TRANSITIONING TO PRACTICE IN LONG-TERM CARE: FROM NEW GRADUATE NURSE TO NURSE LEADER

TRANSITIONING TO PRACTICE IN LONG-TERM CARE: FROM NEW GRADUATE NURSE TO NURSE LEADER

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ABSTRACT

This project, which used a qualitative, explanatory case-study design explored the transition to practice of new graduate Registered Nurses (RNs) and Registered Practical Nurses (RPNs) in long-term care (LTC). Specifically, this study focused on the self-described transition to practice experience of the new graduate nurse (NGN), the contextual factors present in LTC that influenced this transition to practice, and how the transition experience was similar and different for the new graduate RN and RPN. Both NGNs and LTC directors were included in the study. In total, 7 NGNs and 2 LTC directors participated in semi-structured interviews. The NGN participants were employed as a nurse in one of the two LTC sites and had been working as a nurse for less than one year. Data were collected through Key Informants (NGNs and LTC directors), and Key Documents (LTC policies and orientation material).

Results of this study introduced six contextual factors present in LTC that influence the transition to practice of NGNs and five processes that, as a result of the contextual factors, accelerate the transition to practice experience. This described accelerated transition to practice refutes the previously universally applied transition to practice theory and contributes new knowledge and understanding to the transition to practice experience of the NGN in LTC and more specifically how the new graduate RPN experiences transitioning. The findings also described the many similarities and some differences between the transition to practice experience of the new graduate RN and RPN in LTC.

With increasing demands on the long-term care sector, these findings will be of interest to a broad audience including policy makers, educators, LTC directors and administrators, as well as nursing students and NGNs. It is anticipated that these results will direct further research on this topic, and inform policy, practice, and educational programs.

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LIST OF ABBREVIATIONS

LTC = Long-term care

LTCH = Long-term care home

NGN = New Graduate Nurse (inclusive of Registered Nurse and Registered Practical Nurse)

NGG = New Graduate Guarantee (a Ministry of Health and Long-Term Care funded initiative)

PSW = Personal support worker

RN = Registered Nurse

RPN = Registered Practical Nurse

CHAPTER ONE: INTRODUCTION

The profession of nursing is facing increasing pressures related to human resource shortages, outpaced demands on the healthcare system, and an overall greater acuity of patients accessing services (Canadian Healthcare Association [CHA], 2009; Canadian Institute for Health Information [CIHI], 2015; Giallonardo, Wong, & Iwasiw, 2010). In Ontario, long-term care (LTC) is not immune to these pressures and is increasingly challenged with responding to the demographic trends associated with the growing proportion of older adults and the increasing acuity of care needs within this population (Canadian Nurses Association [CNA], 2008; Giallonardo et al., 2010). Hiring new graduate nurses (NGNs) of both nursing designations (ie. Registered Nurses and Registered Practical Nurses) into LTC is a strategy utilized to counteract these pressures and shortages within this setting; however, little is known about how NGNs transition to practice in LTC or how they experience this transition. This gap in knowledge is evident for both the Registered Nurse (RN) and the Registered Practical Nurse (RPN) within LTC. Without this understanding, LTC and academic institutions are challenged to provide support during the transition to practice and necessary training upfront for those NGNs hired into this setting.

This thesis project explored the 'transition to practice experience' of new graduate RNs and RPNs in LTC and the influence of contextual factors on the transition to practice experience of NGNs. In this chapter, the significance of this issue and the purpose of this research study are explained.

New Graduate Nurses and Transitioning into Practice

A predicted global nursing workforce shortage has accelerated the establishment of programs and services that support NGNs during their transition to practice (Rush & Adamack, 2013). These programs have emerged internationally as well as across Canada to facilitate positive NGN transition experiences and support integration into the workplace (Rush & Adamack, 2013). While there is a significant body of literature exploring general transition to practice in acute-care settings (Baumann, Hunsberger, Crea-Arsenio, & Rizk, 2015; Beaty, Young, Slepkov, Issac, & Matthews, 2009; Duchscher, 2008; 2009), the transition to professional practice for NGNs in LTC is relatively unknown as is the general transition to practice of RPNs.

Transition to practice and the professional nursing role is a period of great stress for new graduate and novice nurses (Duchscher, 2008; McCalla-Graham & De Gagne, 2015; Rhéaume, Clément, & LeBel, 2011). The New Graduate Guarantee (NGG), a program developed by the Ministry of Health and Long Term Care, exists for new graduate RNs and RPNs in Ontario. This program aims to aid in the transition to practice experience with the novice nurse functioning as a supernumerary temporary full-time employee, buddied with an experienced mentor for a predetermined amount of time (Baxter, 2010; Baumann et al., 2015; Beaty et al., 2009; Ministry of Health and Long Term Care [MOHLTC], 2014). Typically, this program provides employer facilities funding for 20 weeks so that the NGN may benefit from a gradual and mentored transition to practice over that time (MOHLTC, 2017). These programs, although supported within the literature as a method for easing transition, (Beaty et al., 2009; Rhéaume, et al., 2011) are not widely utilized outside of acute-care settings and are very competitive appointments dependent upon government funding, facility participation, ability of the facility to place the new graduate into a full-time position following completion of the program, and mentor availability

(Baumann et al., 2015). At this time, there is no understanding of the impact of supportive programming such as the New Graduate Guarantee within LTC.

Significance of the Study

LTC comprises 55% of total healthcare employer organizations in Ontario; however, only 14% of LTC organizations participate in the New Graduate Guarantee program offered by the MOHLTC (Baumann et al., 2015). This dearth of participation in programs designed to ease transition to professional practice may challenge the NGN. This is especially true within highly autonomous settings such as LTC where both RNs and RPNs work to a more full scope of practice (Ferguson-Pare, 1995). While there is literature examining NGN transition to practice within acute-care and other hospital settings, there is a paucity of literature examining this phenomenon within the context of LTC. Additionally, there is little to no explicit discussion of the transition to practice of RPNs in LTC despite this nursing designation comprising the majority of regulated healthcare workers in this setting. Couple this with the increasing acuity of patients receiving care outside of the acute-care setting, the growth in care needs for older adults, and more nurses leaving the profession than those entering it (CHA, 2009; CIHI, 2015; Giallonardo, et al., 2010), understanding the experience of NGNs and their transition to practice within LTC is becoming increasingly more important.

Purpose

Aligned with documented demographic trends related to the increasing proportion of older adults in Canada, those requiring service from LTC continues to increase along with the acuity of care required (Canadian Nurses Association [CNA], 2008; Giallonardo et al., 2010).

RNs and RPNs comprise a large proportion of the staff team employed within LTC with each designation independently and collaboratively fulfilling and managing the diverse and variable care needs of the residents served (CNA, 2011; CHA, 2009). The level of care and service provided by nursing staff within LTC is influenced by many factors including: staffing ratios, educational opportunities, as well as regulation and funding models to support nursing staff (CHA, 2009; CNA, 2008; Robertson, Higgins, Rozmus, & Robinson, 1999). Additionally, as in the acute-care setting, there is no standardized orientation or training for newly hired nurses (Baxter, 2007), placing NGNs at increased vulnerability, and potentially impacting patient safety, professional turnover, and the quality of care provided (Baxter, 2010).

The purpose of this qualitative explanatory single case study (Yin, 2014) is to explore how NGNs transition to practice within LTC in Southwestern Ontario. The central phenomenon of interest, transition to practice, is defined broadly as a non-linear experience with a relatively predictable trajectory involving emotional, intellectual, sociocultural, and developmental changes leading to a progressive evolution of the person within the professional role (Duchscher, 2008; Schumacker & Meleis, 1994). Utilizing Yin's (1994, 2014) case study approach, the contextual factors that influence transition to practice for both the RN and the RPN were explored as well as the benefits and risks that NGNs identified during their transition to practice experience.

This research will be of interest to a broad audience including nursing students, NGNs of both designation, managers and directors of LTCHs, educators, and policy makers. It is anticipated that these results will: help inform organizational policy and programs to better understand and support NGNs during their transition to practice; direct further research on this important topic, especially as it relates to the experience of the new graduate RPNs; and

ultimately support a better practice experience for NGNs within their chosen practice setting to decrease vulnerability, professional turnover, and increase quality of care.

This case report is divided into several chapters and structured according to the linear-analytic approach described by Yin (2014). A review of the literature as it relates to new graduate transition to practice and the LTC context is provided in Chapter Two. In Chapter Three propositions and the central research question are introduced. The methods utilized throughout the research study are described in Chapter Four. Findings from this study are presented in Chapter Five and are discussed in Chapter Six. Conclusions, implications, and recommendations are provided in Chapter Seven.

CHAPTER TWO: LITERATURE REVIEW

The primary purpose of a literature review in a case study report is to aid in the development of a more precise, insightful research question and not to discover the available answers about what has previously been known about the proposed topic (Yin, 2014). Creswell (2013) articulates that a review of the literature helps to establish a lens through which the researcher can view the proposed research topic as well as provide an opportunity to discover a theoretical framework to direct the research. The literature review for this case report will be used to provide context for the study and then revisited in the discussion to assist with overall interpretation of the data collected (Creswell, 2013). This ensures that the study findings remain inductive and allow for a summary of broad themes informed by the literature (Creswell, 2013).

This literature review is organized into four components to present arguments for why this study is needed, as well as to provide a description of what gaps this study will address within the available literature. The first component introduces and defines the key terminology utilized throughout this case study report while the second presents available literature on theory related to the transition to practice of the new graduate nurse. The third component presents literature that explains and explores what is presently known about the transition to practice experience of NGNs inclusive of barriers and facilitators to good transitioning as well as readiness to practice and the clinical settings that this phenomenon has been previously studied within. The fourth and final component presents an overview of LTC, inclusive of the provision of care, nursing roles and responsibilities, the influence of administration and supervision, and the limited knowledge available about those NGNs working in LTC. In keeping with the approach of Yin (2014), an a priori literature review was conducted.

An electronic database search was conducted utilizing CINAHL, PubMed, OVID, MEDLINE, and Google Scholar. Ancestry searching was utilized to find formative works, along with Google to search for gray literature. Search terms, used separately and in combination, included: new graduate nurse, novice nurse, new graduate role, Registered Nurse, Registered Practical Nurse, Licensed Practical Nurse, transition to practice, and transition. The literature review was limited to English and set to include works published between the years 2000 and 2017. This time period was selected due to the substantive changes in both the role and the educational requirements for the RN and RPN in Ontario (Registered Practical Nurses Association of Ontario [RPNAO], 2014).

Key Terminology

Transition to practice. Transition to practice is operationally defined as an active process of holistic learning and growth within a professional role (Duchscher 2008; 2009; Laschinger et al., 2010) and is a phenomenon that has been investigated and studied in a general manner for several decades. The academic interest with this topic exists because of described relationships between transition to practice and nurse retention within professional role, educational preparation, patient safety, and job satisfaction (Baumann et al., 2015; Duchscher 2008; 2009; Dyess & Sherman, 2009; Laschinger et al., 2010; Purling & King, 2012; Sasichay-Akkadechanunt, Scalzi, & Jawad, 2003; Wolff, Regan, Pesut, & Black, 2010). For this study, transition to practice was defined as "a nonlinear experience that moves through personal and professional, intellectual and emotive, and skill and role relationship changes and contains within it experiences, meanings, and expectations" (Duchscher, 2008, p.442). This broad definition of

transition to practice allowed the research study to remain inductive in nature and for themes to be explored within this phenomenon of interest.

New graduate nurse. The timeframe used to define NGNs in the literature ranges from six months (MOHLTC, 2014) to three years of practice (Benner, 1982; Bitanga & Austria, 2013; Laschinger, Grau, Finegan, & Wilk, 2010). In consideration of the literature the NGN was defined as a nurse, inclusive of either designation (RN or RPN), within the first 12 months of practice (Casey, Fink, Krugman, & Propst, 2004; Duchscher, 2008; 2009; Dyess & Sherman, 2009). This definition allows for the inclusion of both nurse designations represented within LTC employ and constitutes a timeframe that permits significant practice development.

Registered Nurse and Registered Practical Nurse. The professional designation of RN or RPN is a protected title legally bestowed upon individuals who have met standardized requirements (College of Nurses of Ontario [CNO], 2014). While both RNs and RPNs study from the same body of nursing knowledge, a greater emphasis on "clinical practice, decision-making, critical thinking, leadership, research utilization, and resource management" grant a greater level of autonomous practice to the RN (CNO, 2014). Additionally, the complexity of the condition of the patient influences the level of nursing care required with more complex and less stable situations or environments requiring an RN or at minimum the consultation of an RN (CNO, 2014). The entry-to-practice educational requirements of the RN are a baccalaureate degree while the RPN is required to complete a college diploma (CNO, 2014). Both the RN and the RPN must complete a professional registration and jurisprudence examination to practice in

the province of Ontario (CNO, 2014). Regardless of professional nursing designation, both the RN and RPN new graduate experience a transition into practice.

Transition to Practice Theory

Within the literature there are two prominent and seminal theories related to new graduate transition to practice: Benner's Novice to Expert Theory (Benner, 1982), and Duchscher's Stages of Transition Theory (Duchscher, 2008). Each contributes to a greater understanding of the acquisition of knowledge and skill over time by the NGN. As this study does not explore the stages of new graduate transitioning nor the progression of new graduate development over time, these theories are presented to provide foundational and seminal knowledge related to the experience of the new graduate nurse during their transition to practice experience and to provide foundational understanding of the phenomenon under study.

Benner's Novice to Expert Theory. Based upon the five levels of proficiency in the Dreyfus Model of Skill Acquisition (1972) and in response to the growing complexity of acute-care settings, Benner's work describes and applies these same five levels of proficiency to nursing work (Benner, 1982). These five levels include novice, advanced beginner, competent, proficient, and expert proficiency (Benner, 1982). Benner's theory was developed as a result of research that included interviews with experienced nurses, NGNs, and nursing students along with observations of these individuals (Benner, 1982). Results of this research introduced the concept that expert nurses develop skills in patient care over time and through experience (Benner, 1982). The Novice to Expert Theory builds sequentially on each of the five levels of the Dreyfus model as the nurse increasingly relies not on past abstract principles but instead upon

past concrete experiences within their own practice (Benner, 1982). In addition, as the nurse progresses through the five levels of experience there is a gradual shift in roles from a detached observer in task completion to an active participant in clinical practice and thinking (Benner, 1982). Each of the five levels, first presented by Dreyfus and further explained by Benner, are described.

Novice. At this beginning level of experience the novice nurse is taught general rules that assist with task performance (Benner, 1982). These general rules are context-free and meant to be applied universally (Benner, 1982). The behaviour of the novice nurse at this stage is observed to often be inflexible and rigid (Benner, 1982).

Advanced beginner. At this level of experience, the nurse demonstrates an acceptable level of autonomous task performance (Benner, 1982). The nurse's ability to provide this level of care is attributed to their past clinical experience and their ability to recognize similar previous situations (Benner, 1982). Principles associated with these meaningful experiences will begin to formulate a guide for future action in practice (Benner, 1982).

Competent. A competent nurse, according to Benner (1982), is typically described as having worked for two to three years in the same clinical area. Overall this nurse will be more aware of their influence on long-term goals and will base actions and interventions on abstract and analytical thinking (Benner, 1982).

Proficient. At this level of proficiency, the nurse understands situations in clinical practice holistically and not just in small, unconnected parts (Benner, 1982). The nurse continues to learn from experience, is able to expect and predict certain situations within practice, and is able to modify interventions to effectively and holistically provide quality patient care (Benner, 1982).

Expert. This fifth and final level of nurse proficiency sees the expert nurse as no longer relying on principles, rules, or guidelines to determine their nursing actions (Benner, 1982). This nurse brings significant experience, has an intuitive grasp on various clinical situations, and performs fluidly with high-proficiency and quality (Benner, 1982).

The use of this theory in the exploration of NGN transition to practice in LTC provides foundational knowledge related to the development of skills and the impact of experience on the NGN working in LTC. The Novice to Expert Theory is seminal nursing research, and emphasizes the need for immersion in practice, time to develop, and the acquisition of experience in the development of the NGN. While this theory was built in the acute-care setting, foundational understanding of the transition experience of the NGN may still be gleaned even in LTC. Benner's theory has since been expanded upon in subsequent theory by Duchscher (2008; 2009) more specifically related to the transition to practice of NGNs and the progressive development of the NGN over time.

Duchscher's Stages of Transition theory. Building upon Benner's (1982) work, Duchscher's Stages of Transition Theory outlines the three stages of transition that an NGN progresses through: doing, being, and knowing (Duchscher, 2008). This theory was based on surveys, interviews, focus groups, questionnaires, and ongoing communication with NGNs in the first year of practice within an acute-care hospital setting (Duchscher, 2008). Duchscher's theory, described as evolutionary and transformative for the NGN, encompasses ordered processes that include "anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring, and engaging" (p. 444) in both personal and professional non-linear development (Duchscher, 2008).

Doing - Transition Shock theory. Doing is the initial period of transition and encompasses approximately the first three to four months of NGN transition to practice (Duchscher, 2008). This period, marked by substantial challenges, feelings of being ill-prepared for the role and role responsibilities was often blamed on a lack of educational preparation by the NGN (Duchscher, 2008). These first four months of practice were marked by intense emotions, and idealistic as opposed to realistic expectations as the NGNs were assigned full patient loads despite feeling unable to care for such an assignment (Duchscher, 2009). Primary concerns identified by the NGN during this stage of transition involved understanding expectations of peers, completing tasks on time and completely, and an expectation to multitask resulting in high levels of stress. NGNs during this phase hid their emotions from their often more experienced and senior peers and worked hard to conceal feelings of inadequacy and fear (Duchscher, 2008). Overall, the Doing phase of the Stages of Transition, and more specifically the Transition Shock stage, is a period of time in which the NGN exhibits self-deprecating behaviour (Duchscher, 2008; 2009). Concurrently, this phase is marked by sociocultural and developmental changes and challenges in the NGN's personal life with the purchase of homes, new cars, and advanced or terminated romantic relationships often with associated new living arrangements.

Being. Being is the period that consumes the next four to five months of the NGN transition process (Duchscher, 2008). This period is described as a rapid advancement and development of thinking, knowledge, and competency level for the NGN, but also a time that they begin to substantially challenge pre-graduate notions and expectations of nursing and the nursing profession (Duchscher, 2008). During this period, NGNs tend to forego staff functions and overtime shifts, and instead choose to focus on their personal lives, their professional image, and a balance between these two (Duchscher, 2008). In contrast to the prescriptive direction

required in the Doing stage, NGNs in the Being period sought clarification and validation for their clinical decisions and grew confident with decisions viewed as safe, appropriate, and astute (Duchscher, 2008). Additionally, NGNs were better able to moderate their perspectives on their professional experiences, further relaxing into a comfortable space in their professional image and better able to balance the angst of what they did not know and the growing confidence in what they did (Duchscher, 2008).

Knowing. In the final months of the NGN's first year of practice, the stage of Knowing describes an apprehension regarding moving out of the comfort of the learner role into a more autonomous and responsible practitioner (Duchscher, 2008). Frustrations during this stage moved from personal and professional challenges to more sociocultural and political observations related to the healthcare system (Duchscher, 2008). These observations included the hierarchy of authority and power that nurses are placed within and the overall institution of healthcare (Duchscher, 2008). NGNs during this period reached a stable level of comfort and confidence in their routine and even found themselves comparing their skill level and abilities to those newest NGNs (Duchscher, 2008). Finally, at this stage, NGNs felt able to assist others with their workloads and answer questions, as opposed to just asking for assistance (Duchscher, 2008).

The use of these two theories by Benner and Duchscher in the exploration of NGN transition to practice provides foundational knowledge regarding the transition process. Benner's Novice to Expert theory posits that the NGN will gradually and sequentially acquire skills in their clinical area over time (Benner, 1982) while The Stages of Transition and Transition Shock theory pose that understanding and explanation of the NGN transition are sensitive to time as well as the position of the NGN in the transition journey (Duchscher, 2008). The disadvantages

to using these two theories are that: neither are born of research in LTC nor explicitly discuss the role and transition of the RPN, and the theory by Duchscher has not been empirically tested. Additionally, the theory by Duchscher provides specific analysis about NGN transition within a specified time frame, and not about a NGN's reflection of their transition experience within practice. For this study, these two theories aided in establishing the guiding propositions and provided an overall understanding of the general NGN transition to practice experience.

New Graduate Nurse Transition to Practice

Within the literature examining NGN transition to practice there is discussion on the barriers and facilitators to positive transitions, the perceived readiness to practice of the NGN, the intention to leave the profession, as well as specific information related to various practice settings that have been explored. The literature in each of these areas is described below.

Facilitators to positive transitions. A good transition to practice, although ill-defined within the literature, can be extrapolated to be the opposite of what the literature describes as a poor transition to practice. This includes a healthy work environment which is deemed an imperative for fostering and supporting NGNs during this time. The literature examining facilitators of a positive transition to practice experience explore appropriate orientation programs which overall foster healthy learning and work environments. Orientation programs are noted as a key facilitator during this time of transition, however, the orientation offered and the structure of that orientation are dependent upon the individual organization with no standardization or specific requirements across the province of Ontario (Baxter, 2007). This is challenging for NGNs as there is no consistency associated with their on-boarding and leaves the

experiences required for skill acquisition to the independent organization. Within the literature there are various components of the orientation program that are strongly associated with positive transition to practice. These include: the length of orientation (Baxter, 2010; Casey et al., 2004; Duchscher, 2008); the materials covered (Dyess & Sherman, 2009; MOHLTC, 2014; O'Rourke, 2012); and the opportunity for guidance from a mentor (Baumann et al., 2015; Laschinger, Finegan, & Wilk, 2009; Winfield, Melo, & Myrick, 2009).

