NEW GRADUATE NURSES AND TRANSITION TO PRACTICE

by

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Abstract

NEW GRADUATE NURSES AND TRANSITION TO PRACTICE

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A widely acknowledged transition to practice gap exists for nursing students who have recently graduated and are starting their first job as a registered nurse (RN). In an attempt to bridge this gap, new graduate nurses (NGNs) working in acute care hospitals are usually offered additional training in unit-specific knowledge and skills, along with time working with a unit-based preceptor. Hospital-based training programs are typically between two and six months in length, but the transition to becoming a competent RN with experience is estimated to take between 12 to 18 months (Duchscher, 2008). NGNs have much to learn and they perceive the first year of practice to be very stressful. As a consequence, NGN turnover rates by the end of the first year are conservatively estimated between 12% and 25% (Spector et al., 2015).

At six months of experience, NGNs report the highest levels of stress and lowest level of job satisfaction (Spector et al., 2015). However, no qualitative studies have been published that focus on the lived experience of NGNs as they are experiencing it during this period. The purpose of this study was to use phenomenology to explore the lived experience of NGNs as they transitioned to professional practice during their sixth to ninth month of experience. Fifteen NGNs were interviewed and their responses were analyzed for reoccurring codes and themes.

Twelve themes emerged from the data and were grouped into four clusters: overwhelmed, relationships, finding my flow, and being a good nurse.

At this stage in their transition, NGNs struggled with knowledge insecurity and effective time management. They felt overwhelmed and verbalized that being stressed all the time is a new normal that they must adjust to. NGNs in this study understood that creating and maintaining workplace relationships was necessary, as they still had questions and needed help from seasoned nurses. These relationships can be complicated because some nurses with experience were critical of NGNs. As a result, NGNs in this study verbalized uncertainty about asking for help for fear that experienced nurses would think they couldn't manage the responsibilities of being a nurse. At this stage, NGNs want to be a good nurse and give good care to their patients, but need more support from colleagues, hospital-based educators, and managers. The themes found in this study were compared to the concepts found in Duchscher's stages of transition theory. Limitations of the study were discussed along with implications for nursing practice and directions for future research.

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New Graduate Nurses and Transition to Practice

Chapter One: Introduction

The purpose of this chapter is to provide an overview of the entire project, beginning with the significance and background of the transition to practice experienced by new graduate nurses (NGNs) in their first year of employment. The middle range theory of stages of transition was used as a theoretical framework to guide this study (Duchscher, 2008; 2012). The concepts of the theory are explained that provided a foundation for the study purpose of expanding the theory. An explanation of the method of phenomenology and its' philosophical perspective is offered.

Significance

New graduate nurses represent the next generation of nursing professionals and offer the promise for a bright future. In order to become a registered nurse (RN), NGNs must pass the National Council of State Boards of Nursing Licensure Examination (NCLEX). In 2015, 157,957 U.S. educated NGNs took the NCLEX for the first time (NCSBN, 2016). According to a survey of NGNs who took the NCLEX in 2014, 72% (n = 1975) worked in an acute care setting (NCSBN, 2015). After they are hired into their first RN position, hospitals offer orientation and training programs to NGNs to help bridge the knowledge and experience gap that exists as they begin their transition from nursing student to competent nurse. This gap reflects the complexity of acute care nursing that must be learned in the first employment setting (Burns & Poster, 2008; Halfer & Graf, 2006).

Although gaining patient care experiences facilitates the transition of an NGN to a competent nurse, NGNs are particularly vulnerable to the stressors that exist in acute care

settings (Casey, Fink, Krugman, & Propst, 2004; Duchscher, 2008; Thomas, Bertram & Allen, 2012). When NGNs do not successfully negotiate the transition encountered in the first year of practice, emotional disequilibrium, job dissatisfaction, and job turnover may result (Peterson, McGillis-Hall, O'Brien-Pallas, & Cockerill, 2011; Spector et al., 2015). NGN turnover rates from first employment settings have been estimated at 4% to 75% in the first year of employment, with costs for training each NGN estimated at $49,000 - $92,000 in training dollars (Goode, Lynn, McElroy, Bednash, & Murray, 2013; Trepanier, Ulrich, Early, & Cherry, 2012). In an acute care hospital with 600 or more beds, annual organizational costs for RN turnover were estimated to be $5.9 million to $6.4 million per year (Jones, 2008).

Background

Transitions involve a movement or passage from one point to another. NGNs are experiencing a developmental transition as they navigate through the first year of nursing practice (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). They are being transformed from a student to a RN with experience. While learning to survive in a new work environment, NGNs are also engaging in a process of inner-reorientation as they adapt to and incorporate the new circumstances into their life (Kralik, Visentin, & van Loon, 2006). Several researchers have studied the transitions that are experienced by NGNs. Kramer (1974) wrote that NGNs were experiencing *reality shock* because they experienced a discrepancy between what they learned in school and what they encountered in their first nursing position in the real world. Benner (1984) indicated that NGNs were *novice nurses* when they first entered practice and were *advanced beginners* by the end of the first year. Duchscher (2008; 2009; 2012) and Schoessler and Waldo

(2006) concluded that NGNs experience three different stages of transition during their first 12 to 18 months of practice from NGN to competent nurse.

Hospitals often create or purchase training programs to help bridge the gap from new graduate to competent practicing nurse, but these programs vary widely in terms of length and content (Spector et al., 2015; Trepanier et al., 2012). Typical programs include opportunities for NGNs to gain additional clinical knowledge, learn hospital-specific policies and procedures, and spend time on the assigned unit with a preceptor (Rush, Adamack, Gordon, Lilly, & Janke, 2012). The influence of preceptors in the professional transition of NGNs cannot be underestimated. Preceptors orient NGNs to the responsibilities of the clinical area, teach technical skills, evaluate and promote clinical decision-making, and facilitate social connections to the unit (Baxter, 2010; Fink, Krugman, Casey, & Goode, 2008; Thomas et al., 2012). When reflecting on the orientation they received, NGNs reported desire to have longer precepted times, more contact with a dedicated unit-educator, more opportunities for skill acquisition in a non-threatening environment, and more techniques to manage lateral violence experiences (Maresca, Eggenberger, Moffa, & Newman, 2015; Nugent, 2008).

Researchers of 12-month residency programs have conducted longitudinal, quantitative, and mixed methods research to gain insight into NGNs' transition to practice. The time period from six to nine months after hire has been associated with the highest levels of stress and the lowest levels of job satisfaction and organizational commitment (Bratt, 2009). In two 12-month residency programs, satisfaction decreased during the initial transition phase. This was followed by a significant increase ($p < 0.05$) in satisfaction at the end of the one-year transition period (Krugman et al. 2006; Williams, Goode, Kresk, Bendash, & Lynn, 2007). The results from these

studies suggested NGNs experience an initial level of reality shock during their transition to practice that causes a dip in job satisfaction during the middle part of their first year but that they emerge from it toward the end of their 12-month residency. Transition programs that are shorter than one year in length may not provide sufficient support or time for new graduates to adjust (Krugman et al., 2006; Williams et al, 2007).

NGNs who do not master the transition to practice are vulnerable and at risk for low satisfaction with their role as a nurse (Peterson et al., 2011; Spector et al., 2015). Novice nurses are in unfamiliar territory, thus making them vulnerable to feelings of stress, powerlessness, and marginalization (Casey et al., 2004; Halfer & Graf, 2006). NGNs may experience feelings of professional isolation and being overwhelmed, especially when no one notices that they are having problems (Dyess & Sherman, 2009). Common frustrations for NGNs in the work environment include caring for high acuity patients, experiencing fears regarding unsafe patient care, and working in settings with undesirable nurse-patient ratios (Bowles & Candela, 2005). Fink and colleagues (2008) identified that dissatisfaction with work schedules, futility of care in certain patient care situations, and perceptions of increased workload with decreased assistance from ancillary staff contributed to low levels of job satisfaction in NGNs. Workplace incivility against NGNs by co-workers, supervisors, and physicians is an additional source of psychological distress and has been inversely correlated with successful transition to practice (Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013; Lim, Cortina, & Magley, 2008).

One result of a less than successful transition to practice is an increased risk of turnover among NGNs (Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2012). Turnover of nursing staff is expensive for employers, and NGNs may be assumed to incur greater turnover costs

compared to nurses with experience because of the extra training time needed to transition to their new role. The ratio of nurse turnover costs relative to salary ranged from 0.31 to 1.3 (Li & Jones, 2013). Using data from a multi-state longitudinal panel design, Brewer and colleagues (2012) reported one-year turnover rates for NGNs at 17.5% and two-year turnover rates at 33.5%. Increases in nursing turnover rates are also related to patient outcomes such as pressure ulcer development and patient falls (Bae, Mark, & Fried, 2010a).

