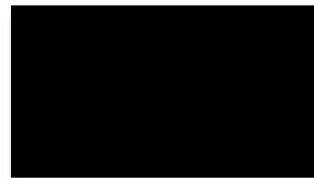
Signature

Date

*Name of person obtaining consent
(Please print)*

Signature

Date



APPENDIX D

Interview Guide

Section A: Responsibilities

1. Tell me what it is like being a new graduate RN working in critical care?

Potential Probing Statements

- i. Describe a typical day on a critical care environment
- ii. Describe how you feel when you are working as an RN....
- iii. What emotions would you use to describe being a new graduate RN working in critical care

Section B: Roles

2. Describe how it feels to no longer be a student, but rather a RN working in critical care...

Potential Probing Statements

- i. What physical differences do you feel are present when working as an RN?
 - ii. Was this experience different that you expected? How/Why?
3. Describe to me what you think were/are some of the facilitators to your transition?

Potential Probing Statements

- i. Tell me some people or programs that have been helpful in the department
4. Describe to me what you think were/are the barriers to your transition?
 - i. What were some things that you found frustrating about your transition?
 - ii. Tell me what you think would have helped you in your transition...

Section C: Knowledge

5. Describe to me how you felt about your knowledge and capabilities of being an RN in a critical care environment?

Potential Probing Statements

- i. Do you feel, or did you feel ready to finish orientation?
- ii. Describe to me if you felt you had the knowledge to be a CC RN after orientation?
- iii. Tell me if you feel you have an understanding of the role of a CC RN?

Section D: Relationships

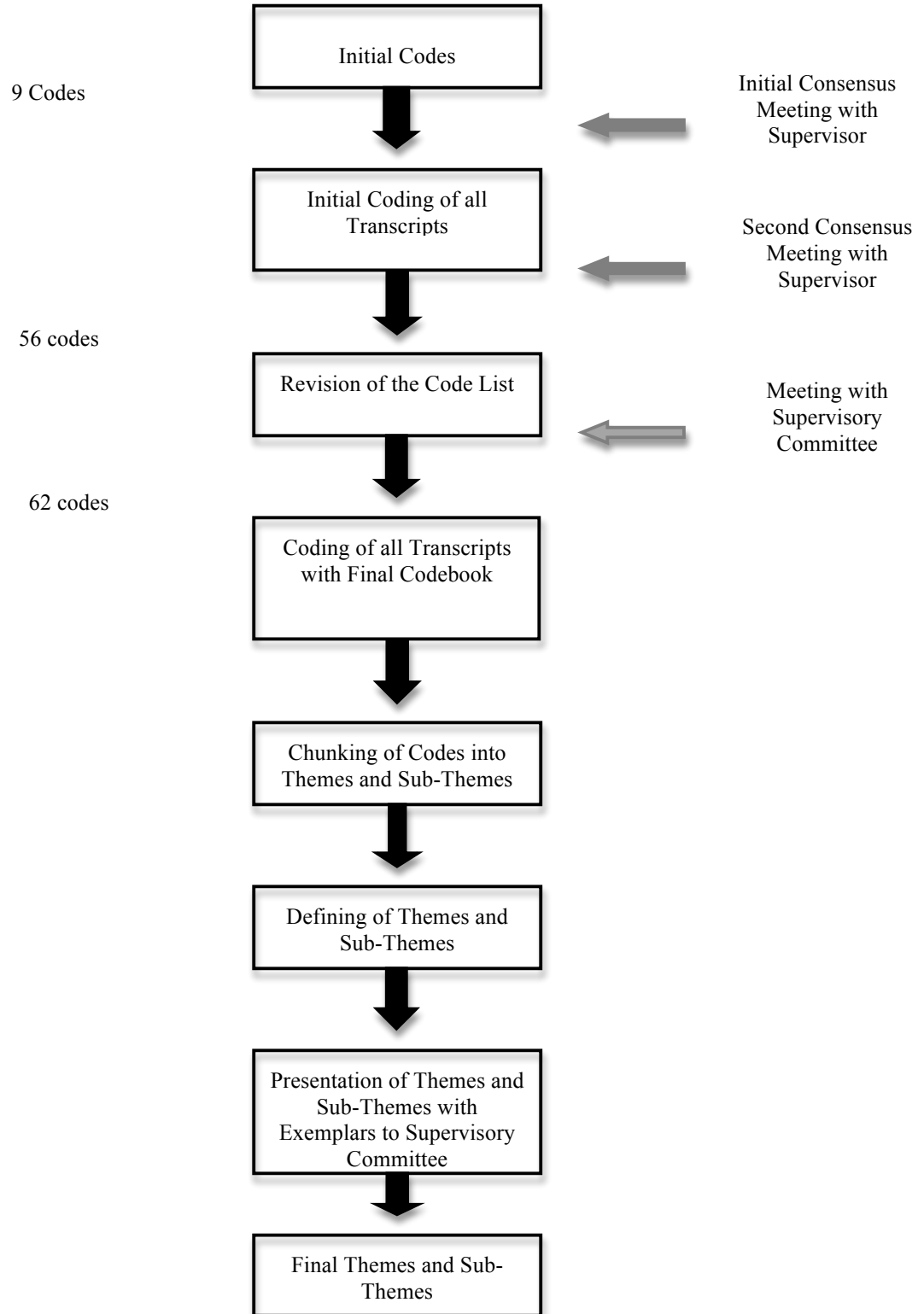
6. Describe to me how it felt to become a member of the critical care health care team