The literature examining the required length of orientation associated with positive transition to practice for new graduate nurses is varied. Orientation length ranges in some facilities from days, to weeks, to months (Baxter, 2010). However, in a systematic review completed by Salt, Cummings, and Profetto-McGrath (2008) needs-based orientation programs that were up to six months in length had positive outcomes related to NGN retention overall. In LTC, like in other healthcare settings, there is no standardized length of orientation and yet nurses practicing within these settings are increasingly challenged with complexity and increasing demand related to growth in service need (O'Rourke, 2008).

Along with the length of the offered orientation program, the content that is included must be relevant and meaningful to the NGN. The employment of the NGN within a supernumerary position with preceptors and facility staff to provide mentorship is an essential aspect of orientation during the transition to practice experience (Baxter, 2010; Chernomas, Care, McKenzie, Guse, & Currie, 2010). The NGN in a supernumerary position means that the NGN is not included in the scheduled staffing ratio and is instead an additional, above-base team member (MOHLTC, 2014). These supernumerary positions allow the NGN time to feel comfortable within their work environment (Chernomas et al., 2010) and promote additional learning opportunities through observation. O'Rourke (2008) introduced an enhanced orientation program

designed to provide nurses orienting to LTC increased learning opportunities, develop capacity for nursing leadership, and enhance knowledge related to geriatrics. This program included a match with a mentor and attendance at six day-long workshops on topics such as geriatric assessment, responsive behaviours, and everyday leadership over the course of seven months (O'Rourke, 2008). This program had an overall reported positive impact on transition to practice and level of confidence of new nurses and also enhanced the leadership capabilities of the mentors (O'Rourke, 2008).

Mentorship and preceptorship involvement in NGN transition to practice has been demonstrated to help facilitate positive transition outcomes (Baumann et al., 2015; Laschinger, et al., 2009; Winfield et al., 2009). The influence of mentors and preceptors was associated with time for role modeling behaviour that ultimately facilitated learning and skill acquisition (Ellerton & Gregor, 2003). Appropriate orientation provides an opportunity for the NGN to ease into their professional practice, thereby promoting retention, (Rhéaume, et al., 2011; Salt, et al., 2008) job satisfaction, (Casey et al., 2004; Laschinger et al., 2010; 2016) and increasing patient safety (Rush & Adamack, 2013). The time required for adequate orientation, along with the need for meaningful, relevant content, supported by a mentor facilitates NGNs skill and experience acquisition. The orientation is strongly related to an overall healthy work environment and facilitates positive transition to practice experiences.

Barriers to positive transitions. The transition to practice of the NGN is a time of great stress and of self-reflection on practice and performance (Duchscher, 2008). Barriers to a positive transition to practice experience include factors that result in unhealthy work environments. Use of negative language toward the new graduate or the experience of horizontal violence (Dyess &

Sherman, 2009; Kelly & Ahern, 2009; McCalla-Graham & De Gagne, 2015), stigmatization of the learner role (Casey et al., 2004), and a lack of empowerment within practice describe elements present within a poor transition to practice experience (Laschinger et al., 2009; 2010; 2016).

In a phenomenological study by Kelly and Ahern (2009), the social expectations of 13 new graduate RNs were explored. This study highlighted that the language used by staff to describe NGNs such as "novice" or "kids" hindered development, made the NGN feel unwelcome, and decreased their feelings of team inclusion (Kelly & Ahern, 2009). Additionally, generally unsupportive work environments further contributed to negative transition to practice experiences through stigmatization of the learner role (Casey et al., 2004) and horizontal violence toward the NGN (Dyess & Sherman, 2009). Horizontal violence may be any act of aggression that is exhibited by a colleague and can include emotional, physical, and verbal aggression (Dyess & Sherman, 2009). This degradation of the NGN negatively impacts the transition to practice experience as well as the retention of the NGN (Laschinger et al., 2009). These social barriers and general incivility result in structural disempowerment of the NGN do not reflect highly upon the profession of nursing and ultimately impact the readiness of the NGN to practice.

Readiness to practice within transitions. Role changes (Casey et al., 2004), low self-confidence (Duchscher, 2009), and the required acquisition of new skills and ability to interact with professional teams (Chachula, Myrick, & Yonge, 2015) within the professional context all contribute to the perceived readiness to practice of the NGN. The expectation for NGNs to "hit the ground running" (Casey et al., 2004) is an unrealistic one as demonstrated by Duchscher's

Transition Shock Theory (2009) and is described as reality shock (Casey et al., 2004; Dyess & Sherman, 2009). Reality shock is defined as a shock-like reaction experienced by the NGN when they initially feel prepared for practice and then realize that they are not (Kramer, 1974). More recently, reality shock has been further explained to be a potential byproduct of a disparity between academic or nursing educational values and those values emphasized by the employer and employment setting (Flinkman & Salanterä, 2015). NGNs experience reality shock while negotiating within themselves personal expectations and ideals conceived while completing their education and then having to adapt to their professional role (Duchscher 2008; Duchscher & Cowin, 2004). This introduces stress and struggle to the transition to practice experience and can lead to burnout and professional turnover (Duchscher & Cowin, 2004; Rudman, Gustavsson, & Hultell, 2014).

In a study by Duchscher and Cowin (2004) that sought to understand causes of attrition in nursing practice, NGNs were described as highly motivated, well educated, and as individuals who often place high expectations upon themselves when transitioning into practice (Duchscher & Cowin, 2004; Price, McGillis Hall, Angus, & Peter, 2013). However, these NGNs are also described to be plagued by a perceived lack of clinical experience, stress related to intimidating work environments, and low self-confidence which challenges their ability to successfully transition and overall obstructs feelings of readiness to practice (Babenko-Mould & Laschinger, 2014; Duchscher & Cowin, 2004). These contributors impact the ability of the NGN to obtain and learn new skills within their clinical environments as well as their ability to successfully and effectively interact within the interdisciplinary team further perpetuating reported fear and low self-confidence (Casey et al., 2004).

In addition, these factors are related to an overall intention of the nurse to leave the profession. The intention to leave or the professional turnover of NGNs is reported as a negative response to the challenges present in healthcare (Flinkman & Salanterä, 2015). Intention to leave is defined as any intention to exit a position, to transfer work facility, or to leave the nursing profession as a whole (Rudman, et al., 2014). Factors reported to influence NGN intention to leave include: structural disempowerment including poor support systems and unsatisfactory work engagement (Laschinger, 2012), bullying and incivility (Babenko-Mould & Laschinger, 2014; Laschinger et al., 2016; Lavoie-Tremblay, Fernet, Lavigne, & Austin, 2015), burnout and increased stress (Rudman et al., 2014), insufficient orientation (Chachula, Myrick, & Yonge, 2015), and increased demands despite staffing shortages (Flinkman & Salanterä, 2015). In a qualitative descriptive study by McGilton, Boscart, Brown, and Bowers (2014) the factors that influence professional turnover of nursing staff in LTC were explored. Through focus groups completed at seven LTCHs, this study described work conditions and increased demand, regulations on nursing role, underfunding as it relates to resources and staffing ratios, and a lack of supportive leadership to be main reasons why staff intended to leave their employer (McGilton, Boscart, Brown, & Bowers, 2014). While this study did not specifically look at intention to leave of NGNs, it can be assumed that these factors, if influential on experienced nurses, may also affect those newly entering the profession.

Transitions within the clinical setting. Literature examining NGN transition to practice has mostly been contained to the hospital setting especially in acute-care (Duchscher, 2003; Duchscher, 2009). Studies have examined gerontological content within nursing education programs (Rosenfeld, Bottrell, Fulmer, & Mezey, 1999) and evaluated in-house general

orientation programs within LTC for new nurses (O'Rourke, 2008; 2012), but there remains a paucity of literature examining NGN transition into LTC. Additionally, the transition to practice experience of the RPN is absent from the literature. While the theoretical literature refers to the RPN designation (Duchscher, 2008; 2009), there remains an absence of explicit discussion of the RPN experience or voice within transition to practice literature.

Long-Term Care Setting

Care provision in LTC along with the roles and responsibilities of the nursing staff is a point of discussion in practice, policy, legislative, and academic circles (McCloskey, Donovan, Stewart, & Donovan, 2015). Limited financial resources, for-profit versus privatized care, regulations and standards, and public perception all weigh heavily on the care provided to older adults with increasingly complex and acute-care needs (Kennedy, 2009; McCloskey et al, 2015).

Care provision. Ontario's cohort of older adults is growing rapidly and the context of care provision in LTC is changing. In 2015, there were 627 licensed and approved LTCHs in Ontario with 57% of these homes privately owned, 27% listed as non-profit or charitable, and 16% run by municipalities (Ontario Association of Non- Profit Homes and Services for Seniors [OANHSS], 2015). Of these LTCHs, over 40% are considered small with 96 or fewer beds and 41% located in rural communities (Ontario Long Term Care Association [OLTCA], 2016). LTC previously accommodated residents with a range of care needs, however, since 2010 and the introduction of the province's aging-in-place strategy, only those people with high or very high care needs are eligible for LTC beds in Ontario (OANHSS, 2015; OLTCA, 2016). Thus, while over 20,000 individuals remain on the long-stay bed wait-list across the province those older

adults entering LTC are older, more frail, and require more medical and personal care than in previous times (OANHSS, 2015; OLTCA, 2016). The implications of these changes on staffing and human health resources have resulted in high resident to staff ratios, understaffing, and a decreased ability to provide adequate medical and personal care to frail and vulnerable older adults (OANHSS, 2015) as well as increasingly challenging NGNs in the provision of care. This contributes to unknown risks within the professional practice of the NGN.

Nursing roles and responsibilities in long-term care. The Long-Term Care Homes Act (Government of Ontario, 2007) has legislated the staffing requirements in LTC as well as aspects of the roles and responsibilities for nurses. Under this act "regular nursing staff" describes a regulated nursing staff member who works in LTC at either a fixed or a pre-arranged interval and additionally mandates that one RN must be on duty and present at all times (Government of Ontario, 2007). This requirement is not dependent on the size of the LTCH meaning that there is great variability in the RN to resident ratio (McCloskey et al., 2015). In LTC, personal support workers (PSWs) or healthcare aides provide an average of 2.26 hours of care per resident per day, while RPNs provide 0.617 hours and RNs provide 0.318 hours (OANHSS, 2015). This skill mix difference, including both regulated and unregulated care providers, is unique to LTC ultimately influencing the provision and quality of care as well as the roles and responsibilities of those regulated staff members.

As the educational preparation of the RN and RPN continues to evolve and the attitudes toward interprofessional relations change, defining the roles and responsibilities of each designation in LTC becomes increasingly difficult (Baumann, Blythe, Baxter, Alvarado, Martin, 2009). Theoretically, the RN possesses a greater depth of knowledge allowing for more

autonomy in decision making however complex or unstable the resident is, whereas the RPN possesses autonomy in decision making in stable and predictable resident situations (Baumann et al., 2009; RPNAO, 2014). However, as the complexity of LTC residents continues to increase, consultation with and availability of an RN should increase proportionately (CNO, 2005; Baumann et al., 2009). Defining complexity and instability in practice varies, especially as the context of LTC becomes more acute and complex (Baumann et al., 2009). The scope of the RN role is broad and can be perceived to be all encompassing yet LTC staffing models are most often designed to support the RN in the role as delegator, supervisor, and provider of other indirect care activities (McCloskey et al., 2015). RPNs, however, spend the majority of their time in direct care activities including medication administration, feeding, and personal care (McCloskey et al., 2015) and are not as well supported or prepared to perform those other duties.

The roles and responsibilities of the RN and RPN in LTC are variable and often dependent upon the home itself. RPNs in LTC often work within a robust scope of practice fulfilling point-of-care resident needs as well as leadership roles in order to suit the needs of the setting (RPNAO, 2014). RNs, despite their broader scope of practice, often fulfill administrative roles, oversee the activities within the home, provide consultations to the RPN when requested, and overall comprise a smaller percentage of nursing staff within LTC (Registered Nurses Association of Ontario [RNAO], 2007; RPNAO, 2014). Within LTC there is a need for further definition of the role and responsibilities of the nurse, especially of the RN, as the enhanced and at times stretched RPN role compresses the role that is typically associated with the RN out of necessity in the setting (McGilton et al., 2016).

In addition to the need to further define the roles and responsibilities of nurses in LTC, is the need to better emphasize and value staff education (CHA, 2009). The culture within LTC has

historically placed little emphasis on staff and their continuing education needs despite the complexity of care and demand in this setting (CHA, 2009). The nurses practicing within LTC are challenged with pressures to care for complex residents and are often overwhelmed by the tasks required of them - resulting in burnout, risks to both the nurse and the resident, and overall influencing quality and safety (CHA, 2009). Those ultimately responsible for encouraging continuing education and the supporting the transition of new staff into the clinical area are administrators and directors.

Influence of administrators and directors during transitioning. Supportive commitment from administrators and directors of care in LTC for both regulated and unregulated care staff is critical to job satisfaction, effective communication, and practice support (McGilton, et al., 2014; McGilton, McGillis Hall, Boscart, & Brown, 2007). For the NGN, orientation programs, educational opportunities, and structural empowerment all weigh heavily on the process of transitioning and readiness to practice and are a functional component of the administration role. While some research has been conducted on the perception of managers, preceptors, and educators on the transition to practice of new graduate nurses, it is relatively unknown what the role of LTC directors is on the transition process for NGNs in LTC.

New graduate nurses in long-term care. In Ontario, 8.2% of RNs and 31.2% of RPNs identify as working in LTC (CNO, 2015). Although the overall number of NGNs entering practice or employed by LTC is unreported, it is reported that 14% of new graduates matched by the NGG program, inclusive of both RN and RPNs, in 2013 were hired into LTC (Baumann et al., 2015). This number has been increasing each year as more LTCHs participate in the NGG

program (Baumann et al., 2015), more nurses exit the profession (CIHI, 2015), and the care needs within LTC continue to increase (CHA, 2009; CIHI, 2015).

Summary of Literature

The literature presented in this review highlights that transition to practice for the NGN can be a stressful and challenging experience intrinsically linked to personal, professional, and contextual factors. While there is theory related to the transition to practice experience of NGNs, the absence of literature regarding NGN transition to practice in LTC and the general transition experience of new graduate RPNs presents a compelling need to further explore this topic. Furthermore, there is a need to investigate how contextual factors affect NGN transition to practice in LTC.

Rationale for Study

Highlighted within the literature review is a gap in available knowledge as it pertains specifically to the NGN transition to practice experience in LTC along with more broadly the transition experience of new graduate RPNs. Through qualitative investigation this study will contribute to the existing literature and add the voices of those experiencing this journey within LTC. In the available literature exploring NGN transition to practice, much of the knowledge that is provided relates to the process of transition within the acute-care hospital setting. However, through qualitative investigation, this study will seek to understand the NGN experience of transitioning into a LTCH and the factors that influence their transition to practice.

CHAPTER THREE: PROPOSITIONS, CONCEPTUAL FRAMEWORK, & RESEARCH QUESTIONS

This chapter of the case study report presents the propositions that emerged from the literature review, along with the conceptual framework and research question posed in this study. The propositions and conceptual framework form the basis of the case study.

Propositions

Yin's case study approach recommends the use of propositions. Propositions: emerge from the literature review; direct attention to what requires further examination within the study; limit the overall scope of the study; and guide the research process (Yin, 2014).

Three propositions were developed based upon the review of the literature:

1. The transition to practice of the NGN in LTC will be experienced similar to that described in previous studies of new graduate nurses in the acute-care setting (Benner, 1982; Duchscher, 2008; 2009).
2. The context of LTC influences the new graduate nurse and their transition to practice experience within the setting.
3. The transition to practice experience of the RN and RPN in LTC will share similarities due to the influence of the professional context and the resident care required, as well as have differences based upon variable education and perceived roles and responsibilities in practice and care provision.

Conceptual Framework

A conceptual framework, supported by Yin (2014) can be driven by theory, literature, and common sense (Miles & Huberman, 1994). The purposes of the conceptual framework include: provision of parameters on who will and who will not be studied; description of what relationships may be present; and provision of an opportunity to organize general constructs (Miles & Huberman, 1994). A conceptual framework may be graphical in nature (Miles & Huberman, 1994). This initial framework (Figure 1) also served as a starting point for the development of a research question. The framework evolved alongside the research project and led to a final conceptual framework presented in Chapter Five.

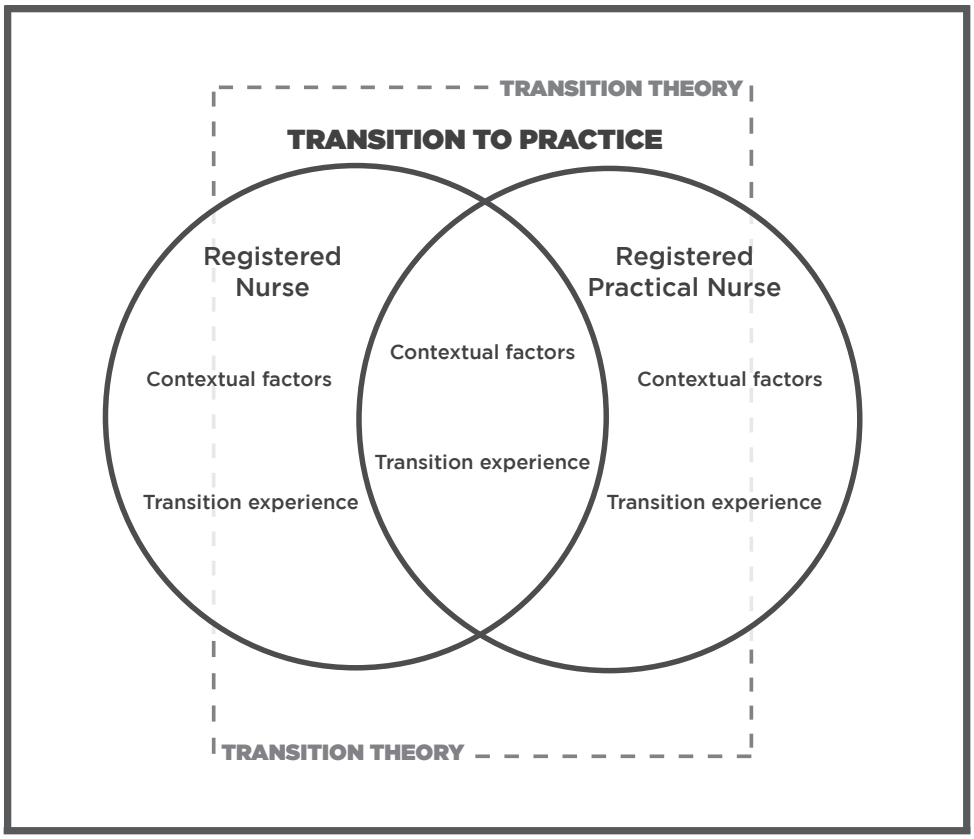

Figure 1. Initial conceptual framework

Research Questions

How do new graduate RNs and RPNs working in LTC in Southwestern Ontario describe their experience of transitioning into practice? What contextual factors influence this experience and how, if at all, does this experience differ according to nursing designation?

Ethical Approval

Final ethical approval was received from the Hamilton Integrated Research Ethics Board (HiREB) on December 2, 2016 (Appendix A).

Funding

This research project was partially supported by a research grant from the Registered Practical Nurses Association of Ontario (RPNAO).

CHAPTER FOUR: THE CASE AND METHODS

This chapter of the case study report presents the methods used to conduct the research. The study design, case binding, data collection, data management, and data analysis will each be described. Additionally, information regarding reflexivity, limitations, rigour, and trustworthiness are presented.

Case Study Design

The case study methodology, rooted in the social sciences, aims to understand the essence of a real, contemporary phenomenon within a specified context using multiple data sources without controlling the behaviour under study (Baxter & Jack, 2008; Creswell, 2013; Hancock & Algozzine, 2006). Case study research is methodologically challenging research as it requires precise binding of the case under study, known as the unit of analysis, as well as the utilization of multiple, comprehensive data sources (Baxter & Jack, 2008; Creswell, 2013; Hancock & Algozzine, 2006). Case study, unlike other qualitative study designs, can be used in both qualitative and quantitative research within a wide variety of fields including medicine, law, and psychology (Baxter & Jack, 2008; Creswell, 2013). Case studies report a case description with an understanding that the context in which the case is bound will influence the phenomenon of interest and the reported case themes (Creswell, 2013; Hancock & Algozzine, 2006).