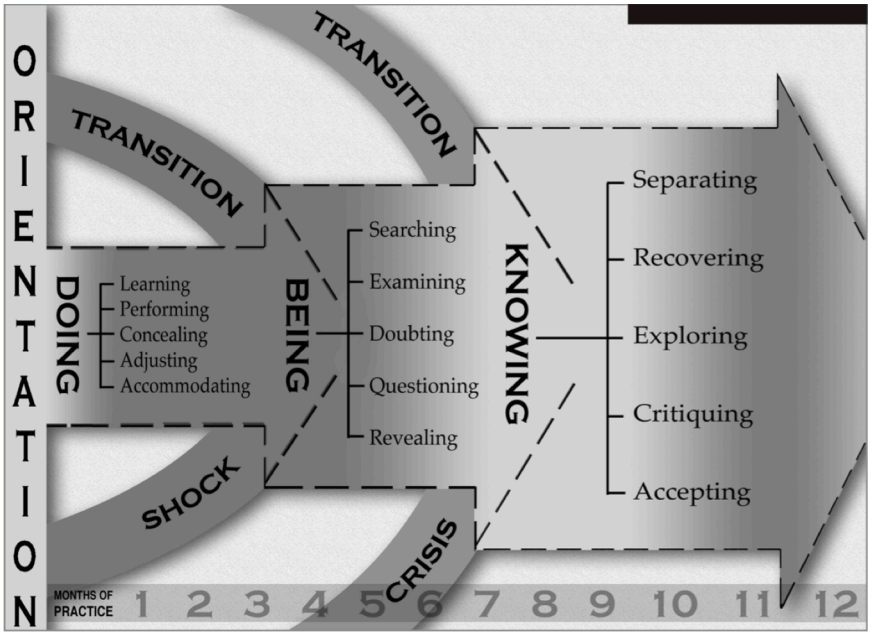
The influences that shape the formation of NGNs' intent to stay or leave in their first position are multifactorial. Intervening before new graduates form the intent to leave requires evidence-based strategies by nurse educators and managers. The most vulnerable period of time for NGNs may be from six to nine months of practice when NGNs are practicing independently and job satisfaction is reported to be at its lowest point. To date, no qualitative studies have been done to explore the lived experience of NGNs specifically during this period of time in their transition to practice.

Theoretical Framework

Identifying a theoretical framework is useful in a qualitative research proposal. This Primary Investigator (PI) used the stages of transition theory (Duchscher, 2008; 2009; 2012) to guide this study (See Figure 1). Duchscher developed the theory by synthesizing several qualitative studies on the NGN transition experience and by building on her own research and experience in working with NGNs. What emerged from this synthesis was a middle-range nursing theory with three stages of personal and professional transition that occur during the first 12 months of professional practice for NGNs (Duchscher, 2008, 2012).

Duchscher (2008, 2012) suggested that the initial 12 months of acute care practice was a personal and professional transition. The initial period of role transition occurs in the first three months of practice and starts with an orientation to the nurses' role. Described as the *doing* stage, this first time period is focused on adjusting to the new roles and responsibilities of the professional nursing position. NGNs focus on learning and performing skills and mastering clinical knowledge that relates to their specific area of practice. They learn to accommodate to new routines for practice and may choose to conceal their feelings of anxiety or inadequacy from others around them (Duchscher, 2009). The *doing* stage is characterized by intense feelings

Figure 1: Stages of Transition Theory



Note: From "A Process of Becoming: the Stages of New Nursing Graduate Professional Role Transition" by J. B. Duchscher, 2008, *Journal of Continuing Education in Nursing, 39*, 441-450. "Reproduced with permission of SLACK Incorporated." Copyright © 2016

of confusion, disorientation, loss, and doubt as NGNs move from the familiar academic environment and role of student to the new role of professional nurse. This is described as *transition shock* and represents an emotional response to finding their way in a work setting for which they had been prepared, but in which they were not completely ready to function (Duchscher, 2009). NGNs must make physical adjustments to the hours and demands of work, cope with emotional highs and lows related to initial learning and practice on their own and continually think about everything that they are doing at work with a high level of intensity (Duchscher, 2008; 2009; 2012).

The second stage, *being*, is characterized by a rapid advancement in NGNs' skills, knowledge levels, and competency (Duchscher, 2008). This stage typically lasts from the fourth through the eighth month, during which most NGNs are working independently. NGNs continue to feel doubt about their performance and professional identity. They often seek clarification and confirmation for actions and thoughts from others when being placed in uncomfortable situations and struggle with feelings of incompetence. They examine and compare who they were as a student with who they want to be as a professional nurse. Although they may not experience as many emotional highs and lows as they did in the first stage, NGNs continue to feel physically drained and full of questions about their practice and their future (Duchscher, 2008; 2012). As a result, NGNs begin to seek balance and separation between their personal and professional lives. This stage is also described as a *transition crisis* (Duchscher, 2008).

The final stage, *knowing*, begins around the ninth month of practice. According to Duchscher (2008; 2012), this stage is about growing an even deeper understanding of what nursing is and who NGNs are as professional nurses. NGNs continue to explore and critique

their new self-identity and their relationship to their employer and the larger community of professionals. An increased awareness of healthcare system issues and a potential devaluing of the nurse role may lead to new frustrations (Duchscher, 2008; 2012). By the end of the twelfth month, NGN recovery is evidenced by feeling a relatively stable level of comfort and acceptance with their roles, responsibilities, and routines. There is a subtle shift from being a learner to being in a position of increased expectations. NGNs at this stage often compare their current level of skill and knowledge with those of the NGNs who are entering the workforce. In addition, NGNs have more emotional energy to invest in relationships or activities outside of work (Duchscher, 2008; 2012).

Duchscher (2008; 2012) described the relationships between the concepts with unidirectional arrows. As NGNs progress through their first year of experience, their journey though the stages may not be strictly linear, but rather marked by a series of forward movements and slight regressions. The one-year journey is transformative and evolutionary for NGNs as they work towards the goal of being competent and confident in their professional role as a nurse.

A weakness of the model is that it does not account for how external factors influence the experience of transition. Past work experience, variations in NGN orientation length and content, and relationships with initial preceptors may influence the NGNs' transition (Spector et al., 2015; Trepanier et al., 2012). The incidence of workplace incivility, unit acuity and staffing levels, and availability of support from nurse educators and managers also may influence NGN transition (Dyess & Sherman, 2009; Halfer & Graf, 2006; Laschinger et al., 2013). No

description or outcome is depicted for those NGNs who do not successfully navigate the transition.

This PI used the stages of transition theory as a framework for understanding NGNs' developmental transitions occurring in the middle of the first year of practice. Simultaneously, the concepts within the theory were tested for their accuracy and sufficiency as a description of the NGN experience. For example, interview questions about positive and negative experiences NGNs had recently had were used to explore the *being* stage. Questions were also asked regarding their perceptions of a future role as a competent and confident nurse as a means of assessing themes more commonly found in the *knowing* stage.

Study Purpose

The purpose of this phenomenological study was to describe the lived experience of NGNs during their first six to nine months of employment within their first year of practice after they have completed their initial training with a preceptor.

Method and Philosophical Perspective

The phenomenological method was used to explore the characteristics of the transition experienced by NGNs after they finished orienting with a preceptor but before they completed their first year of practice. This method focuses on understanding the basic structures of consciousness as experienced by individuals from their unique first-person perspective (Munhall, 2012). As a philosophy, the primary goal of phenomenology is to assign meaning to the things people consciously experience. Perception, thought, memory, imagination, emotions, time, and actions are all aspects of the basic structure of consciousness and help provide meaning to the individual who is experiencing them (Dowling, 2007). Phenomenological philosophers and

researchers attempt to delve deeper into these forms of lived experience and expressions of meaning using existential investigation techniques such as interviews, journaling, and experiential descriptions found in other places such as literature, theories, art, and anecdotes (Munhall, 2012). The goal of using these techniques is ultimately to increase awareness of self, others, actions or choices, and/or activities within a culture and to describe the subjective reality of the individuals with regard to the phenomenon of interest (Norlyk & Harder, 2010).

Traditionally affiliated with the discipline of psychology, several philosophers have shaped the development of the philosophy and therefore the research approach of phenomenology. Martin Heidegger thought that it was important to understand the individual's experience of "being in the world" (Dowling, 2007). This was gained by first gathering a description of the individual's experiences and perceptions and then interpreting that description through the analysis of verbal and written language (Dowling, 2007). Heidegger also believed that a researcher's understanding of the human experience was influenced by his/her own experiences and interpreted from within the context of his/her involvement in the world. The suspension of the researcher's beliefs and prejudices while attempting to understand the experience of others (also known as bracketing) was not possible (McConnell-Henry, Chapman, & Francis, 2009).

Building on the writings of Husserl and Heidegger, Maurice Merleau-Ponty pointed out that perception and interpretation of an individual's situatedness in the world were crucial to understanding (Dowling, 2007). He focused on developing the concept of the four existential life worlds. The four existential life worlds are space (or environment), the time in which one lives, corporeality (or the physical experience), and the relationships one has with others

(Dowling, 2007). A researcher should assess the applicability of the life worlds to the narrative material that has been gathered from participants in order to gain a more complete contextual processing of the content (Munhall, 2012). The branch of phenomenology that is characterized by the early influences of Heidegger and Merleau-Ponty, and later work of Max van Manen, is often called interpretive or hermeneutic phenomenology (Dowling, 2007; McConnell-Henry et al., 2009; Munhall, 2012).

Building on the work of Heidegger and Merleau-Ponty, Max van Manen (1990) has been credited with developing six research activities or guidelines for phenomenological researchers. The first research activity, turning toward the phenomenon, requires the researcher to pick a research phenomenon (or lived experience) that sincerely interests him/her and commit to the process of discovery. The plan is to ask: "What is the nature of the lived experience of this phenomenon?" Investigating the experience as it is lived, rather than how it is conceptualized by the researcher, is the second research activity. Conducting interviews allows the researcher to collect rich experiential information and create a dialogue between the researcher and the participant about the phenomenon's meaning (Dowling, 2007; Van Manen, 1990).

Reflecting on the central themes that comprise the phenomenon is the primary task of the third research activity (Van Manen, 1990). The act of deeply thinking about or reflecting on the information revealed in the second research activity can help the researcher discover the essence of the experience and units of meaning or themes that help to describe the phenomenon's structure from the individual's point of view may become apparent (Earle, 2010; Van Manen, 1990). A cornerstone of Van Manen's (1990) approach is seen in the fourth research activity: writing and re-writing. This assists the researcher's thoughts to be externally observed, allows

themes and structure to emerge more fully, and encourages us to act on what we have discovered (Van Manen, 2005).