Potential Probing Statements

- i. Do you feel comfortable as a member of the health care team
- ii. How or when did you feel accepted as a member of the health care team
- iii. What terms would you use to being a member of the health care team?

APPENDIX E

Data Analysis Process



APPENDIX F

Research Ethics Board Approval

RESEARCH ETHICS BOARD

October 5, 2010

RE: R.P.#10-3387

Study Title: An exploration of the experiences of new graduate registered nurses transitioning to an adult critical care unit

Received date: 23 August, 2010

Review type: Expedited

Initial Approval: 17 September, 2010

Final Approval: 05 October, 2010

All Received Enclosures:

Application Form - General Research Application

Protocol - Study Protocol ver: 1 30 July, 2010

Interview Guides - Interview Questions ver: 1 30 July, 2010

Other - Proposed Timeline ver: 1 30 July, 2010

Other - Encryption Protocol for E-Mailing of Interviews to

Transcriptionist ver: 1 30 July, 2010

PI Letter - Letter received October 04, 2010 responding to conditions

Consent Form (Main) - Participant Information/Consent Form ver: 2 29

September, 2010

Recruitment Ad - Revised Advertisement Poster for graduates 2009 or

2010 with tear-off contact information

Recruitment Ad - Revised Advertisement Poster for graduates 2008, 2009

or 2010 with tear-off contact information

Participant Letter - Letter of Introduction to Participants ver: 2 29

September, 2010

Data Collection Sheet - Demographic Collection Form ver: 2 29

September, 2010

Approved Enclosures:

Protocol - Study Protocol ver: 1 30 July, 2010

Interview Guides - Interview Questions ver: 1 30 July, 2010

Other - Proposed Timeline ver: 1 30 July, 2010

Other - Encryption Protocol for E-Mailing of Interviews to

Transcriptionist ver: 1 30 July, 2010

Consent Form (Main) - Participant Information/Consent Form ver: 2 29

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Page 2

October 5, 2010

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Participant Letter - Letter of Introduction to Participants ver: 2 29 September, 2010

Data Collection Sheet - Demographic Collection Form ver: 2 29 September, 2010

Acknowledged Enclosures:

Application Form - General Research Application

PI Letter - Letter received October 04, 2010 responding to conditions



Please be advised that a member of the Research Ethics Board's Subcommittee reviewed R.P. #10-3387 on 17 September, 2010 and approved it with some conditions. Those conditions have now been met. You have final approval to commence your research.

This approval will be for a period of 12 months **ending 05 October, 2011**. We will request a progress report at that time.

If your project is terminated, it is your responsibility to notify the REB. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board prior to implementation.

Please ensure that all study personnel are familiar with the REB requirements on the appended page.

Please reference R.P. #10-3387 in any future correspondence.

We wish you well in the completion of this research.