Selection of case study approach. Robert Yin (2014) and Robert Stake (1995) describe two distinct case study approaches. Both of these approaches place emphasis on a deep exploration of an identified phenomenon for the purpose of revealing essence and stress the

importance of using multiple data sources (Baxter & Jack, 2008; Creswell, 2013). Where Yin and Stake's respective approaches differ is in the methods employed and the level of abstraction permitted (Creswell, 2013; Hyett, Kenny, & Dickson-Swift, 2014; Yazan, 2015). Yin's case study methodology is an empirical, stand-alone research approach that employs the use of rigour in the study design, encourages the development of propositions to guide the study, offers guidance in framing the question, utilizes an inductive strategy for data analysis, and has a post-positivist leaning (Yazan, 2015; Yin, 2014). Stake's approach, conversely, is not positioned as a research methodology, instead presenting the case as a bounded system under study (Creswell, 2013). Overall, Stake's research approach is more abstract, permitting for significant flexibility in the study progression, employing only qualitative data sources, and is overall a constructivist approach to inquiry (Stake, 1995; Yazan, 2015).

In selection of the most appropriate approach for this case study, consideration of the research question was a significant factor. Through examination of the research question as well as the available literature, the need for guiding propositions and the opportunity for embedded analysis of the separate nursing designations within the same phenomenon and context presented Yin's approach as most appropriate to answer the research question. The four main considerations for case study research as identified by Yin (2014) were met when the research question was developed. Firstly, the focus of the identified study was to understand a "how" or "why" question. The research question utilized "how" as the dominant action approach as the emphasis of the question was to explain the phenomenon of interest. Secondly, the transition to practice experience examined within this study would not be manipulated by the researcher. This study proposed no intervention related to the phenomenon and instead was interested in understanding the phenomenon as it occurred naturally within the identified context. Thirdly,

there was a belief, as identified by the literature and supported within the posed propositions, that the context of LTC influenced the transition to practice of the NGN. This consideration had implications for transferability of the study results and whether the conclusions could be applied in other contexts. In concert, the fourth consideration was that the boundaries between the context and the identified phenomenon were unclear but that a clear case could be identified.

Binding the case. In case study research, there is emphasis placed upon providing boundaries for the phenomenon under study in order to avoid having a research study that is too broad (Baxter & Jack, 2008). These boundaries provide clarification of what will and what will not be studied within the research study (Baxter & Jack, 2008).

The case. Case study research requires precise binding of the case under study. According to Miles, Huberman, and Saldaña (2014), the case is defined as the phenomenon occurring within a bound context with emphasis on multiple dimensions inclusive of the conceptual nature, social size, physical location, and temporality of the case. Utilizing this definition, the identified case was identified as: the experience of new graduate nurse transition to practice in LTC in Southwestern Ontario. Once the case has been identified, then it must be bound. This binding may take into consideration time, activity, location, as well as definitions to guide subsequent protocol decisions such as sampling and recruitment (Baxter & Jack, 2008). The case for this study, bound by the definitions of transition to practice and the NGN, was further bound by the study setting, as well as the study timeframe.

Study setting. This study was based in Hamilton, Ontario with the sample taken from two LTCHs. Similar in size and staffing structure, these two LTCHs served as the study context. In Yin's (2014) case study research, the context is an important component of the case further

contextualizing the phenomenon of interest. The setting not only provides a physical location, but also social size and temporality.

This explanatory case study, containing one single typical case, aimed to uphold the external validity of the experience. As described by Yin (2014), a typical case is utilized to capture and describe the conditions of a common situation. This typical single-case design ensured representativeness of a typical LTCH, with similar staffing structure and patient care ratios to that of the average LTCH in Ontario. The context, that of two LTCHs, was meant to bind and influence the case but the geographic location was not intended to influence the phenomenon of interest. Additionally, in selecting two large LTCHs within the city of Hamilton, the typicality of the single case is sustained and the research results will support transferability of the research findings.

Embedded units. Yin's approach includes the possibility of examining embedded cases within a single-case study design (Miles, et al., 2014; Yazan, 2015; Yin, 2014). This is an important consideration when studying the context of LTC as both nurse designations are employed and working within a high degree of autonomy and serve as the basis of the two embedded units. These logical sub-units add further context and binding to the case under study, allowing the researcher to study both within sub-units, between sub-units, and to then make assertions about the entire case (Baxter & Jack, 2008; Yin, 2014). This case binding is graphically represented in Figure 2.

Timeframe. The timeframe for this study is bound within the established NGN definition of one year of practice. This timeframe allowed for sufficient growth and experience of the NGN during their transition to practice without allowing for too much variability in experience or recall bias.

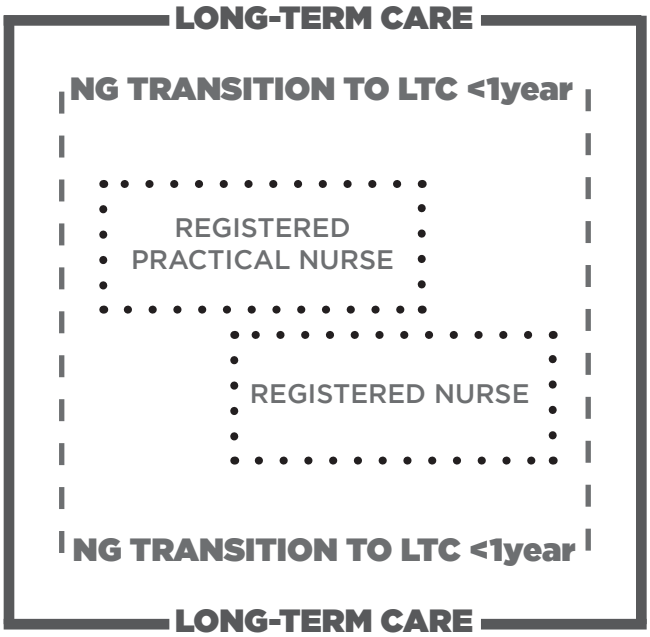

Figure 2. Case study binding

Method

Data sources. A key characteristic of the case study approach is the use of multiple data sources (Yin, 2014). This study involved Key Informants and Key Documents; two primary sources of data in case study research (Yin, 2014).

Key Informants. For this research project, Key Informants were those individuals who shared information, perspectives, and observations to inform the research study. Key Informants in this study included NGNs and LTC directors. NGNs were considered to be the primary sources of data because of their proximity to the phenomenon of interest and their ability to accurately describe their transition to practice experience. LTC directors were considered secondary sources of data because of their interaction with NGNs in their practice settings. These secondary sources were able to describe the transition to practice experience of NGNs because of their engagement and relationship with the new graduate nurses.

Key Documents. The collection of Key Documents is an important component of case study research as documents serve to corroborate evidence from other data sources, provide clarification of terms or concepts, and can promote further investigation related to inferences drawn from the document content (Yin, 2014). For this research project, Key Documents included orientation packages, programs to support NGN transition to practice, and policies related to nursing practice and orientation. These documents varied between the two LTCHs in both availability and content.

Sampling Strategy

In case study research methodology, sampling and recruitment strategies must be identified for each of the multiple data sources (Baxter & Jack, 2008; Yin, 2014). Within Yin's approach, it is important to identify the primary data sources which include Key Informants and Key Documents, a priori (Yin, 2014).

Sample size. Sample size within case study research is not explicit. Yin's (2014) case study involves a priori sampling decisions, inclusive of sample size, suggesting that as opposed to formulaic direction for sample size calculation, the complexity of the phenomenon is considered. Data collection included both new graduate RNs and RPNs, LTC directors, and various Key Documents. As such, from each of the recruited LTCHs the objective was to include a minimum of one to two new graduate RNs, two to three new graduate RPNs, one LTC director, and two Key Documents (Marshall, Cardon, Poddar, & Fontenot, 2013).

Sampling. Sampling within this study included various strategies as outlined in Figure 3

for each of the five identified samples including the geographic setting, the LTCHs, the primary Key Informants, and Key Documents.

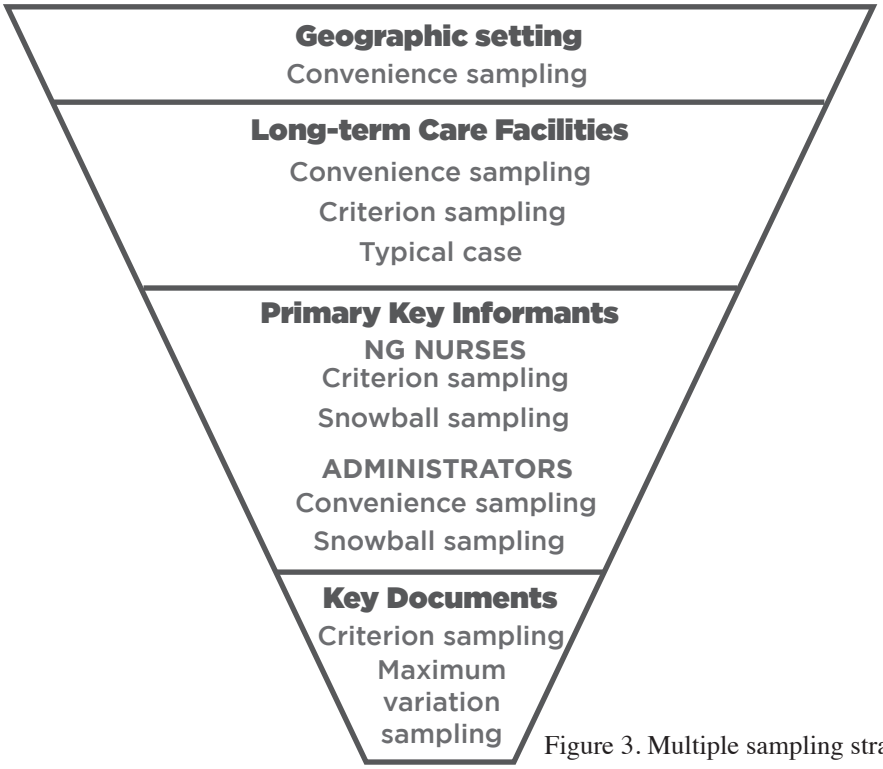

Figure 3. Multiple sampling strategies

Geographic setting. Southern Ontario and more specifically, Hamilton, was selected via convenience sampling (Creswell, 2013). The justification for the geographic setting of this study was twofold. Firstly, as the phenomenon of interest is NGN transition to practice, Hamilton is advantageously home to McMaster University and Mohawk College, both institutions with highly reputable nursing programs in Ontario. This provides an ample source and connection to NGNs of both professional designations. This geographic setting selection allowed for greater generalizability, as Hamilton is a large and diverse urban city comparable with many other Canadian cities. Secondly, Hamilton was convenient as it possesses 86 LTCHs within the Local

Health Integration Network representing the greatest LTCH density in the province (OANHSS, 2015). These LTCHs serve as the case context and provide sufficient opportunity for recruitment.

Long-term care. Sampling for the two included LTCHs involved combination sampling: convenience sampling based upon the geographic setting and criterion sampling to ensure the typical case study design (Creswell, 2013; Yin, 2014). In order for a LTCH to be recruited, certain sampling criteria must have been met: the home must have been located in Southern Ontario and must employ NGNs.

The justification for recruiting two LTCHs for study participation was in addressing the feasibility and timeline of the study. Since the phenomenon of interest is transition to practice within LTC, a sample of new graduate nurses within their first year of practice and still actively transitioning was required. In approaching two large LTCHs, it was more feasible to obtain the required sample size to answer the research question, recognizing that it was unlikely a LTCH would have more than a few NGNs at one time.

Primary key informants - New graduate nurses. Sampling of primary Key Informants, those NGNs employed within LTC, involved purposive sampling strategies (Baxter & Jack, 2008; Creswell, 2013; Yin, 2014). Purposive sampling ensures that the researcher has the opportunity to fully explore the case under study as well as the posed propositions (Baxter & Jack, 2008; Creswell, 2013). In holding true to the overall inductive approach to the study, purposive sampling provided opportunity to those who are information-rich within the case to share their stories, contribute to the understanding, and to inform the case themes (Creswell, 2013). Additionally, this sampling strategy provided a deeper understanding of the interplay between the sub-units, within the sub-units, as well as between the context and the phenomenon (Baxter & Jack, 2008; Creswell, 2013).

Sampling strategies for NGNs included criterion sampling (Creswell, 2013) as it is the phenomenon of transitioning to practice that this study aimed to explore. Within the literature there is an understanding that each NGN will experience transition to practice in some form or another. As such, exclusion criteria were set with NGNs being excluded from the study if their employment in LTC was not their first or only nursing employment position, whether in their current nursing designation or not, or if they did not meet the selected definition of NGN and had practiced for more than one year prior to the recruitment date. Additionally, snowball sampling (Creswell, 2013) was utilized in order to ensure that the sample size was met. NGNs sampled within this study were asked to share the study details and contact information with other NGNs within their LTCH.

Primary key informants - LTC directors. LTC directors were sampled through combination sampling that included convenience sampling, incorporating those directors who were willing and able to participate in the study; and snowball sampling, requesting that Directors of Care pass on study information to other potential study participants. These strategies facilitated varied information gathering while ensuring information-rich participation.

Key documents. Sampling strategies for Key Documents utilized criterion sampling (Creswell, 2013). Transition to practice, as per the literature review, is influenced by orientation programs as well as the systemic facilitators and barriers that the NGN experiences. To capture this context, important documents such as programs and policies were collected. Inclusion criteria for Key Documents, broad to accommodate the potential for variability between LTCHs, included any document related to the orientation of new staff or policy that may have guided the NGN. This strategy also employed maximum variation sampling as each participant was asked to discuss any relevant documents during their interview.

Data Collection

Yin's case study approach can involve the collection and analysis of documents, archives, interviews, observations, and artifacts (Yazan, 2015; Yin, 2014). The act of gathering data, as discussed by Yin (2014), is influenced by the individual researcher, as well as the a priori decisions established within the case study protocol. For this study, data collection involved semi-structured interviews with recruited Key Informants and Key Documents.

Recruitment. Recruitment for this study occurred within the binding of the case and within the natural setting. In order to gain entry into LTCHs in Hamilton, connections that thesis committee members possessed were utilized. The strategies for recruitment of Key Informants, such as NGNs, were varied in order to facilitate trust and awareness of the study throughout the LTCH (Namageyo-Funa et al., 2014). These strategies included posters (Appendix B), face-to-face recruitment, e-mails from identified gatekeepers, as well as the use of incentives such as a $25 coffee shop gift-card.

Interviews. This study involved semi-structured interviews conducted with Key Informants to explore the transition to practice in LTC (Yin, 2010; 2014). Interviews are a preferred data collection strategy in case study design as the purpose of the study is not to manipulate behaviour (Yin, 2014). Semi-structured interviews are not strictly scripted and instead involve a conversation based around a framework of questions (Yin, 2010). This organic approach allows for a two-way interaction, containing open-ended questions, and presenting the researcher with an opportunity to identify trends and context throughout the discussion (Yin, 2010).

Each interview was directed by an interview guide (Appendix C, D) informed by the reviewed literature, the transition to practice theory, as well as the study propositions, and designed to ensure appropriate questions were posed to the participant (Yin, 2014). The interview guide was pilot tested on two NGNs who had previously worked in LTC to ensure both construct validity and to gain practice in the interview delivery. NGNs were asked demographic questions with each participant interview scheduled outside of scheduled work hours at a mutually agreed upon, neutral location such as a public library or coffee shop. The focused interview was audio-recorded with two digital recorders and transcribed verbatim (Creswell, 2013; Yin, 2014). During each interview, notes and observations were recorded to add to the rich description yielded from the interview. LTC directors were interviewed (Appendix D) during work hours with emphasis placed upon their perceptions of and experience with good transition to practice. Interviews lasted for approximately 30 up to 90 minutes.

Once the interview guide was completed and it appeared that the topic of transition to practice had been exhausted, the data provided was summarized for the interviewee. Each interviewee was then encouraged to confirm or expand upon this summary of findings as a form of member checking (Creswell, 2013). At the close of each interview, participants were thanked for their participation.

Document review. In case study research, document review is an important data collection strategy (Yin, 2014). Key Documents were reviewed to determine how they contributed or influenced NGN transition to practice. Notes were transcribed onto the document during conversation with the NGN or LTC director.

Data Management

All interviews, documents, and notes were transcribed verbatim or scanned and imported into N-Vivo v.11.4 with all identifying information removed or redacted. The use of a qualitative data management system such as N-Vivo11 allowed for a greater amount of time for critical thought and interpretation of data and eased the access and retrieval of data during coding.

Data Analysis and Interpretation

In qualitative research, data analysis involves the preparation and organization of the data collected (Creswell, 2013) with all sources of evidence within this study reviewed and analyzed together (Yin, 2014). In reviewing and analyzing all evidence simultaneously, the findings of the study are based upon data convergence and not merely conclusions from each of the individual data sources (Yin, 2014). Yin describes the data analysis process in five iterative stages: compiling, disassembling, reassembling, interpreting, and concluding (2010).

Analysis process.

Compiling. Data were collected and analyzed concurrently in order to identify emerging themes, to inform future interviews, and to determine the point of data saturation (Creswell, 2013; Miles, et al., 2014). Data management software included N-Vivo11, allowing for data manipulation, coding, and ease of identification of themes (Creswell, 2013; Miles, et al., 2014; Yin, 2014).

Disassembling. The data reduction stage involved a hybrid approach to coding, allowing for the opportunity for inductive, a posteriori code generation while respecting the a priori decisions within the study and thus the data generated (Creswell, 2013; Yin, 2010). Initial codes

used in the analysis were based upon the literature review and the propositions that guided the study. This study utilized an edit organizing style of qualitative data analysis in which the researcher acts as an interpreter of the data, searching for meaningful units and organizing into categories (Creswell, 2013). These units were the codes, and the categories the broader themes. During the analysis process, any code that could not be categorized with the initial code-list was given a new code. Additionally, a constant comparative method was employed so that themes within the data could be identified (Yin, 2014).

To begin data analysis, two transcripts were coded independently, once by the researcher and again by the thesis supervisor. A meeting was held to discuss the coding and determine consensus. Following the initial consensus meeting, all remaining interview transcripts were coded with a final consensus of codes established by the supervisory committee. The final step of analysis involved a re-coding of all transcripts with the final code-list to ensure consistency across all transcripts.

Reassembling, interpreting, and concluding. Following data reduction and the coding of all transcripts, the data were reassembled for content analysis and interpretation (Miles, et al., 2014; Yin, 2010). This aided in the formulation of an overall description of the case as well as in establishing patterns (Creswell, 2013). Themes were identified from the code-list with some consideration of the frequency of codes within analysis. Code counts provided preliminary results to guide theme assembling but are not reported (Creswell, 2013). Themes and sub-themes were used to construct a fictitious narrative related to transition to practice in LTC. This interpretation of the reassembled data forms the analytic component of the thesis supported by the findings within the Key Documents.

Reflexivity

Within qualitative research it is widely accepted that the researcher is the research instrument (Pezalla, Pettigrew, & Miller-Day, 2012) and it is this level of researcher involvement within the study that presents the potential for researcher attributes, experiences, values, and belief systems to inform and influence every stage of the research process (Finlay, 2002). Reflexivity, the process of explicit analysis of self and role, is presented as a means to account for potential biases, transform biases into opportunities, and to improve the trustworthiness of the research study (Finlay, 2002).

As the primary researcher within this study, and as an identified RN and a novice nurse myself, reflexivity throughout the research process was important. As a novice nurse, I have been privileged to have spent a great amount of time with nursing students and NGNs in both informal and formal situations and have been privy to their voices and stories of their experience and transition. Through my involvement with the Canadian Nursing Students' Association as the national president, a voting board appointment with the Canadian Nurses Association, and work with other professional associations, unions, and education groups as a student representative, I have been tasked with sharing the student stories of unmet education needs, workplace violence, and the idea of nursing student leadership. It was these positions and these stories that challenged me to want to do this research, but more so, to want to continue to share the stories of new graduate nurses.

Throughout the research project and especially during data collection and analysis, I engaged in active reflection and journalling so that my personal feelings, biases, and presuppositions could be examined. This process allowed me to examine factors that may have influenced my interpretation and thus my report of the data. As a novice nurse versed in the

transition to practice literature at times there was a lot to unpack. To further bolster the rigour and trustworthiness of this study, I utilized member checking with the interview participant, and sought consensus on data analysis with my supervisory committee.

Rigour and Trustworthiness

Rigour and trustworthiness within qualitative research remains a contentious debate amidst the research community (Greenhalgh et al., 2016). Yin's (2014) case study research, from a positivist lens, is concerned with judging internal and external validity, construct validity, and reliability paralleling the qualitative concepts of credibility, transferability, confirmability, and dependability, respectively (Lincoln & Guba, 1985).

Internal validity. Internal validity of this study was enhanced through data convergence. Data in case study research is collected from multiple sources to establish convergent themes and a deepened insight into the phenomenon. This study included the analysis of interviews from Key Informants and notes from Key Documents. Additionally, the study included rival explanations in the discussion, furthering the plausibility of results presented and enhancing the interpretive validity of the study (Yin, 2014).

External validity. The objective of qualitative research is not to find a representative sample or to generalize findings beyond the study to other individuals (Creswell, 2013). Instead, qualitative research seeks to deliver a rich understanding of the phenomenon under study and in the case of case study, within the natural context. The external validity of this study was enhanced through a detailed description of the setting, the use of researcher and committee

member knowledge and expertise to inform the study propositions and data analysis, utilization of purposive sampling, as well as the inclusion of rival explanations within the discussion of results (Lincoln & Guba, 1985; Yin, 2014).