The fifth research activity is to maintain a strong and oriented relation to the phenomenon (Van Manen, 1990). The goal is for the researcher to externalize the lived experience of the participants through writings that are oriented toward their specific discipline and deep, rich, and action-focused. "Balancing the research context by considering parts and whole" is the sixth research activity identified by Van Manen (1990, p. 33). Here he encouraged the researcher to not get lost in the details of the phenomenon while writing, but to seek balance by continually comparing the details against the overall structure of the phenomenon. Another suggestion for organizing and writing about the phenomenon includes organizing themes around the four life worlds, an existential approach (Earle, 2010; Van Manen, 1990).

The purpose for selecting an interpretive or hermeneutical phenomenological approach, such as one used by Heidegger or Van Manen, was to answer the question: What is the lived experience of new graduate nurses (NGNs) during six to nine months after graduation when they have completed their initial training with a preceptor? This PI was attempting to understand the experiences of NGNs as they experience the middle stage of Duchscher's (2008) stages of transition theory, which is known as *being* and described as a transition crisis. An abundance of research and literature exists regarding the experience of NGNs in the first three to four months of practice, when they are still participating in an organized training program and working with a preceptor. Little research has been done to describe what is occurring with the professional transition of NGNs during the remaining 6-9 months of their first year of experience, which is described as *being* and *knowing* in the stages of transition theory (Duchscher, 2008). A

phenomenological study was appropriate to conduct with NGNs in order to gain a better understanding of their lived experience, connect their experiences to Duchscher's stages of transition, and to inform future studies in this area.

Essential Assumptions

Assumptions are "ideas that are taken for granted or viewed as truth without conscious or explicit testing" (Rebar, Gersch, Macnee, & McCabe, 2011, p. 221). Assumptions influence how we view a research problem and can be difficult to identify because they are generally understood or agreed to by others. A lack of awareness of assumptions limits how a research problem is investigated (Rebar et al., 2011). This PI identified the following assumptions:

1. NGNs are willing to talk about their memories of their precepted time and their transition from precepted time to independent practice.
2. NGNs are able to discuss abstractly their experiences of nursing as they are experiencing them now.
3. NGNs are aware of their future plans and what expectations they have of being a competent in their role.
4. Understanding the lived experience of NGNs by examining their personal feelings and thoughts may be best achieved through the use of a phenomenological methodology.

Chapter Summary

NGNs have been the subject of nursing research for many decades. The first year of practice for NGNs is challenging as they work to acquire experience and develop professional competence. Evidence exists that the highest levels of stress and lowest job satisfaction are reported by NGNs at six months of experience, when many have completed their initial training

and are working independently (Bratt, 2009; Krugman et al., 2006; Williams et al., 2007). When high stress and low job satisfaction continues, this may contribute to turnover by the end of their first year of employment (Brewer et al., 2012). Prior to this study there were no published qualitative studies that used a phenomenological method and that focused on describing the lived experience of NGNs specifically from the sixth through the ninth month of experience. Gaining a deeper understanding into their lived experience may offer insights into further development of the stages of transition theory (Duchscher, 2008).

Chapter Two: Background and Significance

The purpose of this chapter is to offer a literature review that supports a study focused on the lived experience of NGNs as they transition to professional practice during their sixth through ninth month of experience. A brief description of the population of interest and the significance of the problem of interest is offered. A background of the pertinent literature is offered with an emphasis on (a) a brief review of the characteristics of transition, (b) transition to practice programs offered to NGNs, (c) positive influences on job satisfaction for NGNs at one year of practice, and (d) common challenges faced by NGNs during their first year. At the conclusion of this chapter, unanswered questions from the literature are identified and a rationale suggested for the study purpose and questions.

A NGN is defined as an individual who is newly graduated from nursing school and who is engaged in the first 12 months of professional practice as an RN. According to the NCSBN, (2016) in 2015 there were 157,957 new graduates educated in the United States who took the licensure examination for the first time. Of these, 10,989 were from Texas. The NCSBN conducted a survey using a random sample of 2,744 individuals who had passed the RN licensure examination in 2014. The typical responder was White, female (87%), with a mean age of 31 years (*sd* = 8.8). The majority of responders worked in an acute care (72%, *n* = 1976) or long-term hospital setting (14.7%, *n* = 403). Within the acute care setting, 27.7% (*n* = 760) worked in medical-surgical units, 4.3% (*n* = 118) worked in intermediate care, and 18.7% (*n* =513) in critical care units. NGNs also reported working in rehabilitation (5.5%, *n* = 150) and in pediatric (3.6%, *n* = 99) environments (NCSBN, 2015).

Significance

The first year of practice for NGNs is an important professional transition because the knowledge and experience that students have gained while in school is typically not enough to allow them to function independently and competently when they start their first RN position. Although the training offered by the employer, the passage of time, and gaining of patient care experiences facilitates the transition of the NGN to a competent RN, NGNs are particularly vulnerable to the stressors that exist in acute care settings (Casey et al., 2004; Duchscher, 2008; Thomas et al., 2012). Theorists also commonly describe the first year of practice as an emotionally challenging year for NGNs while they work to acquire experience and develop professional competence (Benner, 1984; Duchscher, 2012; Kramer, 1974). Turnover rates of NGNs, and the problems associated with RN turnover, may reflect one response of NGNs to their challenging first year.

Emotional Consequences of Transition for NGNs

NGNs report experiencing feelings of professional isolation, being overwhelmed, or feeling stressed, especially when no one notices that they are having problems (Dyess & Sherman, 2009). In the first three to four months of practice, NGNs are focused on tasks and performance, time management, lack of knowledge and self-confidence, safety issues, and high workload (Duchscher, 2008; McCalla-Graham & DeGagne, 2015; Penphrase, 2012). They see the complexity and conditions of patients as challenging (Schoessler & Waldo, 2006). Although initially excited about their transition, many report also feeling a disparity between their preparation and the work world (Duchscher, 2008; Halfer & Graf, 2006). NGNs also have to

become physically acclimated to the demands of the job, deal with a sense of loss about what is being sacrificed to be a nurse, and cope with the emotions from work that affect them during their non-working hours. They complain of sleep disturbances, changes in appetite, feelings of anxiety, and worrying about the next shift even though they are at home (Ashton, 2015).

At five to eight months of practice, NGN's knowledge, critical thinking skills, and skill competency are steadily improving (Duchscher, 2008). During this period of time, many begin to work on their own and no longer receive active precepting, unless they are in a 12-month residency program. NGNs at six months' experience a drop in job satisfaction, a decrease in satisfaction with scheduling, and a decrease in comfort in asking questions of others (Halfer & Graf, 2006). Even in 12-month residency programs, the time period from six to nine months after hire is associated with the highest levels of stress and the lowest levels of job satisfaction and organizational commitment (Bratt, 2009; Krugman et al., 2006; Williams et al., 2007). Work-related stress is at its highest levels at this time, irrespective of what type of training program the NGN has or is experiencing (Spector et al., 2015). NGNs also report struggling with effective communication with physicians in order to advocate for patients and fear being presented with questions from physicians and patients/families that they cannot answer (Schoessler & Waldo, 2006). Their self-confidence may be tenuous as they begin the process of working alone (Etheridge, 2007).

NGNs report a significant increase in job satisfaction as their first year of practice comes to an end (Bratt, 2009; Halfer & Graf, 2007; Krugman et al., 2006; Williams et al., 2007). This indicates that NGNs experience an initial level of reality shock during their transition to practice but emerge from it toward the end of their 12-month residency (Kramer, 1974). Other evidence

that NGNs have achieved a successful transition to the RN role include an increased level of comfort with the knowledge and skills needed to care for patients and an increased level of self-confidence and competence (Benner, 1984; Schoessler & Waldo, 2006). NGNs who have transitioned successfully report learning more efficient time management skills, how to think critically, how to prioritize, and how to communicate with the healthcare team. Experiencing social support, camaraderie, and positive interactions with co-workers are also sources of job satisfaction (Fink et al., 2008; Goode et al., 2013; Peterson et al., 2011). When they do not report these characteristics near the end of their transition year, NGNs may be at risk for job turnover.

Transition Outcomes for Hospitals

Turnover rates and costs. A review of the literature on nursing turnover revealed that there is no standard definition of nursing turnover or method of measurement of this phenomenon (Li & Jones, 2013). Jones (2008) described nursing turnover as the process by which nursing staff leave or transfer within the hospital environment. Turnover may be for voluntary reasons, such as moving or returning to school, or for involuntary reasons, including being terminated from a position, a serious illness, or death. There are no state or national databases that track nursing employment, retention, or numbers of nurses who leave the profession (Kovner, Brewer, Fatehi, & Jun, 2014).