APPENDIX G**Research Ethics Board Approval**

HHS/FHS REB: Student Research Committee

Final Approval

Date:	December 1, 2010
REB Number:	10-628-5
Title of Study:	An exploration of the experiences of New Graduate Registered Nurses Transitioning to Critical Care Units
Student PI:	Melissa Whitson, MScN Student
LPI:	Dr. Pamela Baxter
Version date:	Document:
	[Redacted] Application (signed Aug 9, 2010) – REB #10-3387 – approved Oct 5, 2010
	Reciprocal Review Application (signed Nov 18, 2010)
Version 2, November 16, 2010	Protocol
Version 1, November 15/10	Recruitment E-Mail
Version 3, November 16, 2010	Participant Information and Consent Form
Version 3, November 16, 2010	Letter of Introduction to Participants
Version 3, November 15, 2010	Demographic Collection Form

Dear Melissa:

We have completed our review of your study and are pleased to issue our final approval. You may now begin your study.

All recruitment and consent material must bear an REB stamp. You may pick up the stamped forms from our office.

Any changes to this study must be submitted as an amendment before they can be implemented. Amendment forms are available on our website.

This approval is effective for 12 months from the date of this letter. If you require more time to complete your study you must request an extension in writing before this approval expires. Please submit an Annual review form with your request.

Please cite the REB number in any correspondence.

Good luck with your research,

A handwritten signature in cursive script, appearing to read "Marie Townsend".

Marie Townsend BA, MBA
 Chair, HHS/FHS Student Research Committee
 Health Research Services, HSC 1B7, McMaster University

The HHS/FHS SRC complies with the guidelines set by the Tri-Council Policy Statement: *Ethical Conduct for Research Involving Humans* and with ICH Good Clinical Practice.

APPENDIX H

Glossary of Definitions of Themes and Sub-Themes

The Times of Transition: the varied levels of comfort based upon the part of the transition experience that they were in. These times represented two distinct time periods in their transition and were broken down into two distinct phases: time one and time two

Time One: Orientation: the orientation period of a new graduate RN in their respective units

Time Two: Autonomous Practice: the ending of the orientation period where the preceptor stepped away and formal orientation programs ended

The Emotional Experience: to all the feelings experienced by the participant during his/her transition experience.

Fear & Anxiety: feelings being scared and nervous about their transition experience

Exhaustion: being emotionally drained of energy or effectiveness.

Overwhelmed: to be overcome completely in mind or feeling, in this study being overcome by tasks, emotions and knowledge required to work in critical care

Excitement: a being happy and joyful about his/her transition experience

Privileged and Pride: feeling special because of an opportunity you have been given

Enthusiasm: an excited interest in beginning one's career in critical care

Valued: valued referred to the new graduate feeling respected and esteemed by his/her colleagues.

Becoming a Professional: as learning and taking on the role of an RN during his/her transition experience

Expectations of being an RN: to the new graduate belief about what it was going to be like to be an RN in a critical care unit.

Realizations: to those instances when the new graduate had an 'a ha' moment, and/or when preconceptions were affirmed or dismissed based on their experiences.

Role Taking: process of looking at or anticipating another's behaviour by viewing it in the context of a role imputed to that other. The assumption of a type of behaviours, often by someone occupying a particular status, such as a nurse (Turner, 1956).

The Unit Environment: the critical care unit that the participants were hired into.

Learning in the Unit: to *what* new knowledge was provided by the unit as well as *how* the new graduates learned within the unit environment.

Facilitators to Transition: Facilitators refer to people or programs within the unit that assisted the new graduates transition experience. These facilitators included past experiences for the new graduates and the programs available to them.

Past Experiences: having a previous clinical placement as a nursing student or a summer job as a clinical extern or as a health care aide.

Programs Available: the external and internal programs used by their organization to provide an extended orientation, as well as individual programs provided to the participants by their organization.

Barriers to Transition: difficulties present within the unit environment that made their transition experience more difficult.

Assignments: the patients assigned to a new graduate, to care for during his/her clinical shifts.

Loss of Orientation: premature termination of an orientation period by the unit leadership

The Unit Team: people within the unit that provided support throughout their transition experience. These anchors included members of the health care team (primarily nurses and physicians)

Nursing Support: support received from all nurses contained within the unit environment

Preceptors: Preceptors are experienced nurses on a clinical unit who are assigned to work one-on-one with new graduates, to share their workload while orienting them to the practice environment

Nursing Peer Support: to receiving support from other RNs present on the floor during one's transition experience

Nursing Leadership: managers, clinical leaders and educators present in the critical care unit.

Charge Nurses: RNs on the floor who are in charge of the department for a 12-hour shift, controlling patient flow and RN assignments. They often do not carry a patient assignment; instead act as a resource to other RNs on the floor.

Team Support: receiving support from other health-care team members other than nursing within the critical care team members.