Construct validity. Construct validity was addressed within the data collection strategies utilized by decreasing the risk for bias and subjectivity (Yin, 2014). Member checking, the use of multiple evidence sources, and consensus from thesis committee members on established codes increased the construct validity of the study. Member checking of data required participants to respond to the accuracy of identified early and emerging themes at the conclusion of the interview (Yin, 2014). Additionally, reflexivity, the process of explicit analysis of self and role to account of potential bias, occurred at all stages of the research process further enhancing the construct validity of the study (Thorne, Kirkham, & O'Flynn-Magee, 2004).

Reliability. Yin (2014) identifies two key principles utilized within this study to increase the reliability of data collection. The first principle, utilizing multiple sources of evidence, is about converging lines of inquiry, a sort of triangulation method. This principle seeks truth value, in an understanding that if multiple sources within the same study provide convergent answers there are fact statements. The second principle, creating a case study database, is completed through the systematic storage of notes and narratives in order to ask questions of the data during coding. This principle allows for deeper and more thoughtful analysis of the data.

The case study report, in itself an identified method of increasing reliability, outlines the use of constant comparison, the development and utilization of a code-list, and the checking of codes with committee members to improve inter-rater reliability (Yin, 2014). Additionally, the

committee members shared their interpretations of the data, providing investigator triangulation and furthering the reliability of study results (Lincoln & Guba, 1985; Yin, 2014).

CHAPTER FIVE: FINDINGS AND INTERPRETATION

Findings from this study describe the experiences of seven NGNs and the perceptions of two LTC directors related to NGN transition to practice in LTC. These NGN participants described their transition into professional practice in LTC as a rapid progression from the NGN to that of a nurse leader. Study findings are first presented in a first-person narrative vignette of a fictitious NGN in LTC. This vignette highlights the voice of the NGN participants and provides an overall impression of the study participants. The vignette is presented with the key themes that emerged in participant interviews on the right-hand side and in three separate sections to present: the characteristics of the NGN, the contextual factors of the LTCH, and the process of becoming a nurse leader within this setting. Following the vignette, groups of themes are presented sequentially as they relate to the process of becoming a nurse leader in LTC.

While these findings are at times presented as discrete themes, it is important to note that the themes presented overlap and influence one another. This is consistent with case study research (Yin, 2014). Exemplars from both NGNs and LTC directors are included in latter sections to illustrate findings throughout this chapter in order of how they appear within the vignette.

Narrative Vignette

Introduction of a New Graduate Nurse *This is a whole new role for me, I'm a fresh RPN and I've not really done much except school… even our preceptors said we had a lot of life to*	Lack of life experience

experience yet, and that being so young we would see things that would be really hard on us. Unlike some of my classmates, I never experienced the death of a patient before or even a family member and I don't know if I'm ready to have that conversation with families yet, like what would I even say?

As a recent new grad nurse, I really didn't think the only place I would find work would be in a long-term care home. I never even had a placement there, and have no idea what a nurse's role is. I'm hoping the consolidation placement I had in medicine prepared me enough for this.

Lack of LTC experience

I'm really scared that this job isn't going to be at all like the hospital and that I will forget a lot of what I learned in school. I remember our teachers talking about how important our skills were as nurses and you know what they say - use it or lose it and I really don't want to lose my skills. One of my friends got a new grad position on a surgical floor and she told me to just be myself and take on every opportunity that comes my way and then I won't have to worry about losing my skills. I know she's right... I just want to be a great nurse.

Fear of losing skills

Willing to take initiative

Influence of the Long-term Care Context

Working in LTC is nothing like I expected, but really I had no idea what to expect in the first place. I was hired into a casual position, so I only get one or two shifts a week and it's really hard to get into the flow of the work. I know if I had a full time position I would be more engaged with the work and have a better idea as to what my job is. I'm here so infrequently that I feel like it's a

Casual workforce

different place every time I come to work, I'm always rushing to finish one task, only to have to scramble to the next.

I feel like there just isn't enough time to get everything done. That's one of the hardest parts about working here, you constantly feel like there isn't enough time and I really struggle with that feeling. I want to be a great nurse, but there are just so many residents that I don't feel like there is enough time in the day to spend a significant amount of time with each one. I mean, I should have figured the pace of this job was going to be rushed, my orientation was even cut short from the three days and three nights down to two of each because of an outbreak on another floor. I know my mentor gave me a checklist and showed me what I'm supposed to do as a nurse here, but I really would have liked more time for orientation and could use more time each day to care for the residents.

Lack of time

for orientation

for resident care

My expectations of what a nurse does in LTC is very different from the reality here. There sure are a lot more expectations put on me as the nurse than when I was a student. Nurses are considered leaders in this role, regardless of the RN or RPN designation. We are expected to be confident, work in a team, communicate effectively, self-reflect, and time manage. I found this really hard because all the hospital placements I had, it really only showed the RN in the leader role. As a new grad RPN in LTC I have a lot more autonomy than in the hospital because I'm often the only registered staff on the floor. I mean, it really forces you to be more confident and to really critically think about scenarios. When you don't know something – which is

Expectations of the nurse role

Autonomy of the RPN role

pretty often, and you only find out once something happens – there often isn't anyone else to ask. I can call one of the nurses on the other floor, but they are often so busy themselves that they can't get back to me very quickly. I don't have the luxury to just wait, so I often just have to make a decision. I know most of my friends from school don't think long term care is a great place to work and even might look down on it as some kind of "lesser" nursing role. Even when people ask me where I work they automatically assume I'm a nurse in a hospital. I'm worried that if I'm finding the work here to be too hard that I won't be able to handle a job anywhere else.	Isolation in practice Long-term care not viewed as a desirable workplace
Transitioning to a Nurse Leader	
There were a lot of expectations placed on me to be a leader when I got this job, and it really took a lot of time and growth to meet those expectations. I really struggled to meet the demands that my colleagues placed on me, but I was quick to see what was expected of me was what I needed to be successful in LTC. I think the hardest part of meeting those expectations wasn't the tasks themselves, but that there was so little time for me to reflect and build on my experiences. I didn't have anyone to help me work through my experiences, and I had to build those skills on my own. Practicing and providing care on my own as a new grad helped me to develop faster than I think I would have in other settings, and I learned to rely on my team and the people I work with. I feel that I am getting better day by day, developing those skills and that confidence despite the hiccups along the way. Really, transitioning here has	Struggling to meet expectations Practicing in isolation Relying on others Developing skill and confidence

been tough but overall I think it has been a positive experience. I now know how complex LTC is, you know, that it is not an easy place to work, but I have come to love it.	Recognizing complexity and value of LTC practice

This vignette was built from the nine completed study interviews. The themes, highlighted on the right hand side of the vignette, serve the basis of a conceptual model (Figure 4) entitled "From New Graduate Nurse to Nurse Leader". The conceptual model introduces four distinct groupings of study themes: 1) the characteristics of the new graduate nurse; 2) characteristics of LTC; 3) the contextual factors in LTC that influence NGN transition to practice; and 4) how these factors accelerate the development of the NGN into a nurse leader. Each of these groupings is further explored.

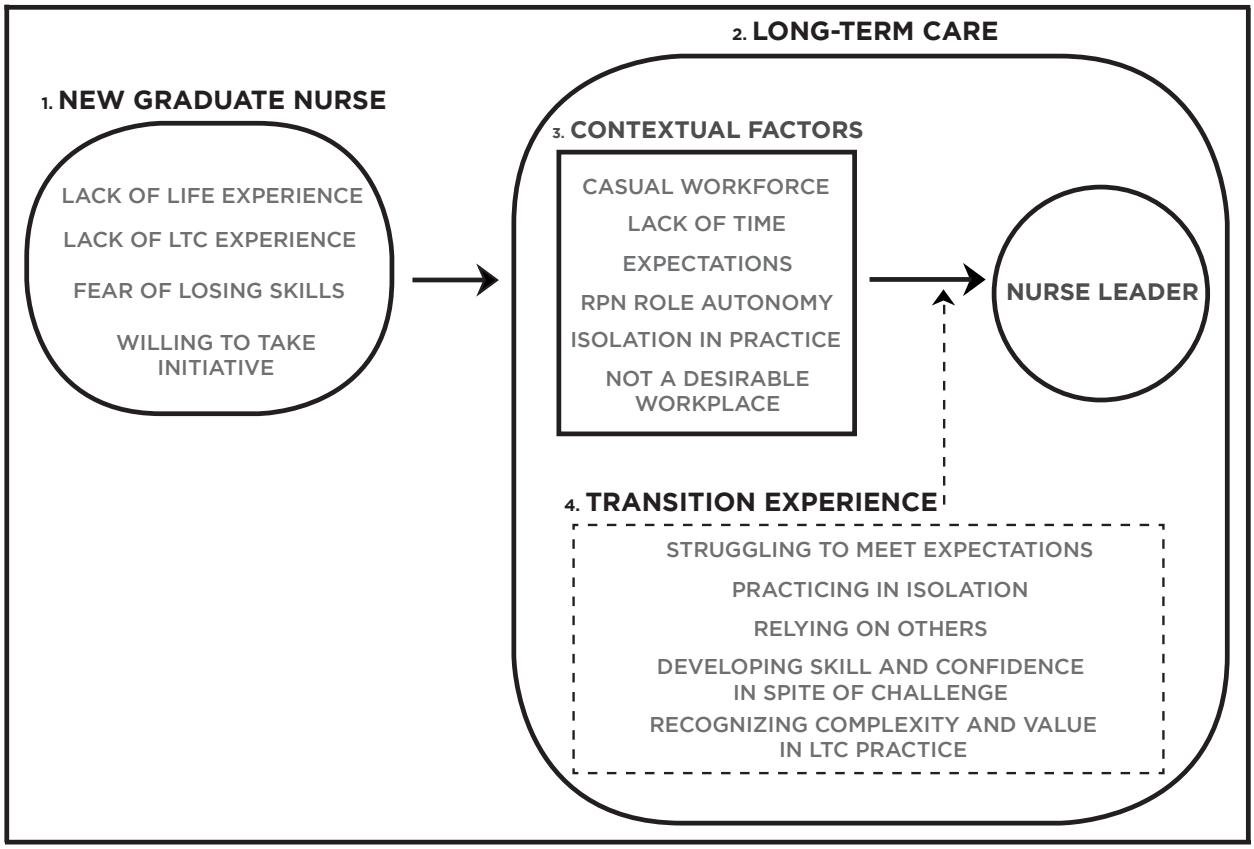

Figure 4. From New Graduate Nurse to Nurse Leader

1. New Graduate Nurse Characteristics

The seven recruited NGN participants in this study were within their first year of professional nursing practice and were employed in one of two LTCHs. The first LTCH had three participants: 1 RN and 2 RPNs; while the second LTCH had four participants: 2 RNs, and 2 RPNs.

New Graduate Nurse Demographic Analysis. Demographic data were collected at the beginning of each of the NGN interviews (Table 1). Of the seven NGNs interviewed in this study, all were under the age of 25 years and six identified as female. The sample included a split of four new graduate RPNs and three new graduate RNs. Four of the study participants described having less than six months experience as a nurse at the time of the interview with the other three having less than one year of experience. Six of the participants interviewed had no previous healthcare experience while one participant had worked as a healthcare aide in a local hospital. Lastly, four of the NGNs were employed part-time at their respective LTCH, while the other three were employed casually with their LTCH employer.

Characteristics. Four general characteristics possessed by the NGN were described by both NGN interview participants as well as LTC directors: lack of life experience, lack of LTC experience, fear of losing skills, and willingness to take initiative.

Lack of life experience. LTC directors described NGNs of both professional designations as young and lacking in life experience.

> *"One of my new grad nurses, she's been here for almost a year now. She's very good but she's young. They're young when they come out [of school] and they don't have life experience. When you've gone through things in your life whether it's deaths at home or different things over time I think you*

build a thicker skin or look at the world differently... They're new, they're fresh, and they expect everybody to be so sweet." - Director participant

Demographic Variable	Number (%)
Gender Identity	
Male	1 (14%)
Female	6 (86%)
Professional Designation	
Registered Nurse	3 (43%)
Registered Practical Nurse	4 (57%)
Age Range	
< 25 years	7 (100%)
Length of Time Practicing as a Nurse	
< 6 months	4 (57%)
6 - 12 months	3 (43%)
Prior Healthcare Experience	
Yes	1 (14%)
No	6 (86%)
Work Status as a Nurse	
Part-time	4 (57%)
Casual	3 (43%)

Table 1. Demographic variables

While this theme was not explicitly confirmed in the discussion with NGNs themselves, NGNs acknowledged fear and apprehension related to experiences such as death and difficult conversations not yet experienced in their lives or previous clinical placements.

> *"In the beginning it was really hard because we had like nine residents die in one week after an outbreak. I had never even lost a family member let alone been there with someone who was dying."* - New graduate RN participant

> *"In terms of speaking with physicians and other nurses I was scared at first just because I mean it's scary to speak with someone whom you don't know very well and I'm a non-expert and have no experience. I was afraid of having those hard conversations and having to meet with families. I wasn't used to that."* - New graduate RPN participant

These findings are supported by the demographic variables as all NGN participants identified as being under the age of 25 and only one described any previous healthcare related experience.

Lack of long-term care experience. The perceived youth and inexperience of NGNs in LTC as described by LTC directors is compounded by their overall lack of experience and exposure to the LTC system. Almost all of the NGN participants described never having had clinical placements in LTC, not knowing the role of the nurse in this setting, and misaligned expectations of LTC and their role as a result of placement experience solely in the hospital setting. Only one of the participants described having had a placement in LTC during their education.

> *"No, I don't think my placement in long-term care really prepared me all that much for working here now. It [the placement] was when I was in first year and it was mostly about giving bed baths. There was nothing about the role of the nurse in long-term care. Now that I'm here it was more PSW work than anything."* - New graduate RN participant

> *"I was so nervous going into nursing in general and then when I went into long-term care as a nurse it was not what I expected it to be. It's a lot different than a hospital environment which is where I gained all of my placement experience and so when I went into long-term care it was a lot different than what I was used to."* - New graduate RPN participant

The lack of life experience, and lack of LTC experience challenged the NGN during their transition to practice as it meant that the experience that they garnered during their professional

practice was often entirely new with little to no ability for the NGN to draw upon previous experience or learning.

Fear of losing skills. Participants described a fear of losing skills acquired in other hospital based placements and education by virtue of being employed in LTC. NGNs feared that by working in LTC that they would be ill-prepared to transition into a role in an acute-care setting in the future because of a loss of specific skills.

> *"I feel like we don't practice as much of our skills. So a lot of things I feel like I'm kind of forgetting how to do which I feel like if I was in hospital I'd probably get more experience doing and I feel like as a new nurse it's probably better to practice those skills now because if you don't use it, you lose it."* - New graduate RPN participant

> *"I guess I am fearful that if I lose my skills I won't be able to get a job in hospital in the future."* - New graduate RN participant

NGNs identified some of the skills that they were concerned about losing of which task-based skills like bladder scanning and tracheostomy care prevailed. The emphasis on task-based skill development and maintenance was described by NGNs of both nursing designation as well as LTC directors.

Willing to take initiative. Another characteristic of the NGN identified in this study was an overwhelming willingness and enthusiasm to take initiative in their learning. NGNs expressed that being unfamiliar and lacking in exposure and experience with LTC required them to be motivated in addressing their own learning needs.

> *"It just keeps me on my toes. [laughter] Not knowing what I am doing some days is hard but it just really makes me want to become a better nurse every single day and so I take the time to learn new things."* - New graduate RN participant

NGNs in this sample were described by one LTC director as "resilient" acknowledging that the context and environment in which NGNs transition into practice within LTC is "challenging"

and “scary”. This described resilience is demonstrated through their willingness to take initiative within their practice despite being “overwhelmed” with new information, tasks, and responsibility. The NGN described a sense of responsibility in their learning and applied that through pushing themselves to learn more and practice new skills.

Summary of New Graduate Nurse Characteristics. The seven NGN participants included in this study were overall quite similar. Demographic data revealed that the majority of participants were female, under the age of 25 years, and had little to no prior healthcare experience excluding their clinical placement opportunities. There was a mix of both RN and RPN new graduate participants. In discussions with the NGNs and the LTC directors, NGNs were further described to be lacking in life experience, lacking in LTC experience, afraid of losing clinical skills, and willing to take initiative in their learning. These described characteristics provide a overall description of the NGN participants prior to entering the LTC practice setting and their transition to practice experience.

2. Long-term Care Characteristics

Participants in this study were recruited from two LTCHs in the city of Hamilton, Ontario. The first LTCH was recruited in December 2016 and is privately owned. The home is of a moderate size with over 100 resident beds, is a faith-based setting, and accredited by Accreditation Canada. Recruitment for the second LTCH occurred in February 2017. This second home is a public, non-profit facility, also accredited, and has over 200 resident beds. Both homes employed a similar number of NGNs and had similar nursing staff to resident ratios for both the

day and night complement. It is important to acknowledge that these two LTCHs have positive reputations for providing quality care in the community that they serve.

3. Contextual Factors that Influence New Graduate Nurse Transition to Practice in Long-term Care

This case study report helps to explain how contextual factors present in LTC influence the transition to practice experience of NGNs in LTC. Six contextual factors were described by NGNs and LTC directors as influencing the transition to practice in LTC: a casual workforce; a lack of time for orientation and resident care; expectations on NGN practice; autonomy of the RPN role; isolation in practice; and LTC not being viewed as a desirable workplace. Each of these factors present in LTC and their influence on the NGN during transition to practice is explained.

Casual workforce in long-term care settings. Supported by the demographic data, NGNs and LTC directors described a workforce that was increasingly casual in nature for both the RN and the RPN. NGNs employed in the sample were employed in either casual or part-time positions with no NGN participants describing their employment status as full-time. Casual employees are those employed in positions that do not have regular work hours with no guaranteed shift hours within a pay period. Most often, those who work in casual positions fulfill call-in shifts and cover vacation hours of those in more regular positions.

> *"For our casual positions they really only get shifts for sick calls and vacations so it tends to only be on-call work."* - Director participant

Part-time NGN employees, although scheduled to work more regularly, experience challenges during their transition to practice along with their casually-employed NGN colleagues. These challenges include expressed difficulty being and remaining engaged in learning and the culture in their LTCH and difficulty finding a rhythm in their practice.

> *"I was really excited to start my job. When I was offered a casual position I took it but now I see how hard it is to attend education and staff meetings when I am only there once or twice a week."* - New graduate RN participant

When asked about how their casual or part-time status challenged their transition to practice, NGNs described not being able to "keep up" with resident changes and home practices and also described not feeling like a part of the team. LTC directors further supported this theme by adding that NGNs, because of their casual or part-time employment status, were unable to attend practice or staff meetings and thus could not fully engage in the staff culture.

> *"We offer monthly nursing practice meetings for all staff, all nurses. We don't see many of the new grads coming. New grads are typically in casual positions here so they're not always here when we have those resources and supports or opportunities in place."* - Director participant

> *"It's really hard to be that engaged in a place where you're maybe only here a couple of times in a month."* - Director participant

Additionally, the casual and part-time work status of the NGNs influenced their ability to find a rhythm or pattern within their practice in LTC because of their sporadic attendance. This included their ability to coordinate care.

> *"Because I am only here maybe once or twice a week, it's hard to organize myself and what the residents need. I do my best, but I find just as I am getting some sort of rhythm the shift is done and I'm not back for another week or something."* - New graduate RN participant

NGNs noted that when they would report for their next shift, they often found themselves on a different floor than previous shifts and even on a floor where they had not received orientation.

> *"I find it very challenging. I love working there, don't get me wrong. I love my job there but it's not like you're starting in a full-time position, you're casual or at best part-time. So you get used to not knowing. You come into a shift and are asked to go to a floor you've never been on so you're jumping around and don't have the opportunity to learn your resident or your care."*
> - New graduate RPN participant

LTC directors widely acknowledged the challenge that NGNs experienced being offered only casual or part-time work and expressed that it was not "ideal" to have to work two or three jobs in order to have full-time hours. When asked about employment preference, RN new graduates tended to prefer the "flexibility" that part-time employment offered while RPN new graduates largely wanted full-time work. Neither designation expressed a desire for casual employment and several of the study participants described actively searching for another job.

Lack of time. The second contextual factor that influenced NGN transition to practice in LTC was a lack of time for the nurse and the nursing role. This lack of time was related to both the orientation period as well as to the time required to provide care to residents.

Lack of time for orientation. Orientation in LTC is variable in comparison to hospital-based orientation for new hires. It was described that within LTC, rarely are there more than one or two nurses hired at the same time, and so the orientation for each NGN tended to be dependent on staffing availability, needs in the LTCH, and, according to the NGN, their own ability to articulate learning needs. On average, both NGNs and LTC directors described an orientation period of four to six mentored shifts inclusive of both day and night shifts. However, dependent on other factors, orientation for many of the sampled NGNs was cut short.