Published NGN turnover rates vary widely according to the setting that is sampled and the measurement used. Using data from a multi-state longitudinal panel design, Kovner and colleagues (2014) reported one-year voluntary and involuntary organizational turnover rates of 17.5% (n = 367) and two-year turnover rates of 33.5% (n = 702). NGNs who changed units but

remained in the same organization were not counted in this rate (Kovner et al. 2014). Residency programs that are available for purchase provide evidence that they reduce the turnover rates among NGNs who complete their programs. For example, Trepanier and colleagues (2012) reported a cumulative rate of NGNs leaving the organization prior to completion of their first year of practice and participating in a 12-month fee-for-purchase residency program in their participating hospitals of 6.4% (n = 15 hospitals). Goode et al. (2013) reported a turnover rate between 4% and 6% at 12 months for hospitals using their fee for purchase 12-month residency program but offered no definition of turnover with these figures. In a multistate transition to practice study, which included 1,464 NGNs, turnover was estimated between 12% at hospitals with established transition to practice programs and 25% in those with limited programs (Spector et al., 2015). Researchers, conducting a survival analysis to estimate the probabilities of 351 hospital-based NGNs in Korea staying in their first job for one year, estimated a turnover rate of 17.7% at one year (n = 62, p = .823), 33% at two years (n = 116, p = .666), and 47% at three years (n = 165, p = .537), demonstrating that NGN turnover is not just a problem in the United States (Cho, Lee, Mark, & Yun, 2012). These figures have significant implications for acute care hospitals because the 2-year mark for NGNs is often the point at which they assume a leadership role as a preceptor, charge nurse, or manager.

Turnover of RN staff is expensive for employers, and the costs can be direct or indirect (Jones, 2008; O'Brien-Pallas et al., 2006). Direct turnover costs include pre-hire costs such as advertising and recruiting, use of agency staff, and expenses related to hiring. Indirect turnover costs accrue after nurses are hired and include orientation and training, decreased productivity while learning the role, and costs related to termination (Li & Jones, 2013). NGNs incur greater

indirect costs compared to RNs with experience due to the extra time needed to learn their new role. From 1990 to 2008, the ratio of nurse turnover costs relative to salary ranged from 0.31 to 1.3 (Li & Jones, 2013). Typical training costs per NGN in the first year of employment are estimated at $49,000 to $92,000 (Trepanier et al., 2012). In an acute care hospital with over 600 beds, annual organizational costs for RN turnover were estimated to be $5.9 million to $6.4 million per year (Jones, 2008).

Impact of turnover on safety. Nursing turnover is also related to negative patient outcomes. Moderate levels of turnover in nursing units contribute to lower levels of workgroup learning and an increase in medication errors (Bae, Mark, & Fried, 2010a). For example, for every 10 percentage-point increase in RN turnover in a quarter, the patient odds for developing a pressure ulcer increase by 4% in the next quarter (Park, Boyle, Bergquist-Beringer, Staggs, & Dunton, 2014). When RN turnover rates are high, temporary RN workers who are external to the organization may be used to fill the gaps. Patients on units with high levels of temporary RNs were more likely to experience patient falls (Bae et al., 2010b).

A stable nursing workforce's contribution to patient safety, development of nursing leadership, and ability to support the training of the next generation of nurses cannot be underestimated by the nursing profession and the acute care hospitals that employ them (Bae et al., 2010a; Needleman et al., 2011). RNs make up the single largest health profession in the United States, and the employment of RNs is expected to grow 16% from 2014 to 2024 (Bureau of Labor Statistics, U.S. Department of Labor, 2015). Unfortunately, 55% (n = 42,294) of RNs are age 50 or older (Budden, Zhong, Moulton, & Cimiotti, 2013). It is projected that one million RNs will reach retirement age within the next 10 to 15 years (U.S. Department of Health and

Human Services, 2014). Identifying the determinants of poor transition and turnover in NGNs and developing strategies to assist with their retention are clearly important to the profession of nursing.

During their first 12 months of practice as a nurse, NGNs are undergoing a transition from the role of student to becoming a RN with experience. Evidence from quantitative and qualitative research indicates that the transition is stressful for NGNs. They struggle with compensating for perceived knowledge, skills, and experience gaps. They report feeling anxiety, self-doubt, trouble with time management, and low job satisfaction during the transitional year. Transition to practice programs and the assistance of a preceptor are essential to NGNs as they navigate this period of professional growth (Krugman et al., 2006; Penphrase, 2012; Williams et al., 2007).

Background

In order to understand what NGNs experience in the first year of practice, it is important to begin with a review of what is known regarding the characteristics of transition. An overview follows of the components of transition to practice programs and the role of the preceptor in training. A brief summary of organizations that provide external influence and support for transition to practice programs is offered. Examples of positive outcomes from the first year of nursing and common challenges encountered by NGNs in their first year of practice are explored as potential contributing factors to NGN turnover.

Characteristics of Transition

Transitions involve a movement or passage from one point to another. NGNs are experiencing a developmental transition as they navigate through the first year of nursing

practice (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). It is theorized that this transition takes 12 -18 months to complete and may have two to three stages (Benner, 1984; Duchscher, 2008; Kramer, 1974; Schoessler & Waldo, 2006). They are being transformed from students to experienced RNs. NGNs must learn to survive in a new work environment and will begin a process of inner-reorientation as they adapt to and incorporate the new circumstances into their lives (Kralik, Visentin, & van Loon, 2006). To become RNs with experience they will have to stop being what they are now. To learn to do things a new way, they will have to be willing to add to or to amend what they have already learned (Bridges, 2004).

Transition to Practice Programs

According to Burns and Poster (2008), the purpose of academic training is to create NGNs who are ready to pass the national licensing exam and begin their career. In a survey of 5,700 nurse leaders and 400 academic deans and directors, 90% of educators believed that their students were fully prepared to provide safe, effective care to patients, but only 10% of nurse leaders agreed (Berkow, Virkstis, Stewart, & Conway, 2008). This gap between preparation and practice reflects the complexity of acute care nursing that must be bridged in the first employment setting (Burns & Poster, 2008; Halfer & Graf, 2006).

Historically, hospitals have created transition to practice or training programs to help bridge the gap from new graduate to competent practicing nurse. These training programs vary widely from hospital to hospital in terms of length and content (Trepanier et al., 2012). In an integrative review of literature on transition to practice programs, the length of the programs varied from less than one month to over a year, with 14 studies not specifically identifying a program length (Rush et al., 2012). These programs also vary in content from hospital to

hospital and may include gaining additional clinical knowledge, learning hospital-specific policies and procedures, spending time on the assigned unit with a preceptor, or even rotating to other units as assigned (Baxter, 2010; Rush et al., 2012).

Within the last 12 years, organizations such as University HealthSystem Consortium/American Association of Colleges of Nursing (UHC/AACN, 2015) and Versant (2015) have created standardized NGN training programs that are available for purchase. They have published positive 10-year outcomes from their programs (Goode et al., 2013; Ulrich et al., 2010). Although these programs have had positive outcomes, not all hospitals choose to purchase them because they can be expensive and are not specifically tailored to the individual needs of the purchasing hospital.

Within these training programs, methods such as structured precepting, team precepting, and frequent contact from unit-based educators were found to decrease staff turnover rates, increase job satisfaction, and increase perceived confidence and competence of novice nurses (Cheeks & Dunn, 2010; Ulrich et al., 2010). For example, in one instance turnover decreased from 30% to 4.3% at the 12 month mark in a pre-training program (Ulrich et al., 2010). Orientation or onboarding programs that promote empowerment are linked to increased commitment to the profession and job satisfaction and to decreased burnout and incivility (b = 0.306, t = 3.17, p = 0.002; Deppoliti, 2008; Smith, Andrusyszyn, & Laschinger, 2010). Efforts to promote clinical reasoning or critical thinking skills and to avoid errors are also a focus of NGN transition to practice programs (Remillard, 2013; Saintsing, Gibson, & Pennington, 2011; Wiles, Simko, & Schoessler, 2013). When given a voice, NGNs report wishing for longer precepted times, more contact with a dedicated unit-educator, more opportunities for skill

acquisition in a non-threatening environment, and more techniques to manage lateral violence experiences (Maresca et al., 2015; Nugent, 2008).

The importance of preceptors and mentors. The influence of preceptors in the professional transition of NGNs cannot be underestimated. Effective preceptors are important because they are tasked with orienting NGNs to the responsibilities of the clinical area, teaching technical skills, evaluating and promoting clinical decision-making skills, and facilitating social connections to the unit (Baxter, 2010; Fink et al., 2008; Thomas et al., 2012). Offering continuing education programs to experienced nurses in order to develop and enhance their precepting skills is necessary (Baxter, 2010; Boyer, 2008; Horton, DePaoli, Hertach & Bower, 2012). Benner (1984) suggested that nurses with 2 - 4 years of experience are well suited for the preceptor role because they are able to break down clinical tasks and explain why they think the way they do. Generation Y nurses, which includes those who are born between 1980 and 2000, may prefer preceptors who are technologically savvy and are quick, effective communicators (Lampe, Stratton, & Welsh, 2011).

Researchers have advocated assigning NGNs to primary preceptors versus to multiple preceptors during their transition to practice program because NGNs report a preference for a primary preceptor when a good relationship can be established (Baxter, 2010; Lampe et al., 2011). When multiple preceptors are used, NGNs have reported needing to be flexible in order to deal with different approaches to learning the same tasks, and some NGNs have verbalized anxiety at not knowing to whom they would be assigned each day (Cheeks & Dunn, 2010). Other new graduates found it beneficial to be assigned to multiple preceptors because it provided exposure to different approaches to prioritizing care and time management (Nugent, 2008).

When preceptor-NGN relationships are not compatible, NGNs feel significant stress (Lampe et al., 2011; Poradzisz, Kostovich, O'Connell & Lefaiver, 2012).

Being assigned to a mentor or buddy on the unit for six months after completion of the orientation period can assist NGNs to develop relationships on the unit, have good work habits reinforced, and receive guidance and feedback with respect to care issues (Guhde, 2005; Newhouse, Hoffman, Suflita, & Hairston, 2007). Establishing a one-year mentoring program with NGNs can increase their job satisfaction and reduce turnover rates (Fox, 2010). The addition of mentor programs to run concurrently with existing orientation methods (internships and residency programs) or to extend beyond the end of initial orientation and training are associated with best practices for NGN transition programs (Rush et al., 2012). Barriers to establishing a mentor program are the financial and administrative costs needed to coordinate and sustain the program, and the need for support for the program from the staff and management on the unit (Fox, 2010). Evaluation of mentoring programs is generally tied to retention, and few authors have discussed assessing the matching process or evaluating mentor training (Rush et al., 2012).