> *"It was supposed to be three days and three nights but I was sick for one day and one night. I only had two days and two nights. Then I was kind of thrown into it."* - New graduate RN participant

> *"I was supposed to have each of my orientations on a different floor but unfortunately because of staffing, I ended up having a majority of my orientation sessions on the same unit. So the first day I just shadowed whichever nurse was working and then after that subsequently they just let me run the floor."* - New graduate RPN participant

NGNs described a desire to have more time for their orientation. This was related to their orientation being cut short in some instances, but also related to an acknowledgement of the volume of tasks, competencies, and skills required within the role.

> *"I think just having more time for orientation would have been helpful because when you're working in the evening or the night, you're the only one there and so there is a lot for you to know especially when you first start out."* - New graduate RN participant

LTC directors described reliance upon the mentor of the NGN during their orientation to ensure a meaningful orientation period and to provide a contact person for the NGN to connect with if they had questions later.

> *"I wish we had more resources and opportunities to support new grad nurses. We have developed a mentorship program here which is probably a year and a half old and we're still fine-tuning it. It's to support that orientation process as well as understanding a little bit about the organizational culture. Sort of what the norms are, what the expectations are, and promoting a safe place to ask questions where you don't feel judged or anything like that."* - Director participant

While one LTCH had an organized mentor program, NGNs did not reap the benefits of the program because of described time constraints on the mentor and the NGN.

> *"When I had my very first shift I was told that I would have a mentor so any time I had any issues with anything, I'd be able to ask my mentor, text them or communicate with them whenever. But since I started practicing, I don't even remember who my mentor was. Early on I tried to connect with them but they were busy. I feel like theoretically, that would've been amazing but in actuality, it just never happened."* - New graduate RPN participant

Neither of the LTCHs in this study had a formal nurse educator employed, potentially further contributing to challenges with orientation for the NGN. Documents and competency pathways

present were designed and described by the NGN and LTC directors to help guide them during their orientation period.

Task- and competency-based skill acquisition was a key characteristic of the orientation period. Each LTCH had an on-boarding document outlining the required competencies and skills for newly hired staff to complete as well as to guide learning plans. These Key Documents were the same for both the RN and RPN, and outlined skills such as: knowing how to process orders in the evenings, how to complete a transfer to hospital, and how to use an insulin pen. In one LTCH, this document required the NGN to have a mentor sign-off on their proficiency in each of the skills. In the other LTCH, the document required the NGN to self-reflect on their competency prior to signing off.

Another Key Document that was examined from the first LTCH was a policy regarding general orientation. This document provided an overview of the mandatory orientation education required of each new hire inclusive of: review of the resident's Bill of Rights, understanding of emergency and evacuation procedures, completion of specific learning modules online, and more general topics such as prompts for the NGN to review material on topics such as duty to report, bullying, and harassment. Complementary to these documents, new hires at both LTCHs were directed to the Registered Nurses Association of Ontario (RNAO) Long-term Care Best Practices Toolkit (RNAO, 2016). This toolkit provides Best Practice Guidelines (BPGs) relevant to LTC, BPGs on healthy work environments, as well as quick links to relevant legislature (RNAO, 2016).

These documents, policies, and toolkits aim to supplement the learning of the on-boarding nurse in LTC. However, the documents and shortened orientation period did not address

many of the nuances of care provision in LTC leading to a misalignment with initial expectations for the NGN during their transition to practice.

> *"I expected my orientation to have more hands-on training related to care provision and I expected there to be, you know, someone available more often to kind of answer those questions and to be that support in case we came into the situation that we needed it."* - New graduate RPN participant

This misalignment challenged the NGN and their practice as many of them expressed that they did not feel ready to leave orientation and practice autonomously.

> *"Oh God no, I did not feel ready. I just got thrown into and sort of hoped for the best."* - New graduate RN participant

Some participants felt that they needed extra time to learn about skills that they did not have previous training for.

> *"I felt like I was ready [to leave orientation] for things like administering meds, doing dressings, those sorts of things. But other responsibilities, like doctor's orders, computer assessments, stuff like that that I had no exposure to prior, I had no idea. Practice-wise I felt okay."* - New graduate RPN participant

One NGN participant described receiving their orientation to LTC from another NGN.

> *"Well I was supposed to receive my training from an RN who had been there for many years but she retired so instead the person who oriented me was actually a nurse I graduated with a few months before. She was still learning as she was training me and so in that sense she was very relatable but I definitely did not feel ready to be on my own."* - New graduate RN participant

When asked during the interview if additional orientation had been requested as a result of feeling unprepared, several NGNs identified that they had asked, but that their request had been denied because of staffing issues or other requirements. This challenged the NGN as they felt disempowered and not in control of their orientation, and subsequently, of their practice.

Lack of time for resident care. Lack of time for resident care was also identified as a contextual factor influencing NGN transition to LTC. NGNs as well as LTC directors identified that the volume of tasks and responsibilities, the nurse to resident ratio, and the rapidly changing clinical environment all at times contributed to a sense of having inadequate time for nursing care.

> *"I've had new graduates say 'I want to sit and talk with them but I don't have the time'. I know. They want to have that moment where they could sit and spend five minutes talking and find out what's going on and really get a good assessment with the resident. You don't get that. There is not the time for it."* - Director participant

This lack of time contributed to many of the challenges that NGNs and LTC directors identified regarding practice in LTC and also overall contributed to a decreased quality of care for the resident. NGNs felt that during their transition to practice experience there was a misalignment between the idealized "nurse I wanted to be" and the nurse that they instead became because of time constraints.

> *"You are so tight for time that I think that the residents aren't getting the care or the services that they need when they need them and that this impacts their health."* - New graduate RN participant

> *"I think there is a realization that they are not the nurse that they wanted to be. Right? With the one nurse to 30 residents and trying to get everything done in a specific time frame."* - Director participant

This significantly challenged the NGN in their transition to practice experience as many of them articulated that "making a difference" and "helping people" were the primary reasons that they entered nursing in the first place.

Expectations of the nurse role in long-term care. Throughout the interviews, NGNs and LTC directors identified several skills and attributes paramount to practice in LTC and to the

transition to practice in this setting. These skills and attributes relate to the overall development of the NGN during their transition to practice experience, were described as supportive during challenges in the transition experience, but were overall framed as expectations of the NGN during their entry-to-practice. These skills and attributes were: confidence, teamwork, communication, self-reflection, and time management and were identified to be expectations of the NGN from LTC directors as well as the NGN. Each of these five skills and attributes are described as they related to the NGN and their transition to practice experience in LTC.

Confidence. Confidence and the "need to feel confident" were identified as essential attributes by LTC directors and the NGNs during their transition to practice. Their level of confidence was identified as an attribute that supported them during their transition to practice experience. This was especially the case for challenges rising out of increased autonomy in their nursing role as the NGN grappled with making decisions and assessments and being confident in those selected interventions. NGNs were able to reflect upon their confidence development as they transitioned into practice.

> *"I've seen drastic changes just in how I perform at work. I have more clarity as to what I'm doing and my critical thinking skills have improved just based on, you know, situations that arise that you can't control and have to think on the spot in. All this experience has improved my confidence level which makes me think that I can do what I need to do."* - New graduate RN participant

> *"There's a lot of differences between being a student and a new grad in terms of confidence level. I think when you're a student your confidence level is pretty up there because you have someone to go to who gives you the assurance that you are doing things correctly whereas being a new grad you are unsure if you are doing things properly, if you're following the policy, and if you are right in terms of medications. I think that the biggest difference between being a student and being a novice nurse is that you have so much responsibility on your hands and you have so much pressure to do things correctly. Confidence is so important and you slowly build it back after becoming a new grad."* - New graduate RN participant

Confidence and the need to feel confident in decision making and task completion was identified by the NGN as required in LTC. Confidence was related to the idea of "knowing the resident". This concept related to NGNs as their casual or part-time employment status hindered their ability to get to know residents and their individual preferences for care.

> *"I think that knowing the resident is the most important thing to know because once you know the residents, everything else becomes so much easier. Once I worked two to three shifts on each unit, when I went into work I just knew what I had to do. When you don't know them, you're kind of thrown into the deep end and you kind of have to sink or swim sort of thing."* - New graduate RPN participant

> *"[Knowing the resident is] very important. It's so super important, especially with this population, because a lot of them, they don't even know their own name. You're going around, and you're wondering, 'Okay, I need to give this medication to Maria' for example. They have pictures on their profiles, however, some of them have been there for many years, and they're not updated for a period of time, and their photo no longer looks like them. You know what I mean? You need to know the resident and once you do you can be confident in your care."* - New graduate RPN participant

Teamwork. The expectation of teamwork was described by NGNs to be inclusive of those healthcare providers that the NGN worked with day-to-day. These team members included physicians, other nurses, PSWs, and the leadership team at the LTCH. Team cohesion and effective teamwork were described to support NGNs when challenged with feelings of isolation, variability in the practice environment, and expected leadership. One of the important components of this team dynamic was comfort in the interactions with the team members.

> *"I think it's important that if I have a silly question or if they have a silly question, we're all comfortable and have to come to each other and ask just because we want to make sure that the residents are put first and are kept safe."* - New graduate RN participant

In addition to comfort, there was a certain degree of trust that NGNs placed in other team members in order to assist them.

> *"Whenever I don't know something I just try to ask someone else like my nurse partner or the director if it's during the day. I guess I sort of just trust that my colleagues will know the answer and will help me."* - New graduate RPN participant

Teamwork was described by NGNs to not only be an expectation in LTC, but a necessity of practice.

> *"Well, you're new and you are just learning and so you, well, you have to work together. Like, it would be so much worse if I didn't have the PSWs to count on. They are my team and I would be lost without their help."* - New graduate RPN participant

Communication. NGNs described the importance of and their overall development of strong written and verbal communication during their transition to practice. NGNs acknowledged that one of the primary foci of nursing education is effective communication and that this focus assisted them in their transition experience and their general practice.

> *"A lot of our education is based on communication and so I think that it has prepared me [for LTC]. Since starting at [LTCH name] I have definitely improved on how I communicate with other nurses and I find that this makes everything better."* - New graduate RPN participant

> *"Communication skills are super important. It's telling your nurse partner that you need help or delegating a task to a PSW. It's processing doctor's orders or having to call the on-call manager in the middle of the night. Communication will make or break you in this environment I think."* - New graduate RN participant

Challenged by a lack of time and many other contextual factors, NGNs developed communication skills in order to effectively deliver patient care and manage the floor that they worked on. NGNs described the role of the nurse as being the "go-to" person for all activity within LTC including the healthcare team, the residents, and their families.

> *"Communication is huge. It's about knowing everything on your floor with your residents. It's about the expectation that you're the first contact with the families, you're the first contact with the PSWs, or the doctor. Communication is really about owning the floor and making solid decisions."* - Director participant

The expectation of being this "go-to" person challenged their practice and their experience as they were trying to settle into their own role and other responsibilities.

Self-reflection. Self-reflection and the ability to ask questions were touted as important activities for NGNs during their transition experience and another expectation of the NGN. Both of these activities were viewed as components of "active growth" and contributed to building confidence and developing further team cohesion.

> *"I think that knowing that I am capable of being a nurse is kind of nice. It's those 'I can do this' thoughts. Every once in a while I will feel like I have no idea what is going on and really ask myself a lot of questions and reflect. Some days there are a lot more of the questions than the answers to be honest but I don't know if that will ever go away 100 percent."* - New graduate RN participant

> *"I tend to use almost a CNO [College of Nurses of Ontario] standard model. I ask myself 'Are you confident enough?', 'Do you have the knowledge, skill, and judgement?' It saves me from getting into trouble and biting off more than I can chew I think."* - New graduate RPN participant

Many of the NGNs credited their education and specifically reflection activities in their education in preparing them for self-reflection in practice.

> *"When something happens, whatever it is, I find myself reflecting. It's how I was taught to process things and it's how I ask myself those important questions. I guess I had really good clinical preceptors who encouraged that."* - New graduate RN participant

Self-reflection and asking questions were reported to help NGNs with the challenge of isolation in their practice, the variability observed between residents, the autonomy of their role, and the leadership required.

Time management. The importance of time management skills was not overestimated in the interviews with NGNs. In an environment identified as "lacking" in time, NGNs felt that it was a necessity and an expectation to develop strong time management skills.

> *"I think time management skills are important everywhere, but I think it's really important in long-term care. You should know how long things take so that you can stay on top of other tasks because it is really easy to get behind."* - New graduate RN participant

> *"How do I give care to all of these residents but also attend to the more chronically ill residents at the same time? Multi-tasking is definitely a factor. Beyond that though you need to be able to manage your time effectively, you can only multi-task for so many tasks."* - New graduate RN participant

Time management skill development required exposure and experience to the day-to-day work and nursing practice of LTC according to NGNs. Participation in every day tasks and developing a routine in the practice setting allowed the NGN to expand their time management skill as there was increased familiarity with expectations of them as well as the ability to predict what would require their time.

> *"Time management skills are definitely something that you develop. The organization of your tasks plays a big role but I think it also just comes with experience because once you're more familiar with the work you need to do, you can organize yourself better whereas if you are not familiar it is harder to do."* - New graduate RPN participant

Summary of expectations. The skills and attributes required and developed by the NGN during their transition to practice assisted in the overall development as an independent practitioner within LTC. These five identified skills and attributes were described to be, at times, unrealistic expectations placed upon the NGN that overall influenced their transition to practice experience and accelerated their development into a nurse leader.

Autonomy of the Registered Practical Nurse role. The fourth contextual factor that influenced NGN transition to practice in LTC was the high degree of autonomy of the RPN role in this setting. Despite a more focused foundational training and education, RPNs in LTC

described a more independent practice than what they had experienced in acute-care settings, and reflected on the high degree of scope in their role in this setting.

> *"To me, working here in long-term care, what the RPNs are doing now here on the floor is what we as RNs used to do 20 years ago. The scope is broader and they have more autonomy in their role."* - Director participant

This is supported by the Long-Term Care Homes Act, as in LTC in Ontario, the minimum requirement for nursing staff specifies one RN employed by the LTCH be on duty at all times (Government of Ontario, 2007). However, because there are no further specifications for RPN staffing ratios, LTC tends to employ RPNs in greater ratios and thereby, with greater responsibility. In the two LTCHs included in this sample, RPNs were regarded as "leaders" on the floor, comprising the vast majority of nursing staff and having roles in delivering the majority of resident care.

> *"We put them [RPNs] as a leader on the floor. They are in charge of their floor, the resident care, and it's about knowing what they need to do."*
> - Director participant

This degree of autonomy, or expected leadership, is different than that expected in the hospital setting for the RPN and very different than the clinical placement experience garnered during their education.

> *"When I first started it was like a whole different world from what I had been used to in school. In school when you're doing your placement, you have other nurses around and a charge nurse that is visible. When I am here at [LTCH name], there is an RN in the building but they're almost never with you. You are the registered staff member on the floor along with your PSWs and you have to direct the resident care. You are in charge basically."*
> - New graduate RPN participant

Both NGN RNs and RPNs were able to articulate the practice differences between the two designations in LTC. However, in the two LTCHs sampled in this study, the role of the RN

varied slightly, with some RNs only doing assessments and specific treatments, where some RNs in the other LTCH also completed tasks similar to the RPN.

> *"So the RPN will do the medication rounds, and the treatments, whereas the RN tends to do more of the acute assessments like a head injury from a fall or a seizure or chest pains. If it's like something that's more acute and severe the RN will do that. The PSW is doing basically everything else like nutritional needs and brief changes."* - New graduate RPN participant

With the RN functioning in an acute intervention role, the RPN in LTC is in an autonomous position to plan and provide holistic care to the resident. This challenged the new graduate RPN as the emphasis on leadership in RPN education as reported by the NGNs in this sample is largely absent. This subsequently requires the RPN to take up a leadership position that they may not be comfortable with and are not educationally prepared for.

Isolation in practice. The fifth contextual factor that influenced NGN transition to LTC was being isolated in nursing practice within LTC. This perceived feeling of isolation was related to "being the only registered staff member", as well as not being able to timely connect with other nursing colleagues when requiring assistance with decision making or assessment.

> *"Well, you're the only registered staff member on the floor so, I mean, you have PSWs and there's other people around elsewhere but I think that you have to really make sure that you're doing everything right. There is not really someone else to monitor what you are doing."* - New graduate RPN participant

> *"During night shifts I'm the only nurse on duty. So when like our residents complain that they can't breathe and I have to rely fully on my own assessments and can't ask another nurse for another opinion that is pretty scary. You are on your own."* - New graduate RN participant

The NGN being isolated in practice is a reality that was acknowledged by LTC directors.

> *"You don't work alongside other nurses like you would in acute-care. So your partner, if you even could call them a partner, is on the other floor,*

> *likely only available via phone or you may see them in the med room when you're both putting your carts away. There's not that support system available. There are less nurses here than there would be in a hospital setting or nurse setting."* - Director participant

This perceived isolation significantly contributes to challenges for the NGN as they feel as if they have to make complicated assessments and decisions on their own, as well as respond to crises or emergencies independently.

> *"What if my thoughts aren't right? Do I do this? Do I not do that? Doing something is sometimes just as bad as not doing something. So what do you do?"* - New graduate RN participant

> *"There are lots of times that I am working and I think 'I don't know what to do.' I think that a lot actually. I feel like there are some specific situations though, like in an emergency, that I know we are not equipped for."* - New graduate RPN participant

This is especially challenging for the NGN as they felt ill-prepared to make these decisions and provide these interventions and subsequently experienced an accelerated transition to practice experience.

Long-term care not viewed as a desirable workplace. The final contextual factor that influenced NGN transition to practice was the perception that LTC was not a desirable workplace for NGNs or for nursing practice. Both RN new graduates and LTC directors acknowledged that this perception was a misconception and that there were many "myths" associated with nursing practice in LTC.

> *"I think there's some misconceptions about working in long-term care. Sometimes my nursing peers will say 'Oh, you're working in long-term care? It's all paper work'. I have to explain what the nurse to resident ratio is and that it's not just paper work. We do so much more than that. I think this belief was one of the biggest challenges to entering into this setting."* - New graduate RN participant

> *"There's this nursing myth within healthcare circles that super nurses always work in the hospital in the emergency department or the ICU. Everyone around me when they find out that I am a nurse ask me 'Oh, what hospital do you work at?' like it's the default nursing job. The people who ask those questions, it's like trying to live up to their expectations of nursing and then they'll say something like 'Oh, you just work in long-term care.' It's a hurtful myth."* - New graduate RN participant

RN new graduates described nursing peers and other healthcare colleagues as the primary sources for these myths and were quick to defend their practice and setting.

> *"I think that they think, you know, that long-term care is the very bottom of nursing. Which there is no bottom of nursing. There are just different types of nursing care. I think that long-term care has a bad reputation because of the sounds of it and working with a geriatric population, but I think until you actually work at a long-term care home you won't understand how fulfilling a career it really is."* - New graduate RN participant

The viewpoint of LTC being an undesirable place to work was also described by LTC directors.

> *"There is a negative reputation for long-term care in the healthcare sector, so that's a struggle. I think that sometimes new graduate nurses who are very keen and clinically strong don't want to come into long-term care because they don't understand what it offers and what they can offer long-term care."* - Director participant

In one of the interviews with a LTC director, the director herself described holding this viewpoint when she initially graduated, linking it back to both the emphasis on hospital in her education as well as the emphasis on task-driven skill building.

> *"I never saw myself working in long-term care... I think that was related to my education and the emphasis on skills and acuity. I wanted to have skills and so I went into the hospital setting."* - Director participant

This contextual factor challenged the NGN in their transition to practice experience because of the negative stigma associated with LTC and the related gaps in knowledge specific to this setting. During educational preparation and when initially searching for first jobs, the

negative stigma associated with LTC contributes to NGNs not fully understanding the role of the nurse in this setting as well as knowledge pertaining to care provision in LTC. These knowledge gaps exacerbate the challenge associated with the lack of experience and exposure in LTC and further challenge the NGN in their transition to practice in this setting. This viewpoint is described to be held by nursing students, NGNs, and even, at times, the directors that provide leadership in LTC. Many of the NGNs including new graduate RPNs expressed that LTC was not their first choice of employment.

Summary of Contextual Factors. Six contextual factors, identified in the completed interviews, influenced the transition to practice of new graduate RNs and RPNs through various challenges to their transition experience and pushing them to become nurse leaders within this setting. These contextual factors, supported from the findings in NGN and LTC director interviews and bolstered by content in Key Documents, provide a comprehensive understanding of the themes influencing NGN transition into practice within this setting. While this study did not include any NGN participants who had left LTC as new graduates, it is reported by NGN participants that it was these contextual factors that contributed to at least two of their NGN colleagues leaving practice in this setting.

4. Transition Experience

Each of the NGNs who participated in this study proclaimed their transition to practice experience to be successful and positive in spite of the many negative experiences and challenges shared. As it was found that these contextual factors accelerated the development and progression of the NGN into a nurse leader, there were various processes that NGNs described

that explained how these contextual factors influenced their transition. These processes included: (a) struggling to meet expectations; (b) practicing in isolation; (c) relying on others; (d) developing skill and confidence in spite of challenge; and (e) recognizing complexity and value in LTC practice. The first three processes involved the NGN struggling against contextual factors, while the last two processes involved the NGN coming to terms with or confronting the contextual factors.

Struggling to meet expectations. The first process, which accelerated the development of the NGN into the nurse leader in LTC, was through the growth and development of the nurse and their practice within the expectations placed upon them. For the NGN in LTC, there were many described expectations placed upon their practice. Throughout the study interviews, NGNs described struggling to meet these expectations and how this struggle influenced their practice and their transition.

> *"It felt like I was expected to go from 0 to 100. Like, you know, as a new grad and someone who hadn't ever worked here [in long-term care] I really had a hard time. I felt like I was disappointing myself but also the people I worked with sometimes."* - New graduate RPN participant

> *"I had to learn very quickly that I was the leader and I was in-charge. And so if I wasn't ready to make a decision then they would be upset and they would, you know? They'll be like, well, I mean, you have to do your job, like be in-charge."* - New graduate RN participant

This struggle with expectations was related to feelings of inadequate performance, "knowledge gaps", and an overall comparison of their current practice to that of an "expert nurse".

> *"I am thinking how things could be missed, something that an expert nurse might pick up on and new grad might not just because it's a whole experience thing. It's like not seeing it before and your clinical judgment is not as well defined as it would be if you've been working for ten or fifteen years."* - New graduate RN participant

In particular, NGNs struggled with the expectation of having confidence in relation to leadership and being in charge. New graduate RNs described the various responsibilities and expectations that came with being in charge and in a leadership role in LTC and noted that it was challenging to learn their own practice rhythm while also functioning in a leadership role. This sentiment was echoed by one of the LTC directors.

> *"And as a new person who's still trying to get their feet in 'what is nursing', 'what am I supposed to do', I think we ask a lot of them as charge nurses."* - Director participant

> *"And you're still just trying to become a nurse, let alone becoming a nurse leader."* - New graduate RN participant

For both NGN designations, this sudden shift to being placed into a position of responsibility and leadership was their transition to practice reality. Each of the NGN participants discussed this movement and were able to articulate how they felt that this was unique to their practice setting compared to the hospital setting where there is more often a designated charge nurse who has a greater amount of experience. Additionally, for the new graduate RNs, there was also an additional expectation of not just leadership, but of being the charge nurse.

> *"Most days, it's okay. I think when the experienced RPNs ask you to reassess a resident for them to see what your opinion is, that's when it gets kind of tricky because you don't have a lot of experience to draw back on... because as the charge, they often rely on you like for directions. So I guess that would be the hardest thing about the charge or one of the hardest things about the charge nurse role and being a new graduate which is relying on that instinct and meeting their expectations of a charge nurse."* - New graduate RN participant

NGNs expressed that through their struggle to meet the expectations of LTC directors, colleagues, and themselves, they experienced both successes and failures.

> *"You don't always get it right and sometimes you have to report your mistakes. It's embarrassing and tough but then you don't repeat that mistake."* - New graduate RN participant

These expectations influenced the NGN during their transition to practice as an overall motivator for development and progression and as an accelerant for growth in their transition to practice.

> *"When you know that there are people relying on you and expecting you to know what you are doing, well, there is pressure for you to perform and for you to do good work."* - New graduate RN participant

Practicing in isolation. The second factor that accelerated the NGN development into the nurse leader in LTC was the requirement for success despite practicing within isolation. For NGNs in LTC their practice was often described to be in isolation from other nursing colleagues. This was due, in part to the low number of nurses in the LTCH working during the same shift and the lack of time for each of the nurses to respond to each other. This isolation influenced their transition to practice because of expectations placed upon them to practice independently and with confidence as well as the associated workload in LTC. NGNs reported having practice questions and concerns related to making mistakes and not knowing how to intervene in clinical scenarios.

> *"There's been, you know, many times where I've been in a situation where I had questions or I needed some assistance or some guidance and no one is answering their phone because they're busy or they're on the floor or you know, whatever the case is and so you're kind of almost left in limbo sometimes because you're left wondering what to do. Do you go with what you're thinking or do you wait to get a response."* - New graduate RPN participant

When asked how the NGN would respond in situations similar to the one described above, participants would most often describe taking some sort of action despite not having clarification from a colleague. The NGN would describe completing an action out of necessity and "hoping"

for a positive outcome as there was not enough time in the shift to wait for a colleague to respond.

> *"Well, you know, I have to make a decision and hope for the best. A lot of times I do not wait because there are other things that I need to do. I know that there are risks in that but I can't wait when there are so many other things going on."* - New graduate RPN participant

NGNs described that a challenge associated with their transition to practice in LTC related to working alone was that of cutting corners because of an intensive workload while feeling like no one was there to help them. This risk was related to various outcomes including medication errors and physical injury of the resident or of the staff member.

> *"There is the risk of medication errors. You're new and there are so many meds. There's no time. So it's the same risk that might be for anybody who is trying to do what we have to do and so we don't always do the second check, or you might pre-pour your medications."* - New graduate RPN participant

> *"When we have to work short because someone called in sick or something like that then there is a lot of risk. Instead of waiting for that other person to do the transfer, you just do it on your own. There is risk to the resident as well as us and I know some staff who have been hurt because of that."*
> - New graduate RN participant

NGNs were forthcoming with the challenges that they perceived and observed in their practice, and did not shy away from describing times where they may not have practiced as safely as they should have or to professional standards. The NGNs described these "short cuts" as necessary, common, and in some cases, something that their colleagues had taught them.

> *"I would be super surprised if I heard of someone who was not taking shortcuts sometimes. Like, for example with our narcotic count. Sometimes when you come in for your shift the other nurse has already left and just signed off on the narcotics. You know it's wrong but they already did it."* - New graduate RPN participant

> *"When I first started I was so slow. One of the more experienced nurses told me that I couldn't continue to be so slow, that I had to find ways to be more efficient."* - New graduate RN participant

In addition, LTC directors described their suspicion regarding the nursing workflow and the likelihood of these shortcuts by the NGN.

> *"I know that the workload is a lot. And I know that sometimes, in order to accomplish what they have to accomplish in their shift they are probably cutting corners. They are on their own in many ways and the workload doesn't always reflect that."* - Director participant

Practicing in isolation was challenging for the NGN and required swift adaptation to solo practice. NGNs often compared their current practice isolation to their previous placement experiences in acute-care and perceived that the isolation significantly contributed to their development as a leader in LTC because of the necessity to perform as such.

Relying on others. Parallel to the previous experience of practicing in isolation, the third process in which NGNs developed into the nurse leader within LTC was an appreciation for the need to rely upon team members to complete their tasks and responsibilities. These team members included other nurses, LTC directors and leaders, as well as the PSWs. Overwhelmingly NGNs identified their trust and reliance on PSW staff during the delivery of personal care to the resident despite PSWs being non-registered staff members. While this trust was helpful in facilitating teamwork, a quality regarded as necessary in LTC, it also facilitated an over-reliance on the PSW and at times a lack of actual assessment by the NGN.

> *"I trust that the PSWs know what they're doing and stuff. Which is crazy that they get only one year of education. It's really interesting. In some ways they do your assessments for you, which is kind of weird. They make that judgement call. Like, is this skin breaking down or not?"* - New graduate RN participant

> *"So, as a new nurse, like, I find myself having to rely on them [the PSWs] a lot. Just because they know the residents better. So, like, I don't just assign them things, like, residents and stuff. They'll tell me which residents they want to take care of and that sort of thing. I give them more direction when it comes to, like, if something changes, when it comes to a resident, or something's wrong with one of the residents, then I will give them direction but otherwise I trust them."* - New graduate RPN participant

This reliance upon the PSW and their interactions with the resident was related back to the lack of time that the NGN experienced in their practice.

> *"Definitely, yes. You just don't have time to go around to every resident and do a full head-to-toe [assessment] on them every day. If I have a question I will go and check for myself but otherwise you have to trust them to let you know if anything is different."* - New graduate RN participant

NGNs described that "in the beginning" this reliance and blind trust was not present but as their practice developed and their required task-list increased, the trust and reliance was fostered.

> *"Well in the beginning when I started, I would do everything myself. All assessments, it all. I didn't have trust in them as much as I do now and so I wanted to make sure that what I was documenting was something that I actually saw myself. However, I was constantly behind [in time] and knew that there was other things to do. Over time and working with them [the PSWs] I saw the way that they work and knew that I could trust them."* - New graduate RPN participant

The challenges associated with the described trust and reliance on PSW staff were explored in the interviews.

> *"Yes and sometimes [trusting the PSW] doesn't go well because they might have said one thing and then you hear something else from someone else and then kind of like have to go check anyway. But yes like a very, very touchy subject because you have to rely on them but sometimes they might not like have the right information."* - New graduate RPN participant

> *"Like, especially in long-term care, we rely on the PSWs because we're not providing all of their [the resident] care. So, if a resident for example has a new wound, or a skin tear, or that sort of thing, we're not going to know unless the PSWs... well, they're like our eyes and ears, right? But I think that new nurses really have to rely on the PSWs because we have not formed a lot of those skills yet."* - New graduate RPN participant

NGNs described times that the PSW's observations were incorrect, acknowledged that if the PSW did not observe or report something that it might be missed completely, as well as the possibility of the "three-step communication" failing them.

> *"Most of the time what they see is right. But the risk is that no one is perfect and if I don't have time to do an assessment on every resident regularly, what might be missed? What are they [the PSW] not seeing? Ultimately, I know it is my job. They don't do assessments."* - New graduate RN participant

> *"The PSW will say that there is something like a skin concern - the PSW will tell the RPN and then depending on where the RPN is or if they're like in the middle of med rounds or she's doing something else then RPN then has to tell me as the RN. And then I have to go back to that resident, like, "Okay, so what is going on?". There are three team members that are trying to communicate for this one person. Who knows what information got lost between that communication."* - New graduate RN participant

For the NGN it was identified that this trust and reliance upon the PSW staff as well as other team members was required. NGNs acknowledged that placing their trust in non-registered staff members was "risky" but because of time constraints, "knowledge gaps", and an inability to "properly assess" the many residents on their daily assignments, it was a risk that they had to take. In taking this risk, the NGN was able to perform as the nurse leader within LTC as they were not as behind schedule with patient care, were able to continue to delegate tasks and work to their PSW colleagues, and were available for important medical interventions as required.

Developing skill and confidence in spite of challenge. The fourth process in which the NGN developed into the nurse leader within LTC was through an overall development in their skill and confidence. In spite of the many challenges that NGNs identified with their practice and their transition experience, they were all able to describe the many ways that they developed both

skill and confidence in this setting. These skills included those that related to "critical thinking" and "leadership", with confidence in their assessments and practice subsequently growing as these skills developed.

> *"It has been positive getting to use things that I have learned in school but never used on an actual client before. When I first entered nursing and I had to do something I would think, 'Oh, I can't do this!' but now, instead, I'll think, you know, back to what was taught to me and use my skills. I am more confident now."* - New graduate RPN participant

> *"So they didn't have time to show me everything that they needed to show me during orientation and so a lot of the stuff that I learned to do was self taught. Really, I think that's like a lot of things though. I taught myself what is important and how to think things through. I had to and I'm proud of myself for it."* - New graduate RN participant

This development of skill and confidence emphasized the observed resiliency of the NGN participants. While LTC directors had formally described the NGN as "resilient" it was through observation in the interview process with the various NGN participants that their resiliency and dedication to positive reframing become evident. Throughout the interviews, NGNs would describe a challenge that they had encountered, whether it was regarding their practice or about the context in which they practice, but were often quick to reframe the challenge as an opportunity for their growth.

> *"I think a big difference to me was that when I was a student the people around you, those working around you, they kind of expect you to ask a lot of questions. Now that I'm a new grad I feel like people kind of expect you to know what you're doing and you know, well, you don't a lot of the time. But you learn through experience and through doing and that's how you build up confidence and knowledge. Just doing it. I guess it's that whole fake it 'til you make it idea."* - New graduate RPN participant

> *"I find that you learn a lot of leadership skills. You learn to think outside the box. You don't always have all the tools necessary and so you have no choice but to become a leader because you have staff who's looking to you for answers and you have to take on that role despite the fact that you might not be ready for it. You are forced into that. And that's not completely a bad*

> *thing as it pushes you to challenge yourself. In the beginning it is scary but once you do it, you feel accomplished because you have taken on that role and that challenge."* - New graduate RN participant

This reframing of challenge demonstrated the resiliency of the NGN and offered a glimpse at how their willingness to take initiative, a previously discussed characteristic of the NGN, transformed the NGN into a nurse leader in LTC.

Another facet of the resilience observed with the NGN participants was that of their overall description of their transition experience in LTC as common. NGNs expressed that the transition to practice experience was a rite of passage, "normal", and that it was necessary for challenge to be present.

> *"I know that I learn best when I am challenged. I have learned so much here [in long-term care] and it is because of some of the really hard decisions I have had to make."* - New graduate RN participant

This transition experience for the NGN was seen as necessary for development, and that the associated challenges were what forged their practice and their progress. However, most striking, was that despite their description of very specific contextual factors that challenged them in LTC, several NGNs felt that it was "likely" that their transition experience was no more difficult than in other settings.

> *"I bet being a new nurse is hard no matter where you are. Like, ICU… that would be really hard. Here [in long-term care] is hard too. I know in hospital you have other people around you all the time to help but it's different there too I am sure. Different challenges."* - New graduate RN participant

Despite significant challenges to their practice and transition, NGNs were able to clearly and confidently articulate the personal and professional benefits of their LTC experience clearly demonstrating their commitment to learning and growth within their setting. These benefits, although focused on mostly skill development within their practice, were driven by necessity and

born out of requirement in this setting as NGNs learn to navigate their practice and settle into their professional role. Their resiliency contributed to their development into the nurse leader in this setting as it provided them opportunity to reframe their experiences into positive experiences sustaining job satisfaction and promoting personal growth.

Recognizing complexity and value in long-term care practice. The fifth and final process in which the NGN transitioned into a nurse leader in LTC was that of their developed understanding of the role of the nurse in LTC. NGNs acknowledged that when they first entered LTC, they were unclear on the role of the nurse, did not understand their responsibilities, and did not appreciate the complexity nor the value of nursing practice within LTC.

> *"I gained my experience within the hospital and so when I went into long-term care it was a lot different than what I was used to. In the hospital you have a lot of support. You know, there's always people around. There's other nurses working on the floor. In long term care you don't have that. You're kind of it. You are the nurse on the floor and that was so overwhelming for me because you know, you're new, you don't have that confidence of an experienced nurse and you're put in a position to kind of make decisions that you're not completely confident with, you know. So, to me, that was very overwhelming."* - New graduate RPN participant

> *"I really had no idea what to expect. I never thought I would be doing medication passes like I am. I thought it was going to be a lot of administrative stuff because that's what was talked about when I was in school."* - New graduate RN participant

As NGNs continued to grow and develop in LTC, their attitudes toward practice within LTC changed. They described challenging the stigma of the perception of LTC with their friends and families and promoting the role of the nurse within their professional circles.

> *"I think like self-discovery is the best part about working here- like you really learn what you're good at and what you need to improve on in terms of assessments or people skills. It's like you get to learn at your own pace and get to know the residents. I have pushed my friends to think about*

> *working in long-term care too because of my experience here. They see how much I have grown. Like it's definitely a bit of forced self-discovery but it's still self-discovery."* - New graduate RN participant

This shift in attitude was most often attributed to the NGN coming to appreciate the complexity, and at times, acuity of the care required in LTC.

> *"The average resident has a cognitive impairment, usually dementia. They also tend to have chronic conditions like diabetes or heart disease. On top of that, you know, sometimes you have people who also need assistance with care or mobility. It can add up pretty quick especially when doing the medication pass."* - New graduate RPN participant

> *"I really didn't think it would be like this here. Not that I really understood what it would be like at all but I was not expecting the acuity. Some days your heart is really pumping, you know? The adrenaline is really going. I didn't think I would love it [long-term care] but now I think I would call myself an advocate of long-term care."* - New graduate RN participant

The wide range of skills required to provide resident care and the developed appreciation for the complexity and value of nursing in LTC promoted the development of the nurse leader in this setting. Despite entering nursing in LTC because of difficulty finding work, NGNs were able to positively describe their practice and articulate how this shift in attitude and challenge of stigma shaped them into the nurse leader and an advocate for practice in this setting.

From New Graduate Nurse to Nurse Leader

The conceptual model, entitled From New Graduate Nurse to Nurse Leader is the graphical representation and summary of the development of the nurse leader within LTC (see Figure 4). Through five processes built upon six described contextual factors the NGN enters practice in LTC and rapidly develops into a nurse leader. NGNs in this sample described their transition to practice experience overall as a sudden movement from being a NGN to identifying

as a nurse leader. While this description was slightly different for the new graduate RPN than it was for the new graduate RN, both nurse designations experienced this jarring shift in role.

For new graduate RPNs, their movement from being a new graduate nurse to that of a nurse leader involved a reflection on their placement experiences as a student, and a comparison of their current state in practice. This was described to be "overwhelming", and made the new graduate RPN feel "alone" and "unprepared".

> *"It seemed to have happened in a blink of an eye, you know? One day I was in school and learning and the next I was the nurse on a floor with a ton of responsibility and leading care."* - New graduate RPN participant

For new graduate RPNs, this was a very different experience for them as their exposure to nursing had been in places where the RN held a leadership role. This aspect of the RPN role in LTC is a "unique" feature of the setting according to NGNs and was something that they grappled with.

In comparison, while new graduate RNs described similar feelings as their new graduate RPN colleagues, the transition to practice was not just about being a "leader" but instead about "being in charge".

> *"Since long term care was completely new to me, I found it a little harder to transition by myself I guess compared to like the hospital, just because I never had that experience before. Since I'm the only RN at the long term care home, I was kind of thrown into the charge nurse role. So going from like a novice nurse to be in-charge was also a little bit of a transition that I had to get used to and dealing with any of the problems that came up."*
> - New graduate RN participant

> *"But in terms of just starting as a long-term care nurse it was different because I would go from you know being a student and having 4 to 5 assignments, patient assignments, to having about 80 assignments and in charge. And not to say that I'm caring for all of them but when I started in long-term care I had a specific floor that I would give out medication to residents but there are three other floors that I'm managing in terms of overseeing PSW's and RPN's and so they would come to me for like a*

> *second opinion and I am also delegating and such on those floors."* - New graduate RN participant

Both new graduate RPN and RN participants experienced transition to practice in similar ways despite their overall responsibility in the setting. This development of leadership and acceptance of the role of being a leader in LTC was one of the most significant benefits identified by NGNs during the completed interviews. NGNs in this sample were able to describe the various aspects of leadership that they were developing including communication, teamwork, and relationship building and acknowledged that like many of the skills learned in LTC, leadership was developed out of necessity.

> *"I would say in all aspects you have to be a leader. You have to decide break schedules, take initiative, and listen to everyone on the floor. You have to know like what the PSWs are doing and where they are and have good relationships with everyone. I think this is different from hospital because like RPNs in hospital work with RNs much closer and so they don't have to be leaders as much."* - New graduate RPN participant

Additionally, there was discussion among some of the NGN participants that where there were opportunities for leadership there were subsequent opportunities for career growth. NGNs expressed that because there was a visible "chain of command" professional growth and vertical movement were possible.

> *"I feel like in long-term care, like if you do want to move up, that possibility is there whereas in a hospital it can be more confusing or not as clear of how to kind of further your career if that makes sense. In long-term care, for example, I can kind of see the chain of command and so I can see a path for development and growth much simpler."* - New graduate RPN participant

Developing leadership skills in this setting was "important" to NGNs and allowed them to effectively function as part of the team, and presented an opportunity for the NGN to "feel like a real nurse."

> *"If they are interested in leadership, this is the place to do it. This is the place to get those opportunities and those experiences if that's an interest for them. Rarely do new graduates get such opportunities. But they do here [in LTC]."* - Director participant

Summary of Findings

Findings from this study present new knowledge as it relates to the transition to practice experience of NGNs in LTC and some of the differences in experience during this transition for new graduate RNs and RPNs. Participants in this study were able to voice the contextual factors that influenced their experience; how these factors influenced their transition to practice; and their experience shifting from a NGN to that of a nurse leader. Overall, NGNs in this sample reported a positive transition experience despite the various reported challenges and speed in which they perceived that they were expected to be leaders.

> *"And you're still trying to become a nurse, let alone become a charge nurse."* - New graduate RN participant

CHAPTER SIX: DISCUSSION

This case study explored the transition to practice of both new graduate RNs and RPNs in LTC. This study builds upon our current understanding of transition to practice by answering the posed, previously unexplored research questions: how do NGNs describe their transition to practice in LTC?; how does LTC influence the transition to practice experience?; and what are the described differences in transition experience between the new graduate RN and RPN? In order to advance the findings presented in the previous chapter, this chapter offers a discussion of the findings in relation to current literature and identifies new understanding for the NGN within this setting. This discussion is organized using the research questions and the three study propositions and includes: transitioning to practice in LTC; the influence of context on transitioning to practice in LTC; and the transition to practice experience of the new graduate RN and RPN. Finally, and in conclusion, the chapter will provide a discussion on the viability of NGNs entering LTC based upon study findings.