External influences on hospital transition to practice programs. The Texas Board of Nursing (Texas BON, 2015), the Institute of Medicine (IOM, 2011), and the American Organization of Nurse Executives (AONE, 2010) have made recommendations for training programs to assist NGNs with the transition to practice. Personnel from the Texas BON (2015) have stated that it is essential for the novice practitioner to seek and receive direction, supervision, consultation, and collaboration from experienced nurses. Experienced nurses should be willing to supervise and mentor new graduates. Direct supervision by an experienced

nurse should occur for six months or a shorter time period if agreed upon by the new graduate and the supervising nurse (Texas BON, 2015). The new graduate and the supervising nurse should mutually determine the NGN's competence and document this process. In addition, the Texas BON recommends that novice nurses not hold leadership positions within the first six months of practice and not practice in independent settings (i.e. home health) for a period of 12-18 months (Texas BON, 2015).

Health care organizations should provide training and support of NGNs and should "implement nurse residency programs for nurses finishing pre-licensure or advanced practice degree programs or when they are transitioning into new clinical practice areas" (IOM, 2011, p. 11). Public and private funders should collaborate where possible to fund the development of nurse residency programs across all areas of practice. Programs offered by health care organizations should be evaluated for turnover rates, patient outcomes, and expansion of nursing competencies (IOM, 2011).

Nurse managers are key drivers for ensuring that the experience of NGNs is successful (AONE, 2010). Nurse managers should recognize that entry into the complexity of nursing work and assimilation of the professional role is a major life event. NGNs need support during their transition from all levels of management in the organization. It is essential for nurse managers to reduce or mitigate work environment stressors where possible (AONE, 2010).

Training of NGNs is offered in most acute care hospital settings, but transition to practice programs are not standardized, despite recommendations from national organizations (IOM, 2011). There is a great deal of reported variability in length and content of transition to practice programs and in preceptor training. The preceptor selection and assignment process and whether

or not an additional mentoring program is offered also vary among acute care settings (Gross, 2015; Spector et al, 2015). Systematic reviews of best practices in transition to practice programs and in preceptor training and assignment have been published since 2012. Despite this knowledge, education departments in acute care settings are slow to implement the evidence found within the research due to a lack of awareness, time, financial support, or upper-management backing (Gross, 2015; Letourneau & Fater, 2015; McDonald & Ward-Smith, 2012; Rush et al., 2012).

Positive Outcomes From the First Year of Practice

NGNs have reported positive outcomes at the end of their first year as a result of their training and experiences (Bratt, 2009; Halfer & Graf, 2007; Krugman et al., 2006; Williams et al., 2007). Unit teamwork, ability to give quality care, job satisfaction, peer relationships, and benefits such as salary and vacation time are major reasons they choose to remain with their employers (Goode et al., 2013; Peterson et al., 2011; Setter, Walker, Connelly, & Peterman, 2011). Receiving praise and recognition for a job well done from peers and those in a supervisory relationship is another source of satisfaction (Goode et al., 2013; Williams et al., 2007). Opportunities for advancement are important to some NGNs as they enter their second year of practice (Ulrich et al., 2010).

Common Challenges Faced in the First Year

Working conditions. NGNs encounter frustrations in the work environment that contribute to their low levels of job satisfaction and increased risk of nursing turnover. They associate feelings of stress with caring for high acuity patients, experience fears regarding unsafe patient care, and work in settings with undesirable nurse-patient ratios (Bowles & Candela,

2005). In addition, NGNs identify stressful situations as their most frequently reported reason for leaving. Additional factors that contribute to stress in NGNs include a lack of support and guidance from management and being assigned high levels of responsibility too early in their nursing careers (Bowles & Candela, 2005). Dissatisfaction with work schedules, futility of care in certain patient care situations, and perceptions of increased workload with decreased assistance from ancillary staff also contribute to low levels of job satisfaction (Fink et al., 2008). New graduates who experience work-based injuries (sprains and strains) also tend to be at risk for higher rates of turnover (Brewer et al., 2012). When asked directly about stress and job satisfaction at hire, six months, nine months, and 12 months, a sample of 1,464 NGNs from 94 hospitals across the U.S. who experienced a variety of transition to practice programs reported the highest levels of stress and lowest level of job satisfaction at six months of practice. Reported stress levels decreased and job satisfaction increased as the NGNs completed one year of practice (Spector et al., 2015).

Incivility, violence, and bullying in the workplace. Workplace incivility is a form of workplace mistreatment where rude, discourteous, or disrespectful behavior is exhibited towards another person (Laschinger et al., 2013). Horizontal violence, bullying, and nurse burnout are related to the experience of workplace incivility and are negatively correlated with job satisfaction ($r = ¯0.325$-$¯0.553$, $p < .05$) and retention ($r = ¯0.257$-$¯0.407$, $p < .05$) in nurses (Laschinger, Leiter, Day, & Gilin, 2009). NGNs may be particularly vulnerable to incivility because of their novice status and their need for dependence on others as they transition into their role. Uncivil behaviors by co-workers ($r = 0.36$, $p < .05$), supervisors ($r = .18$, $p < .05$), and physicians ($r = .23$, $p < .05$) are sources of psychological distress for NGNs which may impede

their successful transition to practice (Laschinger et al., 2013). Experiences with co-workers or superiors that resulted in a lack of teamwork, respect, or instances of workplace incivility are factors that contribute to job dissatisfaction (Fink et al., 2008; Laschinger et al., 2009; Weaver, 2013).

Interventions to increase resilience in NGNs assist them to manage workplace incivility encountered in the first year of practice, and resilience is associated with improved retention rates (Laschinger et al., 2013; Moran, 2012). There have been no studies published in which researchers examined the rates of incivility events experienced by NGNs in the first year of nursing practice or whether the rates of incivility decreased as an NGN gained more experience.

Research Gaps

The most vulnerable period of time for NGNs is from six to nine months of practice when they are no longer engaged in a training program or paired with a preceptor as evidenced by high levels of job stress and low levels of job satisfaction reported during this timeframe (Bratt, 2009; Halfer & Graf, 2006; Krugman et al., 2006; Spector et al., 2015; Williams et al., 2007). Few studies have directly measured the NGNs' perceptions of stress levels (Spector et al., 2015) and incivility (Laschinger et al., 2013), and no studies have been published that quantitatively measured anxiety or depression as they progress through their first year of employment. No studies were found that attempted to utilize the characteristics of the stages as described by Schoessler and Waldo (2006) and Duchscher (2008) for NGN education and support or for the development of quantitative assessments of stage or role attainment.

Studies have been conducted that explore the experiences and concerns of NGNs during their first three to four months of practice. Several qualitative studies have been published in

which nurses with experience were asked to retrospectively recall their first year of practice. No qualitative studies have been published that focused on the lived experience of NGNs specifically from six to nine months of practice. In addition, no qualitative studies have been published with the intent of more fully developing the *being* (4-8 months) stage of Duchscher's stages of transition theory (2008). Based on these gaps, the purpose of this study was to explore the lived experience of NGNs as they transitioned to professional practice during their sixth through ninth month of experience.

Chapter Summary

This chapter offered a literature review to support a study focused on the lived experience of new NGNs as they transition to professional practice during their sixth through ninth months of experience. A brief description of the population of interest and the significance of the problem of interest were presented. An overview of transition to practice programs offered to NGNs when they are initially employed and a review of the literature on the importance of preceptors and mentors were provided. In addition, a review was presented of positive outcomes from practice and common challenges faced by NGNs during their first year. Although researchers have identified that a vulnerable period of time may be from six to nine months of practice when NGNs are no longer engaged in a training program or paired with a preceptor, little was known about the lived experience of NGNs (specifically, perceived levels of stress, depression, and anxiety) during this timeframe.

Chapter Three: Methods and Procedures

Chapter Three provides a review of the methods and procedures used by the PI in this qualitative phenomenological research study. A review of the philosophy and specific method of hermeneutic phenomenology is provided along with a rationale for the choice of this method. The inclusion and exclusion criteria for the sample are identified along with plans for identifying and recruiting participants to be interviewed. Ethical considerations and information that were presented to the appropriate institutional review board are discussed, and demographic and interview questions are presented as appendices. Methods for data analysis and maintaining rigor are summarized, using the phenomenological approach developed by Van Manen (1990).

Method

As a post-positivism philosophy, the goal of phenomenology is to study and understand the basic structures of consciousness as experienced by individuals from their unique first-person perspective (Smith, 2013). Researchers who hold a positivist philosophy believe that they can only learn about the truths of the natural and social world through observation, measurement, or manipulation of it (Trochim, 2006). The world is knowable and predictable. According to researchers with this viewpoint, if it cannot be directly observed, measured, or manipulated, then it is not a relevant topic for research or scientific exploration. A post-positivist believes that not everything can be studied using objective methods because some phenomena are ambiguous, complex, or open to interpretation. The post-positivist is critical of science's ability to understand reality perfectly but continues to try to reach that goal using multiple approaches, including phenomenology (Trochim, 2006).

The primary focus of phenomenology as a philosophy is to assign meaning to the things people consciously experience. Perception, thought, memory, imagination, emotions, time, and actions are all aspects of the basic structure of consciousness and help provide meaning to the individual who is experiencing them (Dowling, 2007). Phenomenological philosophers and researchers attempt to delve deeper into these forms of lived experience and expressions of meaning using existential investigation techniques. Existential techniques include obtaining experiential descriptions from others through interviews, engaging in personal reflection through the use of journaling, and looking for experiential descriptions in other places such as literature, theories, art, and anecdotes (Munhall, 2012). The goal of using these techniques is ultimately to increase awareness of self, of others, of actions or choices, and/or of activities within a culture and to describe the subjective reality of the individuals with regard to the phenomena of interest (Norlyk & Harder, 2010).

Although traditionally affiliated with the discipline of psychology, there are many philosophers who have shaped the development of the philosophy and therefore the research approach of phenomenology. Edmund Husserl (1859-1938) is credited with the initial development of phenomenology (Smith, 2013). He was concerned with how to understand people in the context of their own lives and wished to examine things simply as they appeared in order to understand the essence of their meaning (Dowling & Cooney, 2012).

Martin Heidegger (1889-1976) was one of the first students of Edmund Husserl and described the essence of the human experience as "being-in-the-world" (Smith, 2013). He believed that a clearer understanding of the meaning of this experience of "being in the world" was gained by first gathering a description of the individual's experiences and perceptions. An

essential second step was to then interpret that description through the analysis of verbal and written language (Dowling, 2007). Heidegger believed that a researcher's understanding of the human experience was influenced by his/her own experiences and interpreted from within the context of his/her involvement in the world. He therefore believed that the suspension of the researcher's beliefs and prejudices while attempting to understand the experience of others (also known as bracketing) was not possible (McConnell-Henry et al., 2009).

Building on the writings of Husserl and Heidegger, Maurice Merleau-Ponty (1908-1961) focused on the importance of perception and the individual's situatedness in the world through experience. He believed that perception and interpretation of experiences were crucial to understanding, and he worked to fully develop the concept of the four life worlds (Dowling, 2007). First generation phenomenologists helped provide the philosophical foundation, and second-generation phenomenologists helped develop the research method. Some of the important phenomenologists of the second-generation era include Giorgi, Colaizzi, Van Kaam, and Van Manen (Munhall, 2012). Giorgi, Colaizzi, and Van Kaam are credited with developing a series of steps for analyzing interview data, and Van Manen has been credited with introducing phenomenological methodology into the field of educational research (Dowling, 2007; Munhall, 2012).

Max van Manen (1990), a Canadian social scientist and educational philosopher, provided six research activities or guidelines for phenomenological researchers. The first research activity, turning toward the phenomena, requires the researcher to pick a research phenomenon (or lived experience) that sincerely interests him/her and commit to the process of discovery. The researcher will ask: "What is the nature of the lived experience of this

phenomenon? What is it really like"? In identifying the phenomenon of interest for exploration through research, Van Manen (1990) also immediately urges the researcher to identify their assumptions and pre-understandings that may cause him/her to prematurely interpret the nature of the phenomenon before any information is gathered. He, like Heidegger, believed that it was not possible for the researcher to bracket away or suspend his/her beliefs about a phenomenon or experience. Instead, these beliefs should be identified and critically analyzed throughout the six-step process (Earle, 2010; Van Manen, 1990).

Investigating the experience as it is lived, rather than as it is conceptualized by the researcher, is the second research activity. Here Van Manen (1990) suggested that it is necessary to become immersed in the phenomenon of interest in order to develop a rich understanding of it. This can be accomplished through reviewing one's personal experiences and beliefs about the phenomenon, observation of others, and in looking for the phenomenon in art, music, diaries, or other types of literature. In addition, conducting interviews can serve the purpose of both collecting rich experiential information on the phenomenon as well as creating a dialogue between the researcher and the participant about the phenomenon's meaning (Dowling, 2007; Van Manen, 1990).

Reflecting on the central themes that comprise the phenomenon is the primary task of the third research activity (Van Manen, 1990). The act of deeply thinking about or reflecting on the information revealed in the second research activity can help the researcher discover the essence of the experience. While reflecting on the data, units of meaning that help to describe the phenomenon's structure from the individual's point of view may become apparent. These units of meaning may also be described as "themes." When several themes are identified, a structure

or descriptive explanation for the phenomenon will begin to emerge. Van Manen (1990) offers three suggestions for identifying themes within the research data: looking at the data wholistically, choosing a selective passage-oriented approach or revealing statement, or evaluating the data line-by-line (Earle, 2010; Van Manen, 1990).

A cornerstone of Van Manen's (1990) approach is seen in the fourth research activity: writing and re-writing. In writing, the researcher's thoughts are brought to paper, making what is internal and hidden now external and observable. It is through the reflective writing and re-writing of themes that a structure can emerge and the meaning of a phenomenon can be discovered. The practice of writing both separates us from what we know and unites us with what we have discovered and understand. Our words can demonstrate our thoughtfulness about what we have encountered and encourage a call to action with what we have discovered (Van Manen, 2005).

The fifth research activity is to maintain a strong and oriented relation to the phenomenon (Van Manen, 1990). The goal is for the researcher to externalize the lived experience of the participants using a strong interpretation that is based on the researcher's awareness and discipline (i.e. nursing). Van Manen (1990) insists that our phenomenological texts need to be written in a way that is deep, rich, and action-focused. They should maintain an oriented relation to the discipline of the researcher in order to contribute to the body of knowledge within that field of study.

"Balancing the research context by considering parts and whole" is the sixth research activity identified by Van Manen (1990, p. 33). Here he encourages the researcher to not get lost in the details of the phenomenon while writing, but to seek balance by continually comparing the

details against the overall structure of the phenomenon. The researcher is encouraged to take the emerging themes and use them as writing guides to allow for systematic explanation of the phenomenon that has been studied (a thematic approach). Another suggestion for organizing and writing about the phenomenon includes organizing themes around the four life worlds, an existential approach (Earle, 2010; Van Manen, 1990).

The purpose for selecting an interpretive or hermeneutical phenomenological approach, such as one used by Heidegger or Van Manen, is to answer the question: What is the lived experience of NGNs during the first six to nine months after they have completed their initial training with a preceptor? This PI was attempting to understand the experiences of NGNs as they experience the middle stage of Duchscher's stages of transition theory (2008), which is known as the *being* stage. An abundance of research and literature exists regarding the experience of NGNs in the first three to four months of practice, when they are still participating in an organized training program and working with a preceptor. Limited research has been done to describe what is occurring with the professional transition of NGNs from their first person perspective during the six to nine month time frame of their first year of experience; therefore, a phenomenological study was appropriate to conduct with this population in order to gain a better understanding of NGNs lived experience and to inform future studies in this area.

Sample

Inclusion criteria are those characteristics that participants must possess to be included in the study (Grove, Gray, & Burns, 2015). For the purposes of this research project, the target population was nurses who were newly graduated from a Bachelor of Science in Nursing (BSN) or Associates Degree (AD) program and who were currently employed in an acute care setting.

They had to have completed the portion of their training that includes active precepting and be assigned to their permanent work unit. In addition, the target population of interest was of either gender and of any race or ethnic background.

For the purposes of this study, participants with previous experience working in healthcare as an emergency medical technician or licensed vocational nurse were excluded from participating in the study. In addition, individuals with more than one year of working full time in another professional position (i.e. as a teacher) or NGNs who had already left their first position of employment as an NGN were excluded from being in the study. Individuals with previous work experience or who have already left their first position of employment would be different from recent nurse graduates who are experiencing the transitions unique to their first professional position.

Sampling was planned to continue until a maximum of 25 participants or until saturation of information was reached through data analysis. In phenomenological studies, samples sizes are small because it is data saturation that determines the size of the sample rather than using power analysis such as in quantitative studies (Munhall, 2012).

Procedures

The following section describes the process of recruiting participants and the settings in which data collection occurred. Data maintenance, data analysis, and rigor are also discussed.

Recruitment

Individuals were recruited for the study using purposeful and network sampling techniques. This PI, who is a nurse educator, contacted prior students whom she assisted while they were in nursing school. These prior students had already completed their nursing degree,

thus the PI had no opportunity to influence their grades. In addition, this PI also contacted nurse managers and staff developers in acute care hospitals in the Dallas/Fort Worth Metroplex with whom she maintains a professional relationship from former employment. She asked them to forward the recruitment e-mail to NGNs in their area who met the inclusion criteria. Individuals who participated in the study were also asked if they had colleagues or friends who met the inclusion criteria. If they identified individuals who were potentially eligible to be in the study, they were asked to forward the recruitment e-mail to them. Please see Appendix A for an example of the recruitment text.

Setting

This PI screened individuals who responded by phone to verify inclusion/exclusion criteria and informed consent. She gave participants the opportunity to choose a convenient time and quiet setting where they were most comfortable for the interview. For example, participants could choose to be interviewed at a local restaurant, library, or public building. This PI provided a copy of the consent form to the participants at the time of the interview and obtained a statement of verbal consent from the participant at the beginning of each recorded interview. To maintain confidentiality, participants were not interviewed within the acute care hospitals where they worked. Because the choice of setting can affect the interview process, the PI noted the location of the setting for each participant and any unusual circumstances related to the setting which occurred during the interview (i.e. noisiness, interruptions, etc.).

Data Collection and Rigor

Data collection consisted of a one-time, in depth interview. This PI obtained verbal informed consent at the beginning of the interview. The process of obtaining informed consent

included reviewing a document that shared the title and purpose of the project, the anticipated duration of the interview, the use of audio recording, and the possible benefits and risks of participating in the project. It was stressed that participation in the research project was entirely voluntary and that a participant may withdraw at any time without consequences. Information about whom to contact should the participants have questions was provided. See Appendix B for the informed consent document.