Transitioning to Practice in Long-term Care

The first proposition in this study posited that the NGN within LTC would describe a transition to practice experience similar to that of the NGN's description within an acute-care setting. This was inclusive of described emotions through consideration of the available literature that explored NGN transition to practice within the acute-care setting as well as theory commonly used to describe NGN transition to practice. This proposition also appreciated that differences in the transition to practice experience would be related to those previously unknown contextual factors that would undoubtedly influence the transition experience. These contextual

factors and the subsequent differences in transition experience are discussed in the next section. Study findings supported this first proposition in that NGNs in this study described their transition to be a rite of passage, reflecting that it was similar to their friends or peers in other settings such as acute-care.

Transition to practice as a rite of passage. NGN participants in this study understood and perceived their transition to practice and the associated challenges to be "normal" in terms of the overall development of a nurse. NGNs described the transition to practice experience as a rite of passage, one that to them was understandably full of challenge, and overall a necessity for their development. They reflected on their transition to practice and compared their personal experience with the described experiences of their friends, peers, and mentors and conceded that the experiences were similar and personally difficult no matter the setting.

Supported within the transition to practice literature in the acute-care setting are the emotions and overall expressed feelings of inadequacy and insecurity that NGNs described in his study. Anxiety, uncertainty, questioning, and feeling overwhelmed, inadequate, and out of their comfort zone were emotions attributed to daily practice for the NGN. These feelings were described by both the NGNs in this study as well as new graduates in previous works exploring transition to practice (Duchscher, 2008; 2009; Dyess & Sherman, 2009; Laschinger et al., 2010; Pfaff, Baxter, Jack, & Ploeg, 2014).

Within the NGN transition to practice literature, Duchscher (2008) has described these emotions as predictable, inevitable, and like the NGNs in this study, as progressive and necessary in the transition process. These emotions, and more specifically the negative feelings associated with transitioning are seminally described as core to the change in identity, role, and behaviours

that constitute transitions (Schumacher & Meleis, 1994). The described feelings are attributed to the automatic and rapid assumption of professional responsibilities by the NGN, the acuity of the patient populations seeking healthcare, and staffing challenges (Dyess & Sherman, 2009). In this study, like in the literature, NGNs described that these feelings contributed to the development of skill in their setting and that confidence, although slow, developed as well. This finding was supportive of the first proposition and in part answered the first research question as the feelings that NGNs in this study experienced were ones that have been described countless times in the literature exploring NGN transition to practice.

However, the findings in this study also revealed a significant difference in the described transition to practice of the NGN in LTC from that described by those NGNs in acute-care settings. This difference was namely reflective of the specific contextual factors present in LTC and further answers the first posed research question. These contextual factors, the influence on the transition experience and how it was described, and how they supported or countered the first two propositions are presented within the discussion of the second proposition below.

The Influence of Context on Transitioning to Practice in Long-term Care

The second proposition hypothesized that the context of LTC would influence the transition experience of the NGNs employed within these settings. This proposition considered that while there was no literature that explicitly explored transition to practice in LTC, the experience of NGNs in the acute-care setting described in the literature was influenced by the professional context related to acuity of patients, staff skill-mix, and the autonomy and responsibility of the NGN. Findings from this study supported this proposition as well as the first proposition related to the similarities of transitioning to practice in acute-care settings.

Additionally, the study findings contribute a novel understanding and explanation of the transition to practice experience of NGNs in LTC and the influence of context within this transition. Three of the previously presented contextual factors along with their accelerating impact on the transition experience are discussed with findings from this study and situated in the available literature.

Contextual factors. Although NGNs in the acute-care setting described similar feelings about their practice and their transition, the factors that contributed to these feelings in the acute-care setting were related to the dynamic of the hospital setting, the team and mentorship received, and the acuity of the setting (Baxter, 2010; Duchscher, 2008; 2009; Dyess & Sherman, 2009; Hofler & Thomas, 2016; Laschinger et al., 2016). In this study, NGNs described six contextual factors, with three that were particularly important to the setting: the influence of unrealistic practice expectations; lack of time; and isolation in practice, that contributed to an overall accelerated transition from a new graduate to that of a nurse leader. These findings are discussed in more detail in the context of relevant literature.

Unrealistic practice expectations. The expectations placed upon the NGN in this study were a significant contributor to the overall development of the NGN into the nurse leader. Overall, these expectations, although well-intentioned and hopeful of the performance and development of the NGN, were described by the NGN to be unrealistic and challenging. In the acute-care literature on NGN transitioning, expectations are a key component of the experience (Duchscher, 2008, 2009). Duchscher (2009) described that unrealistic performance expectations placed upon the NGN by the institution, peers, as well as the NGN themselves contributed to a traumatic professional adjustment. NGNs in the study by Duchscher (2009) described attempting

to conceal the difficulty associated with basic practice in their new role despite experiencing greater pressure to perform at an even higher level. Performing advanced clinical judgement, assessment, and making practice decisions with confidence and leadership are expected of the NGN in both the acute-care literature (Duchscher, 2008; 2009; Gillespie & Peterson, 2009) as well as described as expectations within this study. This finding is supportive of the first proposition, as NGNs within LTC overall experienced the influence of expectations and similarly felt that the expectations were often unrealistic of their current performance capabilities.

However, what differed in this study from previous literature examining NGN transition to practice was the expectation that the NGN in LTC would rapidly move from the novice provider role and competency level to that of the proficient provider skipping those stages described by Benner (1982) and Dreyfus (1972) in-between. The expectations of the LTC directors as well as the nature and required practice in LTC demanded that the NGN spend little to no time as a novice provider and instead almost immediately function as a proficient and skilled nurse leader. While there is commentary describing this phenomenon in settings outside of LTC (Hofler & Thomas, 2016) the nursing team that supports the NGN in the acute-care setting protects the NGN from the expectation of the NGN to rapidly transition to nurse leader that is thrust upon the NGN in LTC. This is because, unlike in LTC, the nursing team works together as a functional unit whereas in LTC there is a great deal of isolation in practice. This finding was supported by the overall described lack of time in the setting and counters the role of time in the transition experience of NGNs in the acute-care literature.

Duchscher (2008; 2009) describes NGN transition to practice as a linear and progressive experience with the NGN moving through predictable emotions and experiences within specific timeframes. Benner (1982) describes nurse skill and competency acquisition as a time-oriented

process, with the nurse over time exposed to different opportunities and experiences contributing to learning. Findings from this study did not support the previously described transition to practice experience nor the literature describing nurse skill acquisition, as it was described by participants in this study as much more rapid and influenced by practice expectations and demands as opposed to specified time periods. This finding contributes to a greater understanding of the experience of NGNs in varied clinical settings, is supportive of the second proposition related to the influence of the LTC context on NGNs, and offers an alternative to previously universally understood and accepted transition to practice theory.

Lack of time. In addition to the contextual factor of those unrealistic practice expectations, time, and more specifically, a lack of time, was found to be a significant contributor to the transition to practice of the NGN in LTC. This study found that it was overall a lack of time that dominantly underscored the accelerated transition to practice of the NGN in LTC. Instead of the traditional time afforded to NGNs to transition to practice as described by Duchscher (2008, 2009), and earlier by Benner (1982) through structured orientation and mentorship programs offered in the acute-care setting, NGNs in LTC were not allocated this time nor were these robust programs offered.

In a pilot project by O'Rourke (2012) an enhanced orientation program was provided to 12 NGNs entering LTC. This project was developed to: a) improve retention of nursing in LTC through providing a better orientation; b) enhance the profile of LTC among NGNs and nursing; and c) enhance and develop the skills and abilities of NGNs within the setting to provide higher quality care (O'Rourke, 2012). The program involved a mentor workshop, a one-day orientation for both mentor and NGN, as well as formal mentorship activities for approximately 8 months (O'Rourke, 2012). Mentor and NGN met informally, often outside of the workplace and attended

six one-day workshops on topics relevant to their practice. This pilot project, aligned with other healthcare setting mentorship literature, demonstrated significant knowledge uptake of the NGN and was perceived as a very positive experience by both mentors and NGNs (O'Rourke, 2012). Mentorship programs, whether they are as robust and intensive as the program piloted by O'Rourke (2012), as well as a positive relationship with a manager, mentor, and the presence of an educator are all factors that positively impact the transition to practice of the NGN in acute-care settings (Baxter, 2010; Hofler & Thomas, 2016; Laschinger et al., 2016; Pfaff, et al., 2014; Scott, Engelke, Swanson, 2008; Woodhead, Northrop, & Edelstein, 2014). Despite the success of this pilot project and in direct conflict with much of the orientation and mentorship literature, LTC continues to offer minimal transitional support for NGNs.

In this study, many of these factors, viewed as protective for nurse retention and positive for transitioning for NGNs in the literature (Baxter, 2010; O'Rourke, 2012; Scott, et al., 2008), were completely absent or very limited in LTC. This significantly impacted the transition experience of the NGN leading to greater feelings of isolation, ill-support, and inadequacy. Findings related to the lack of time for orientation and mentorship further emphasizes the differences for NGNs in LTC in comparison to those NGNs entering practice in acute-care settings and supported the second posed proposition. NGNs in LTC are not afforded the same amount of time to transition, develop, and thus, as described by Benner (1982) develop competency in skill as those peers working in the acute-care setting. Furthermore, the findings highlight the need to promote more structured orientation and mentorship opportunities in LTC in order to support NGNs in their transition to practice experience and to provide consistent transition to practice support, reinforced by the literature, no matter the setting.

This lack of time for the NGN was not only related to the orientation or mentorship, but also the time afforded to the NGN to provide care to the resident. NGNs in this study described a sense of being rushed to deliver care and a feeling of never having enough time to perform their responsibilities. The workflow and the provision of care from the nurse in LTC varies between LTCHs and to some extent between nurse designation with emphasis in the literature placed upon optimization of the time for each task (Bowers, Lauring, & Jacobson, 2001; McCloskey, et al., 2015). Supported by the literature was the finding from this study that nurses employed in LTC work within a shortage of time for care (Bowers, et al., 2001; McCloskey, et al., 2015). NGNs in this study described rushing from one task to the next, and always feeling behind in what they needed to complete.

In order to compensate for this, like in the study by Bowers, Lauring, and Jacobson (2001), NGNs in this study described developing shortcuts and strategies to "keep-up" including delegation of tasks and assessments to the PSW (McCloskey, et al., 2015) and forgoing work that contributed to quality resident care in order to complete mandatory "must do" work (Bowers, et al., 2001, pg. 486). However, counter to the finding by McCloskey, Donovan, Stewart, and Donovan (2015) that described nurses in LTC not delegating tasks that could be delegated to unregulated staff members, this study found that NGNs often inappropriately relied on PSWs for initial resident assessment and continued monitoring. This inappropriate reliance on PSW staff members was understood by the NGN to be unsafe and places the resident at risk. Despite some literature exploring new physician reliance on nursing staff (Hughes, 1988), this study is the first of its kind to discuss the interprofessional reliance of nursing staff members on unregulated care providers in LTC. While this finding is significant as it impacts the quality of care provided, it is merely a symptom of the various challenges that nursing staff contend with within LTC.

Similar to a study by McGilton, et al. (2014), this study found that a lack of time negatively impacted the very reason that nurses chose to work in LTC and become a nurse in the first place. NGNs in this study described a drive to "make a difference" and to have quality time to care for those residents that they served and that the time constraints that they practiced within all impacted their ability to do this. This finding, as described by McGilton, et al., (2014) highlights that "the delivery of person-centred care" and a "creation of home-like environments" is difficult for the nurse to achieve (pg. 921). While the finding of nurses being "crunched for time" in LTC is supported in the literature, these study findings indicate the need to further explore how the transition to practice is specifically impacted by a lack of time, how NGN job satisfaction in LTC is influenced, and how a lack of time for resident care may inappropriately result in unsafe practices.

Unlike in the acute-care setting, overall it was a lack of time that was found to underscore the accelerated transition to practice of the NGN in LTC. NGNs in this study were not afforded the luxury of time to ease into practice, to spend additional time in orientation or with a mentor, and were expected to be independent and practice-ready despite their NGN status which was often not the reality of the NGN in the acute-care setting. The literature was supportive of these findings from a general nurse perspective in LTC, with these findings contributing a more specific understanding of the influence of a lack of time on the NGN in LTC. This finding supports the hypothesis posed in the second proposition as this contextual factor was not described in the acute-care transition literature and is instead specific to LTC.

Isolation in practice. Another contextual factor described by participants in this study was that of the perception of being isolated in practice. NGNs perceived that because of the staffing numbers, the nurse to resident ratio, and the difficulty in reaching a registered colleague

for assistance, that they were practicing alone during most clinical decisions and assessments. This finding was different from the acute-care literature as NGNs within the hospital setting described having the support and guidance of a nursing, and often, interdisciplinary team around them (Duchscher, 2008; 2009; Pfaff, et al., 2014). In fact, in the acute-care setting, the team is such an omnipresent aspect to the NGN's transition to practice, that incivility and bullying are often described as significant barriers to successful transition for the NGN in the acute-care setting (Laschinger et al., 2016; O'Brien, et al., 2010). In the acute-care setting, the effects of bullying and incivility often contribute to retention challenges (Johnson & Rea, 2009; Laschinger et al., 2016), increased cynicism (Laschinger, et al., 2010), and poor transitioning (Duchscher, 2008; Feng & Thai, 2012). This is different than in LTC, as while NGNs in both acute-care and LTC describe feeling alone and often unsupported, bullying and incivility were not themes identified by NGNs in this study, nor ones that are discussed in the literature related to LTC.

While there is a noticeable difference in the presence of bullying or incivility between the LTC and acute-care settings for NGNs, the ever-increasing complexity and acuity of patients across healthcare settings is consistent (Hofler & Thomas, 2016). This is of particular importance when considering the perceived feelings of practice isolation for the NGN in LTC, as the acuity of the resident and variability in clinical presentation continues to widen. This study found that NGNs struggled in their practice because of the variability in resident presentations. The feelings of isolation in LTC practice are supported in the literature and contribute to nurses having to practice with greater independence and further prioritize and delegate important tasks (McGilton, et al., 2014; Woodhead, et al., 2014). This is important, as those NGNs that describe feeling alone and unsupported may potentially further isolate themselves through acts of delegation to other team members in order to keep up to the demands of the acute LTC setting.

Like the previous finding, this finding of the isolating work environment supports both the first and second proposition. As the first proposition posited that the experience of the NGN in LTC would be similar to the experience of the NGN in the acute-care setting, the perception of being unsupported and isolated was found to be a mutual feeling shared by both groups. However, and aligned with the second proposition, while NGNs in acute-care settings may feel unsupported, the literature attributes this feeling to social isolation potentially rooted in bullying or colleague incivility differing from the root of the feelings of isolation for the NGN in LTC in this study. While the effect of feeling isolated from colleagues is similar between the two different settings for the NGN, feelings of isolation for the NGN in LTC are related to practice and the environment as opposed to negative social interactions. This is a significant finding as it adds further understanding to the potential root causes of feelings of isolation for the NGN, and highlights a need to further study isolation in LTC and its influence on practice.

Each of the six contextual factors described by NGNs and LTCF directors in this study contributed further understanding to the previously unexplored and unexplained transition to practice experience of the NGN in LTC. While there were many similarities between the transition experience of a NGN in acute-care and the studied NGN in LTC there were also several differences. Differences between those NGNs transitioning into acute-care and those transitioning into LTC related to the contextual factors specific, and often unique to LTC all cumulating in an overall accelerated transition to practice experience for the NGN.

Accelerated transition to practice. Despite NGNs in the acute-care literature describing their transition to practice experience as a rapid transition from nursing student to that of the new graduate nurse (Duchscher, 2008), this study is the first of its kind to report on an accelerated

transition experience of the NGN in LTC. This phenomenon is described in the resulting conceptual model (Figure 4) and was reported as an overall accelerated transition for the NGN to that of the nurse leader within LTC. The accelerated transition to practice experience described in this study, born of the contextual factors and the subsequent processes that NGNs grappled with during their transition, challenges the widely understood transition to practice literature.

For the NGN in the acute-care setting, the transition to practice experience involves drawing upon previous clinical placements, coursework, and acquired task- and soft-skills in order to be successful (Duchscher, 2008). Conversely, the NGN in the LTC, inclusive of both the RN and RPN in this study, described lacking previous exposure to LTC and an overall lack of educational preparation for their new place of employment. This further challenged the NGN in this study as they lacked sufficient knowledge and experience in LTC, did not receive adequate orientation or mentorship, and were still required to perform as a nurse leader despite their NGN status.

As described in Duchscher's Stages of Transition theory (2008), NGNs pass through three distinct stages of transition over the course of one year with, on average, each stage requiring three to four months to progress through. Like with Benner's Novice to Expert theory (1982), Duchscher's theory emphasizes the role of time within transition and development. Conversely, in these study findings, following the initial scheduled six orientation shifts, the NGN was expected to practice independently and with a greater degree of competence than their acute-care peer group in that same time frame. While the NGN in LTC still may slowly work their way through these Stages of Transition, they were not afforded the luxury of time to do so directly contradicting existing leadership and mentorship literature. In comparison to Benner's Novice to Expert theory (1982), NGNs in this study were, in many ways, expected to be competent

providers able to practice independently despite their peers in acute-care progressively building from novice, to advanced beginner, to competent. Without adequate time for orientation or suitable mentorship opportunities, the NGN is expected to rapidly transition from their NGN status to that of a nurse leader within an accelerated timeframe.

Through an examination of the contextual factors present in LTC and the resulting accelerated transition to practice experience of those NGNs employed there, this study has provided insight into how NGNs describe their transition, and how contextual factors present in LTC influence the transition experience. While NGNs describe their transition to practice experience as a rite of passage, one with emotive and developmental challenges and growth, they also described it as an accelerated experience, one that is resulting from unique contextual factors and resulting processes in LTC. The third and final research question which sought to explain the difference in transition experience between the new graduate RN and RPN, is explored in the section below.

The Transition to Practice Experience of the New Graduate RN and RPNs

The third and final proposition of this study posited that the new graduate RN and new graduate RPN would share similarities in their transition experience as well as differences based upon their education and their roles and responsibilities within LTC. As this study was designed as a single case with embedded units (Yin, 2014), with the new graduate RNs and new graduate RPNs serving as the two embedded units, it was important for not only comparison across unit groups within the case but also examination of the single case with both sub-units. This proposition acknowledged that the NGN transition to practice in LTC had not been previously explored or explained and that in general the transition to practice of the RPN remains widely

unknown in almost all settings in healthcare. Each of the similarities and differences are discussed in detail with available literature presented.

Similarities between new graduate RN and RPNs. Broadly speaking, the transition to practice experience of the new graduate RN and new graduate RPN in this study were quite similar. Entering LTC, both the new graduate RN and RPN in this study presented homogeneously as they all had a described lack of life and LTC experience, expressed a fear of losing clinical skills, and were all willing to take initiative and were generally young. While not all of these characteristics are explicitly supported in the literature, NGNs in the acute-care setting are often described as young and inexperienced (Berkow, Virkstis, Stewart, & Conway, 2009) and are perceived to be overall committed to the profession and willing to learn (Laschinger et al., 2016).

In addition to the general characteristics of the NGN in this study, many of the contextual factors described throughout the findings related to and influenced the transition experience of the new graduate RN and RPN in very similar ways. This finding was not unexpected, as the roles and responsibilities of the RPN, although distinct from the role of the RN in LTC, tends to more closely resemble that of an RN in the hospital setting. This advanced functioning of the RPN in LTC is captured in the literature with Stone and Harahan (2010) describing the RPN in this capacity as the nurse who "provide[s] direct patient care" (pg. 110). While the scope of the RPN is often more limited than their RN colleagues, the RPN in LTC will "act as charge nurses or team leaders with responsibility for supervising and directing the care provided by nursing assistants and other direct care workers" (Stone & Harahan, pg. 110). As described by the NGNs and LTC directors in this study, the expectations of the new graduate RN and RPN were very

similar. NGNs, regardless of professional designation, were expected to transition rapidly into their role as nurse leader within an overall lack of time.

The last similarity between both the new graduate RN and RPN in this study is a described sense of not receiving adequate educational preparation for their transition into LTC practice. RPN participants described little to no exposure to LTC as well as very little discussion or practice on the skills of leadership and delegation whereas RN participants described having a placement in LTC early on in their education but that it was mostly related to medication administration or providing a bed bath. NGNs in this study articulated a need for further development of nursing curriculum to address this gap in education as they described this lack of exposure, misalignment between education and practice expectations, and misunderstanding of the role of the nurse in LTC to impact their transition experience. This need for development of the nursing curriculum to address gaps in LTC content is supported in the literature as it impacts more than just the transition to practice of the NGN and instead contributes to retention and recruitment challenges (Newton & McKenna, 2007; O'Rourke, 2008) and the ongoing negative portrayal of nursing in LTC (Williams, Nowak, & Scobee, 2006).

This misalignment between education and practice was especially challenging for the new graduate RPN in LTC as their nursing education, as described by the RPNAO (2014), prepares the RPN to work in less complex environments with less of a focus and emphasis in their education on leadership or resource management. RPNs in this study described receiving little to no education or practice in placements in delegation tasks or leadership opportunities - all activities commonly carried out by the RPN in LTC. In a study by O'Brien, Ringland, and Wilson (2010) funding was received by eight LTCHs in Ontario to develop programs and tools to address known barriers to recruitment and retention of both RNs and RPNs in LTC. One of the

identified barriers of this project was that of clinical leadership development and the specific leadership skills required within LTC (O'Brien, et al., 2010). This project was linked to the practice of the NGN, although the programs and tools were not specifically geared for the NGNs (O'Brien, et al., 2010) and was entitled Excelling as a Nurse Leader in Long Term Care. This program saw improvement in participant's ability to provide positive feedback, empower others, use leadership styles, and deal with conflict (O'Brien, et al., 2010); all important components in leadership skill development.