The structured interview questions (see Appendix C) were based on the initial research question: What is the lived experience of NGNs during the first six to nine months after they have completed their initial training with a preceptor? The interview questions were created by this PI based on a review of the literature of the experiences of NGNs and the personal experience of the researcher in working with NGNs. The questions also included an evaluation of the four existential life worlds of the participants: space, time, corporeality, and relationality. The question that opened the interview was: "Can you tell me a little bit about what it is like for you to be a nurse with X months of experience?" Other questions inquired about their initial training, how connected they felt to their unit, and to describe a positive and a challenging experience they've had since working alone. This PI took brief notes during the interview as needed. A $15.00 Starbucks or Target gift card was given to all participants who completed the interview to thank them for their time.

Due to the philosophical and methodological differences that exist in phenomenology, there is no universal agreement on procedures for ensuring rigor in phenomenological studies. This PI followed Van Manen's (1990) six research activities to provide consistent methodological structure. An audit trail of the data analysis process was created so that it could

be reviewed by other researchers (McConnell-Henry et al., 2009). As hermeneutic phenomenology suggests, the experiences of this PI could not be ignored or bracketed away. This PI felt it was important to reflect upon one's pre-understandings with a goal of acknowledging these to the participants and integrating these into the research findings. Continuous self-reflection and self-scrutiny through journaling was essential, as the goal was to investigate the experience of being a new graduate as it is lived rather than being based on this PI's expectations (Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013; Van Manen, 1990).

Phenomenologists such as Heidegger and Van Manen would see evidence of rigor as the creation of a written text that evidences shared understanding and resonance (McConnell-Henry et al., 2009, Van Manen, 2005). This PI must represent the participants' experience as transparently as possible. Pringle and colleagues (2011) would correlate rigor with whether the experience is reflected in a written account that is rich and meaningful to the participants and interested readers. Colaizzi (1978) and Bradbury-Jones, Irvine, and Sambrook (2010) suggest sending the themes uncovered in the data analysis back to those participants who are interested and willing to review them and ask for feedback. Lincoln and Guba (1985) would describe these activities as establishing credibility and indicate that this increases the trustworthiness of a qualitative research project. This PI contacted two hospital-based educators and four of the original participants to review the final themes discovered in data analysis.

Ethical Considerations

The protocol for this study was submitted to the Institutional Review Board at the University of Texas at Arlington. This study involved human subjects, so *Form #1: Proposal for Research Involving Human Subjects* and an *Informed Consent* document were submitted. This

protocol qualified for an expedited review because the emotional risks related to discussing their work-related experiences were low and the highly educated target population from which the participants were recruited could easily refuse to participate or end their participation at any time. See the consent form in Appendix B.

There was no direct benefit for the participants in the study, however it provided an opportunity for them to think and speak reflectively on their experiences in nursing over the past six to nine months. There is a potential benefit to future new nurses in transition because the data may eventually assist others (educators, managers) who have an interest in working with new graduate nurses to know how to work with them more effectively during this time period of their career. A risk for the participants was that thinking reflectively on their experiences may cause them to experience strong emotions, both positive and negative, and the length of the interviews (30 to 60 minutes) was potentially fatiguing. This PI, who is a Registered Nurse, monitored participants for evidence of psychological distress. If distress had been observed, the interview would have been stopped, and a referral to a physician or a mental health specialist would have been made.

Data Analysis

In order to analyze the data, this PI transcribed the interviews within 48 hours of the completion of each interview. These transcription files were stored on an encrypted drive at the University of Texas at Arlington. To ensure confidentiality, demographic and interview data were identified using a coding system so that no personally identifiable information was present on the documents. The data were used to complete a dissertation and will be published or presented at scholarly meetings without identifying the participants.

This PI initially read the transcript in order to begin the process of dwelling and reflecting on what was expressed in the interview, making the individual the focus for meaning (Van Manen, 1990). On subsequent re-reads of the interview transcript, the content for each question in the interview was explored looking for repetition of words, analogies, linguistic connectors, and other expressions of meaning. The participant's responses were evaluated for the situated context and life world content (Van Manen, 1990). As codes or words and ideas revealed themselves from the data using this approach, they were documented in the right hand margin of the transcript. Transcripts were read through more than once on more than one day in an attempt to identify potential codes. Potential codes with line numbers were transferred to a code summary table.

After several interviews were coded, groups of codes were identified that seemed to cluster together or be closely related. When this occurred, these codes were grouped unto a single theme or category. Themes and their definitions (related codes) along with quotes or phases from the participants that seemed to clearly support the theme were identified and listed in a master document. This process was followed in order to create an audit trail so that saturation could be identified and in order to facilitate collaboration with colleagues. In addition, a review of the available literature and journaling to enhance understanding was done during the data collection and analysis phase. Continuous self-reflection and self-scrutiny through journaling was essential, as the goal was to investigate the experience of being a new graduate as it is lived rather than being based on the expectations of the researcher. This is consistent with the interpretive phenomenological reflection methods (Van Manen, 1990).

Chapter Summary

Phenomenology can be conceptualized as both a philosophical movement and as a qualitative research method suitable for use in nursing. Relying heavily on re-reading interviews and immersion in the data that was collected was useful for understanding the meaning of the lived experience of NGNs who are in the first six to nine months of practice. The goal of this method was to provide a thorough and rich heterogeneous description of their transitional experience. Demonstrating an understanding of the history of the philosophy and early philosophers in phenomenology provided a foundation for conducting a research study using this approach. Being able to summarize the procedures, data collection, and data analysis methods and being sensitive to the ethical considerations of this type of research was an important step towards maintaining quality and rigor in a qualitative research study.

Chapter Four: Findings

This chapter presents the findings of 15 interviews focusing on the lived experience of NGNs who have completed their in-hospital training and are now practicing independently with six to eight months experience as a nurse. The characteristics of the sample are presented. The process of data analysis is explained and the following clusters and their subthemes are discussed with participant quotes that support the findings: overwhelmed, relationships, finding my flow, and being a good nurse. A chapter summary concludes the findings.

Sample Characteristics

Convenience and snowball sampling were used to obtain a sample of 15 NGNs who met the inclusion criteria. Participants ranged in age from 22 to 50 years (*mean* 28.4 years, *sd* = 7.4 years). Thirteen participants (86.6%) were female. Participants described themselves as White (60%), Hispanic (26.6%), African American (6%), and Asian American (6%). This is similar to the nursing population in Texas, with 87.8% females, 60% White, and 14% Hispanic (Health Professions Resource Center, 2016). Table 4 -1 provides a summary of the demographics of the sample.

Table 4-1: Demographic Characteristics of the Sample

Characteristic	Mean (*SD*)	Range	n, Frequency (%)
Age	28.4 (*7.4*)	22 - 50	
Gender			Female: *n* = 13 (86.6%) Male: *n* = 2 (13.3%)
Ethnic / racial group			White: *n* = 9 (60%) Hispanic: *n* = 4 (26.6%) African American: *n* = 1 (6%) Asian/White: *n* = 1 (6%)
Type of Nursing Program completed			Associates Degree in Nursing *n* = 4 (26.6%) Bachelor of Science in Nursing *n* = 11 (73.3%)

At the time of being interviewed, participants had worked for an average of seven months (*range:* 5.5–8 months). All were hired into full-time positions, with 33% working during the day (7am to 7pm) and 66% working nights (7pm to 7am). Forty-six percent of the nurses in the sample were required to sign an employment contract when hired into their position as an NGN. Employment contracts identify a minimum amount of time that an NGN will be required to work for the organization or be responsible for paying back the costs of training should they choose to leave their position. The average length of time for participants' employment contracts was two years. Participants worked in a variety of units including the emergency department, adult intensive care, telemetry, medical surgical, labor and delivery, neonatal intensive care, and operating room. The average length of training prior to working independently was 17.26 weeks (*range:* 8-24). Table 4-2 provides a summary of the work characteristics of the sample.

Table 4-2: Work-related characteristics of the sample

Characteristic	Mean (SD)	Range	n, Frequency (%)
Full-time nursing experience (in months)	7 (1.76) months	5.5 – 8 months	
Current shift assignment			Day Shift: n = 5 (33%) Night shift: n = 10 (66%)
Employment contract required			Yes: n = 7 (46%) No: n = 8 (54%)
Nursing Unit Type			Intensive care / ED: n = 7 (47%) Telemetry / Med-Surg: n = 3 (20%) Women's Services: n = 3 (20%) Operating Room: n = 2 (13%)
Weeks of work-related training	17.26 (4.81)	8 – 24 weeks	

Clusters of Themes

There are four major clusters of themes revealed in the data analysis that describe the lived experience of NGNs during this period of their work experience: overwhelmed, relationships, finding my flow, and being a good nurse. Each cluster has multiple themes that add detail to the overall understanding. Quotes are provided to support all themes. This analysis reflects that NGNs face a number of challenges unique to becoming an experienced nurse. They have different and sometimes confusing feelings during this time of intense intellectual and personal growth and are rapidly changing in their transition to becoming an experienced nurse. Table 4-3 provides a summary of the four major clusters and their related themes.