In general, the transition to practice experience of the new graduate RN and new graduate RPN in this study were very similar contributing a greater understanding of the transition experience of the RPN - a previously unexplored topic. These findings supported the third proposition, which hypothesized that there would be similarities between the new graduate RN and RPN experience based upon the overlap in roles within LTC. However, there are also small nuances in the transition experience between the two nursing designations present in LTC that are described in more detail in the next section.

Differences between new graduate RN and RPNs. Despite both the new graduate RN and new graduate RPN being expected to rapidly transition from their new graduate status to that of a nurse leader, RN new graduates in this study described having to function not only as a nurse leader, but as a charge nurse within this short time frame. In Ontario, according to the Long-Term Care Homes Act, there must be one RN working at minimum in the LTCH at all times (Government of Ontario, 2007). The new graduate RN, once completed their orientation period, may quickly be scheduled and work as that only RN in the LTCH fulfilling that government mandated requirement. The challenge for the new graduate RN then becomes not

only serving as a nurse leader, delegating tasks, interacting with the physician, and coordinating quality and safe care, but serving as the charge nurse in a large LTCH. This phenomenon for the NGN not only rapidly progressing from a new graduate to a nurse leader, but instead from a new graduate to a charge nurse, is not one that is presently captured in the literature. The rapid progression of the RN from new graduate to charge nurse supports the third proposition that there would be differences in the transition experience based upon the roles and responsibilities of the nurse in the setting.

In addition, and more specific to the disconnect between what is practiced in placement and what is experienced in practice discussed previously, the new graduate RPN in LTC also observed an overall increase in their perceived leadership potential. RPNs in this study described observing a clear chain of command in LTC and knowing and directly reporting to their manager on a regular basis. This visibility permitted the new graduate RPN to see how their career could develop from a point-of-care position to a more formal leadership position such as management as some of these formal roles were held by RPNs. In LTC, this opportunity for the RPN is fairly unique, as the acute-care setting more often promotes RNs with advanced education such as Master's degrees into formal leadership positions. This finding is a gap in the available literature and is one worth exploring more in detail as the role and responsibility of the RPN in LTC continues to develop and evolve. This finding is supportive of the second proposition, as this is not practiced in the acute-care setting, and a unique contextual factor for LTC.

Through an examination of the similarities and differences in the transition to practice experience between the new graduate RN and RPN, it becomes increasingly clear how homogenous the experiences are. While the RN in LTC is ultimately responsible for the coordination and care of each of the residents within the charge nurse role, due to many of the

exposed contextual factors such as unrealistic practice expectations, lack of time, and isolation in practice, the RPN fulfills very similar duties. This overall translates into the experience of the NGN and, while challenging for the new graduate RN, represents a steep learning curve for the new graduate RPN due to increased gaps in educational preparation and leadership knowledge. With increasing demands on LTC, increasing acuity of the resident in LTC, and with significant numbers of RPNs being employed in LTC (RPNAO, 2014), the need to further research, better support, and take effort to understand the experience of new graduate RPN is immensely clear.

These findings add further understanding to the transition experience of the NGN in LTC and emphasize the need to address practice gaps and challenges experienced by the NGN as they are ultimately responsible for coordinating the care of increasingly fragile and acutely unwell residents. In examining the similarities and differences between the new graduate RN and RPN transition to practice experience, this study was able to provide increased understanding of how context in LTC influenced the transition to practice of the two nurse designations.

New Graduate Nurses in Long-term Care

When examining the findings from this study from a broad perspective, this study makes important new contributions to the understanding of the transition to practice experience of NGNs in LTC, as well as the nursing skill-mix employed within LTC. While it is unknown how many NGNs are currently employed in LTC, as much as 10% of the staff in hospital are new graduates (Berkow, et al., 2009) and with the well documented retention challenges in LTC, this figure may be higher in this setting.

Hiring NGNs into LTC is one strategy employed to address the recruitment and retention challenges that LTC is facing. The findings from this study illustrate that while hiring NGNs into

LTC can be successful, the current approach - lacking in mentorship and other supportive programs and resources - is not as effective as it could be in supporting the NGN in this setting. Building upon robust mentorship programs, engaging meaningfully with academic centres through teaching nursing homes (Mezey, Mitty, & Burger, 2008), establishing proper and protected time for orientation, and funding and emphasizing full-time employment opportunities are just some of the ways to challenge the perception of LTC and raise the profile of nursing in this setting. Despite the challenges, the unrealistic expectations, and the complexity of the setting, NGNs in this study were able to recognize their value in LTC and develop skill and confidence that will carry them through their careers no matter the setting.

Summary of Discussion

Through discussion of the study findings, the results were found to be supportive of the three guiding propositions hypothesized and despite the challenges associated with transitioning in LTC, NGNs described a positive experience and overall demonstrated significant resiliency. Findings from this study are consistent with the new graduate literature, but also present new findings related to the transition to practice experience of the NGN in LTC and the transition experience of the RPN. This study refutes the findings by Benner (1982) and Duchscher (2008; 2009) as the transition to practice for the NGN in this study was not a gradual or progressive experience. Instead, as described by the NGN and LTC directors, it was a rapid jump from the new graduate status to that of the nurse leader. In addition, this study also provides important new knowledge as it relates to the contextual factors present in LTC, as well as a discussion on the transition to practice experience of the new graduate RPN.

Limitations of the Study

As with any study, there are limitations to be considered. Of importance is to note my inexperience and novice researcher status. Qualitative research is dependent upon the judgement and perceptions of the researcher (Creswell, 2013). My inexperience was addressed with the support of my supervisory committee.

A limitation of this study may be that the participants were at variable stages within their transition experience. Recall bias for those nearing the end of their first year of practice may have limited the study results and ultimately decreased the internal and external validity. It is likely that if participants were interviewed several times over a period of time their experiences would be better captured and some recall bias may be avoided. In addition, there was a lack of participants that were employed full-time in LTC. Some of the factors discussed may have had a greater influence on the NGNs included in this study because of their part-time employment.

It is also noted that only two LTCHs within the geographic setting were recruited for this study. These two sites may not be representative of the full scope of LTCHs in Ontario and may differ in size and number of beds, location within the city, funding source, and staffing structure. Additionally, there were only a small number of NGNs included in the study related to the small number of NGNs available in each LTCH.

Another limitation of the study may be that my professional designation and education intimidated NGNs during recruitment and data collection. As a novice nurse myself, it was hoped that despite my power role, I would be able to relate to NGNs regardless of their designation. This power imbalance may have negatively impacted NGN participant recruitment especially for those RPN new graduates, and also their willingness to fully disclose their transition to practice

experience out of fear of being judged. As an RN recruiting RPNs potentially not accustomed to research participation, I provided reassurance whenever possible.

CHAPTER SEVEN: IMPLICATIONS, KNOWLEDGE TRANSLATION, AND CONCLUSION

This study provides insight into the transition experience of NGNs transitioning to practice in LTC. Due to the previously unexplored and unexplained nature of this phenomenon in this setting, there are a number of implications for clinical practice, policy, nursing education, and research. This chapter discusses these implications, recommendations, and knowledge translation opportunities as well as the contributions of this study to nursing.

Implications and Recommendations for Clinical Practice

The findings from this study and discussion support the implementation and maintenance of a standardized and protected orientation period for NGNs entering practice in LTC. While there is not consensus on the length of time for formal orientation, promotion and support for increased funding for a minimum of 12 weeks is recommended (Accreditation Canada, 2013; Alameddine, Baumann, Onate, Crea, Arnaout, & Deber, 2017). Despite some research indicating that the NGG initiative may not contribute to great transitional support or job satisfaction in comparison to the hospital setting (Alameddine et al., 2017), this period of time would assist NGNs in establishing routine, building collaborative relationships, and promoting adequate time for skill acquisition and confidence building. Findings from this study suggest that NGNs should not have their formal orientation time cut short and that they should have protected time to orient. This time allows for adequate socialization into the new role as well as the practice setting and promotes skill acquisition from more experienced staff members.

In addition to this orientation period, the findings from this study along with the literature support the formalization of a mentorship program within the LTCH that the NGN is employed. NGNs should be placed on the same or similar schedule as their mentor so that they may follow-up, debrief, and connect with the mentor both formally and informally on a regular basis. Mentorship is an essential component to effective and successful transitioning for the NGN and permits a more informal and reciprocal passing of knowledge and experience.

More broadly, and in support of the findings in this study, it is recommended that the competencies of the nurse in LTC be further refined and clarified (McGilton et al., 2016). Due to the ratio of nurse to residents in LTC, and the lack of time for tasks and care, the RPN is often required to fulfill the duties otherwise expected of the RN (McGilton et al., 2016). The heavy influence of task-based work upon both the RN and RPN in LTC leaves neither working to their full scope of practice or the RPN stretching their scope to meet the needs of the residents (McGilton et al., 2016).

Implications and Recommendations for Policy

As outlined in the literature as well as the findings of this study, there is a need to provide greater emphasis on policy development in LTC. This is in regards to the retention and recruitment challenges that exist in LTC, in relation to the lack of full-time employment in LTC, and the negative perception of working in LTC. Health sciences programs across the country should cultivate formal relationships and affiliations with LTCHs in their communities such as those fostered through teaching nursing homes (Mezey et al., 2008) and other community partnerships (Health Quality Ontario, 2016). These alliances and relationships would promote transformation of LTC, motivate learning in this setting, and challenge the negative perception of

employment in LTC. Policy that supports these relationships should take into account the unique and challenging complexity of the setting in order to promote the value of a nursing or health sciences career in LTC.

At an organizational level, the establishment of hiring policies would better support the integration and transition of the NGN within LTC. Hiring NGNs into LTC is a viable and practical solution to the staffing challenges and the predicted growth in nursing jobs in coming years, however, from an organizational standpoint LTCHs must support orientation and mentorship so that the NGNs hired are effectively supported in their transition to practice.

Implications and Recommendations for Nursing Education

Results from this study demonstrate the value of providing clinical placements and gerontological learning opportunities to nursing students throughout their education. Results indicated that LTC exposure was lacking for the NGN and that this was one of many factors that contributed to challenges in the transition to practice experience, as well as the negative perception of the setting. Educators and academic centres, better linked and affiliated with LTC in the community could stress the importance, complexity, and value of these settings and begin to build understanding of the role of the nurse in LTC.

The findings from this study emphasize the need for educators and academic institutions to formally discuss the transition to practice period with nursing students. This could create a better understanding of the process and normalize the experience thus better preparing NGNs to advocate for themselves, socialize and support one another, and overall experience a more positive transition to practice.

Additionally, and more specifically for the new graduate RPN, there is a need for educators and academic institutions to provide opportunity for the nursing student to practice leadership and delegation activities. NGNs in this study described having little experience with leadership and for the budding RPNs, there was no emphasis on this skill set in their education. In acknowledgement of the major employment base that LTC provides for the RPN workforce, better preparing the new RPN to work in this setting, inclusive of knowledge of the context and setting, would better support the NGN and improve their transition to practice experience.

Implications and Recommendations for Research

The findings from this study and the gaps in current literature demonstrate need for further research in the area of NGNs in LTC. From the findings of this study, several subsequent areas of research should be considered with two presented in more detail.

Firstly, flowing from the emphasis of this study on the unique contextual factors that influence NGN transitioning in LTC, further research on these established contextual factors and their impact on resident care and nursing practice could be studied. Using a mixed methods study, the impact of these contextual factors, and more specifically, lack of time and isolation in practice, on the resident and the nurse could be explored.

Secondly, this study is one of few within the literature that has explored the experience of both the new graduate RN and RPN as the nurse, and the first of its kind to do so in LTC. Stemming from the findings supporting the similarities and differences of the new graduate RPN transition to practice, there is continued need for research to emphasize the distinct and individual contributions that RPNs offer within healthcare and more specifically within LTC. There are significant gaps in the literature exploring RPN practice and even more significant gaps

in new graduate RPN practice. As the landscape of healthcare continues to develop and nurses are more broadly utilized in variable settings with increasingly acute patients and residents, it is not enough to solely study the practice of the RN and refer to it as nursing.

Thirdly, as the NGG initiative in Ontario continues to be promoted and facilitated within the hospital and acute-care setting, there is continued need to further assess its efficacy and success in LTC. The financial benefits, retention rates, and job satisfaction scores of NGNs in the NGG initiative should be studied. Additionally, in support of O'Rourke's work in Manitoba, the pilot mentorship project should be tested and studied in other LTCHs to explore feasibility and positive transition to practice indicators.

Knowledge Translation and Exchange

According to the Canadian Institutes of Health Research (CIHR), knowledge translation is a process of "synthesis, dissemination, exchange, and ethically sound application of knowledge to improve the health of Canadians" (CIHR, 2010, para. 4). The emphasis of knowledge translation is in appreciation that new knowledge often does not lead to implementation on its own (CIHR, 2010).

As this current study was completed as one part of the thesis requirement for a Master's of Science in Nursing degree, this thesis, once defended, will be housed in the McMaster University library system. At this time, results from this study have been disseminated in the form of a oral presentation at the Faculty of Health Sciences Plenary session in May 2017. Further dissemination will include submission of a manuscript for a peer-reviewed journal publication to contribute these results to the body of existing transition to practice literature as well as peer-reviewed presentations at nursing education and practice conferences.

In addition to the plans for dissemination, knowledge exchange, or the process of sharing results with the knowledge user (CIHR, 2010), will occur with the two LTCHs. Findings from this study will be shared with the LTCHs as well as with the individual participants who requested the results.

Conclusion

This study makes important and novel contributions to the understanding of the transition to practice experience of NGNs in LTC and of the transition experience of new graduate RPNs. Despite each participant, regardless of whether they are a new graduate RN or an RPN experiencing transition to practice in their own unique way, six contextual factors and five transition experiences were described. These six contextual factors: casual workforce; lack of time; expectations; RPN role autonomy; isolation in practice; and an undesirable workplace, all contributed to an accelerated transition experience for the NGN from a new graduate to that of a nurse leader in LTC. This accelerated transition to practice was a result of the experience of five processes: struggling to meet expectations; practicing in isolation; relying on others; developing skill and confidence in spite of challenge; and recognizing complexity and value in LTC practice.

While NGNs are expected to be "work-ready from the moment they flip their tassels" (Hofler & Thomas, 2016, pg. 133) the educational preparation and the practice environment that they inherit must continue to support the new graduate in the unique context in which they work. Overwhelmingly, the participants in this study, regardless of the challenges that they experienced in their transition to practice, demonstrated resilience in character and dedication to nursing and the profession of nursing. In LTC, as care needs continue to grow, the acuity of those served continues to increase, and the fiscal restraint on care provision continues to

tighten, nurses and more specifically, new graduates are positioned to meet the needs of an aging population.

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APPENDIX A

Hamilton Integrated Research Ethics Board Approval

HiREB
Hamilton Integrated Research Ethics Board

2 December 2016

Project Number: 2420

Project Title: The transition to practice of new graduate nurses in long-term care.

Student Principal Investigator: Ms. Carly Whitmore

Local Principal Investigator: Dr. Pamela Baxter

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

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
consent-admin-V2	22/Nov/2016	V2
consent-NG-V2	22/Nov/2016	V2
demographics	22/Nov/2016	V2
ExplanatoryCSProtocol-CWhitmore - Submission-V2	22/Nov/2016	V2
interviewguide-admin	22/Nov/2016	V2
interviewguide-NG	22/Nov/2016	V2
introdletter-V2	22/Nov/2016	V2
recruitmentposter	28/Oct/2016	1

Any changes to this study must be submitted with an Amendment Request Form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study please submit a **Study Completion Form**.
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 QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Good luck with your research,

Kristina Trim, PhD, RSW
Chair, HiREB Student Research Committee
McMaster University

The Hamilton Integrated Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations;for studies conducted at St. Joseph's Hospital, HHSR complies with the health ethics guide of the Catholic Alliance of Canada

APPENDIX B

Recruitment Poster

APPENDIX C

NGN Interview Guide

The Transition to Practice of New Graduate Nurses in Long-Term Care

New Graduate Interview Guide

Section 1: TRANSITION TO PRACTICE

1. What has your transition to practice experience been like?
   Probes:
   What has been positive?

   What has been negative?

2. Do you feel that you were prepared for the responsibility of being a nurse?
   Probes:
   What do you feel has prepared you for the responsibility?

   When have you felt unprepared?

   Did you feel ready to leave your orientation?

   What did your orientation program look like?

3. Describe to me the difference between being a nursing student and being a new graduate nurse?
   Probes:
   Is the experience different than what you expected?

   What is different?

4. What resources help you with your transition experience?
   Probes:
   Where do you find these resources? Who? What? Where?

5. Describe for me what a good transition to practice would look like?
   Probes:
   Orientation program, support system, mentorship, other

6. Do you feel that there is a difference in the transition to practice between a RN and a RPN?
   Probes:
   What does that difference look like?

   Do you feel like one designation is more prepared than the other?

New Graduate Interview Guide (CONTINUED)

Section 2: LONG-TERM CARE CONTEXT

7. Tell me what it is like being a new graduate nurse in long-term care?
   Probes:
   - Describe a typical day for you
     - What is your typical patient load? What skills do you use?
   - What are the expectations of you as a new graduate nurse in LTC?
     - Is the experience different than what you expected?
   - Was long-term care your first choice of employment?
     - Why did you choose long-term care for employment?

8. Describe to me your understanding of the role of a nurse in the long-term care setting?
   Probes:
   - What is your role? What are your responsibilities? How do they differ between the RN or the RPN?

9. Describe to me what the average patient clinically presents like in long-term care?
   Probes:
   - How acute are they? What are their care needs?
   - How do you support the patient?
   - Do you feel properly equipped/supported to provide the necessary care?

10. Describe to me what the staffing skill mix looks like in long-term care?
    Probes:
    - Who do you work most with during a shift?
    - Who do you turn to for support/resources?
    - What is the benefit of the current staffing structure?
    - What are the risks of the current staffing structure?

New Graduate Interview Guide (CONTINUED)

Section 3: RISKS and BENEFITS

11. Describe to me the benefits of working as a new graduate nurse in long-term care?
    Probes:
        What are the personal benefits?

        What are the professional benefits?

        What are the benefits to the residents?

12. Describe to me the risks of working as a new graduate nurse in long-term care?
    Probes:
        What are the personal risks?

        What are the professional risks?

        What are the risks to the residents?

13. How are these benefits and risks assessed in your practice?
    Probes:
        When are they assessed?

14. How do these benefits and risks influence your practice?
    Probes:
        What influences your decision making?

        What influences your patient care?

15. Describe to me an example of how transition to practice in long-term care was easy.

16. Describe to me an example of how transition to practice in long-term care was hard.

17. How do these benefits and risks influence your transition to practice?

18. What other contextual factors related to long-term care influence your assessment of benefit and risk or your transition to practice?

APPENDIX D

LTC Director Interview Guide

The Transition to Practice of New Graduate Nurses in Long-Term Care

Facility Administrator Interview Guide

Section 1: TRANSITION TO PRACTICE

1. Tell me what you think it is like to be a new graduate nurse transitioning to practice in long-term care?
   Probes:
   - What are some expectations of new graduate nurses in this setting?
   - Do you think that their education prepares them for this transition? This experience? This setting?

2. Describe to me the orientation program offered here for new graduate nurses?
   Probes:
   - Is there a difference in the orientation of the new graduate RN and the RPN?
   - Once a new graduate nurses have completed their orientation, what supports remain in place for them?

3. Describe to me what a good transition to practice for a new graduate nurse would look like?
   Probes:
   - Who is involved?
   - What supports/resources/documents?

Section 2: LONG-TERM CARE CONTEXT

4. What is the role of the nurse in long-term care?
   Probes:
   - What is the role of the new graduate? What are their responsibilities? How do they differ between the RN and the RPN?

5. Describe to me what the average patient clinically presents like in long-term care?

Facility Administrator Interview Guide (CONTINUED)

6. Describe to me what the staffing skill mix looks like in long-term care?
   Probes:
   - Who does the new graduate nurse turn to for support/resources?
   - What is the benefit of the current staffing structure?
   - What are the risks of the current staffing structure?

Section 3: RISKS AND BENEFITS

7. Describe to me the benefits of working as a new graduate nurse in long-term care?
   Probes:
   - What are the personal benefits?
   - What are the professional benefits?
   - What are the benefits to the residents?

8. Describe to me the risks of working as a new graduate nurse in long-term care?
   Probes:
   - What are the personal risks?
   - What are the professional risks?
   - What are the risks to the residents?

9. How do these benefits and risks influence the practice of a new graduate nurse?
   Probes:
   - What influences their decision making?
   - What influences their patient care?

10. How do these benefits and risks influence their transition to practice?

11. What other contextual factors related to long-term care influence their assessment of benefit and risk or their transition to practice?