Table 4-3: Summary of Clusters and Related Themes

Cluster	Related Themes
Overwhelmed	Knowledge Insecurity
	High Anxiety
	Taking the Job Home
Relationships	Work Relationships
	Safe People
	Getting Bitten
Finding my Flow	Flying Solo
	Organizing Myself
	Getting it Right
Being a Good Nurse	Giving Good Care
	Using my Voice
	Proving Myself

Cluster One: Overwhelmed

At this stage of independent practice, NGNs are feeling somewhat comfortable with routine patients and tasks commonly encountered on their unit. When faced with novel, urgent, or emergent situations, their thinking slows, and they feel anxious and stressed. While at work they are constantly thinking and applying what they have learned thus far in the care of their patients. Thinking hard at work is both time consuming and emotionally exhausting. As a result, their thoughts and feelings about work can intrude into their private lives. The themes in this cluster are: knowledge insecurity, high anxiety, and taking the job home.

Knowledge Insecurity

Nursing school experiences and initial hospital-based training programs are designed to provide NGNs with basic knowledge to care for patients that are considered by their unit to be normal or routine; however, the reality of independent nursing practice far exceeds the artificial experience of nursing school and hospital-based training. In the current healthcare setting, hospitalized patients are high in acuity with a potentially long list of co-morbidities and previous health history. At this stage, NGNs realize their own lack of knowledge to deal with anything other than the usual patients and their routine care on their assigned units.

> I mean in general I feel like 'I know what I am doing!' (*said with confidence)*. And then you get a neuro ICU patient and it's like 'I know the basics! *(laughing)*. So then it's like, 'Walk me through the basics of what we do with this patient?'
>
> There is the every day stuff you see pretty frequently and then there is the outlying sort of cases or types of patients that you do not see often but you

are still expected to know what to do or how to manage that. It's

overwhelming when I think about it!

NGNs also don't know enough to deal with novel, urgent, or emergent patient situations. They must try to remain flexible during their shift because they fear that something emergent will come up that they did not anticipate happening or that they will not know how to manage. When faced with this type of situation, their thinking slows down or they feel alarmed because they do not know what to do and cannot quickly process the next step that is needed quickly enough.

"I mean you have to stay flexible, you know like in the moment. There's still stuff everyday that you kind of learn a little bit….you just have to like stay flexible and be alert."

They told me 'Your patient has seizures,' and I said 'Ok, no problem.'

Well the patient then had an active seizure. I learned in nursing school or

I learned a med somewhere in my head but at that moment I panicked and

I looked at my charge nurse and said I don't know what to do.

Thinking and applying knowledge is constant, time consuming, and exhausting for NGNs at this level of experience. They need time to think, ask questions, and process what they are learning. The act of thinking through a task or patient problem takes time. Some NGNs admit that it can be easier to focus on "tasking" than to stop and reason clinically or think critically about what to do next.

You are still learning. You're still learning so much. I think as a nurse it's

hard not to, based on the unit you're in, it's hard not to learn something

new every single day. It's very exciting. It is hectic at times when you're

> trying to remember what you just learned and they are trying to teach you more.
>
> I can get everything done. But you know they (experienced nurses) don't have to think about it, whereas I do. Even when it's an easy case that I know, I still have to think all the time. That's the difference between me and them. They don't have to think about it.

"My biggest challenge is because I am still a new nurse. I am using critical thinking little by little but right now I know I'm still tasking."

High Anxiety

NGNs experience overwhelmingly high levels of stress or anxiety while at work. This is related to their knowledge insecurity and the steep learning curve associated with the first year of nursing. At this stage, they are feeling overwhelmed, like they are drowning, and they fear failure. They question whether this high level of stress and anxiety is "normal" for where they are in their journey to competence as a registered nurse. NGNs realize that they have to get used to feeling stressed and still be able to do the job required of them.

> For the longest time, I wouldn't eat at work. It's a work in progress. I still don't eat as much, but now I am able to take bites, so I think I'm working on it. I guess one way to put it is like being stressed out is what my life is like right now. I'm hoping it doesn't stay that way forever, but it sure feels that way right now.
>
> You get used to it. You get used to being stressed out, pretty much. And then it kind of feel sometimes that I'll come home and feel like "I didn't

see any sick patients today". And then I think, wait, I had a STEMI and a septic shock patient. And then it's like, I guess I did. You kind of get used to it.

I should be hacking it right now. Yeah, like I should be able to handle this. There is something wrong with me if I am not handling it well. Nobody else feels this way. I must not be competent because I feel this way. In nursing, you can't talk about it. You just put a smile on your face and keep going. And so my need to express what I'm feeling must be wrong.

NGNs are acutely aware that they need more experience in order to become more comfortable. They are mindful of the fact that the health misfortunes of their assigned patients become a "good experience" from which to learn. In addition, NGNs must sometimes cope with their intense feelings without being able to leave work. This may include stepping away from the situation (ie. going to the break room) or having to continue working while they are feeling these feelings.

"I hate it that critically ill patients are a 'good experience for me'. I hate that because you know I'm getting an experience off of somebody's downfall."

"I have definitely cried at home and on my way home. I actually cried feeding a baby one day. I had to suck it up so no one would know I was crying (*quick laugh*)."

The charge nurse goes 'Do you need a minute? Go sit in the break room and when you are ready to come out, you can come out.' And I was like 'Ok.' So I went there and sat. But it's just weird though. Ten minutes

later they are like, 'We're putting the next admit into that same room' and you know…back to business.

Taking the Job Home

What NGNs experience at work intrudes into their personal life, whether they want it to or not. Some NGNs cry while driving to and from work. Once they are at home, they review the day mentally and dwell on actions they took or outcomes that occurred. NGNs often describe being pre-occupied with thinking about patients who were not doing well when they left work.

I would cry and stuff when I got home. And say to myself 'I cannot do this.' Yeah, it is stressful. It would even make me feel like 'Is this the right area for me?' And 'Are you doing the right thing?'

I mean I am thinking about it *(said with emphasis)*. We spend so much time at work, and when I go home I'm always thinking 'Ok, what could I have done better?' and 'What can I learn from this?' Yeah, sometimes it's a really long day and I just can't turn off my brain when I leave.

Similar to nurses with experience, NGNs follow up on patients when returning to work or call in to work to ask a co-worker about a patient if they are off for several days.

"I do go back and check on my babies that don't do well. NICU nurses are really good about keeping us informed and it helps me feel a little better. Most babies do OK long-term."

NGNs notice changes in their mood at home, for example feeling more quiet, anxious or sad than usual because of work-related experiences. They indicate that they need space and time alone and away from their families and non-nursing friends so that they can work through their

thoughts and feelings. After a long shift or series of shifts they have little emotional energy left for their families, skipping out on previously made plans in order to be alone.

> When I get home, I don't want a single phone call. Sometimes, I just tell my boyfriend not to talk to me for a little bit. I just need some me time. I need to not talk to anyone or see anything.
>
> There've been a couple of times when I woke up, where I have plans with family, and I'm like 'No I don't really feel like it.' I'm still feeling kind of depressed about something that happened at work that night or night before. I tell them I just don't want to go.

Their experiences at work affect their sleep. NGNs find themselves sleeping more than their usual amount of time because they are so tired. NGNs also dream at night about work. They describe re-living patient care scenarios, dealing with patient emergencies, and hearing alarms in their sleep.

"Since I've been on my own I've been really exhausted. I sleep longer. Just want to do it all correctly so I've probably been way more stressed."

> My husband told me that I uh…sleep talk. He said that one time I woke him up because I was shaking him and I told him 'I can't leave yet. I got patients. I got patients. I have to go do CPR right now!'. He says I do that a lot. Like 'Room 32 needs blah blah blah,' and he gets a good chuckle out of it. I've cried in my sleep about patients I've lost.

NGNs report different techniques to help them cope with the stress. They work out, choose solitary activities like coloring, or try to talk with family and friends to relieve the stress.

They sometimes escape by looking back nostalgically to their recent past experiences in nursing school as an easier time. Day-dreaming about less stressful options is another way to cope, such as planning to transfer to a unit that seems easier or happier, or looking ahead to their next academic choices. NGNs go out with co-workers after the shift ends and discuss work with peers who understand.

> What I like to do is sit at my desk at home and just watch movies. I have a Harry Potter coloring book that I like the color in. I have a light that I turn on. I have blackout curtains so it feels cozy. I just need to feel in a small space after work. I just want to sit and not worry about people.
>
> I was like, 'Man, nursing school was really hard. But at the same time, now it feels like this job is really hard.' And so now I am like, 'That wasn't so bad. Like in school… I had a month off at Christmas and the whole summer off, and now I am like, you know, 'adulting'.

While they are at work, NGNs also think about other ways to make the high levels of stress go away, as this individual described:

> That day I wanted to go home and have a couple of beers because it was such a bad day. It's one thing to have somebody to talk to, but I just needed it to go away. I shouldn't be bringing it home and so I needed something extra to get it off my mind.

Cluster Two: Relationships

Relationships with co-workers are important in healthcare because patient care requires teamwork. Relationships begin for NGNs when they are assigned a preceptor for training. This

initial relationship forms a foundation for NGNs' nursing practice and underscores the need for working together as a team. As training comes to an end, they must transition to relying on other relationships they have formed with their co-workers. NGNs recognize and appreciate when relationships at work are going well with co-workers, charge nurses, and other healthcare professionals. They value teamwork within their units because they understand that situations exist at work where they will need help. Relationships are complex. For NGNs, relationships may be positive and supportive, or negative and add an additional layer to their work-related stress. Themes within this cluster are work relationships, safe people, and getting bitten.

Work Relationships

All participants in this study were assigned to a preceptor for hospital-based training prior to practicing independently. This NGN-preceptor relationship was the first relationship they had at work and provided a foundation for socialization, skill development, and learning the knowledge and reasoning needed to provide good care for a typical patient in their setting. When this relationship is positive, NGNs feel safe and can work on acquiring the skills and knowledge they need.

"My first preceptor had a year and a half of experience. It was good because you know that she was still learning some stuff as she was teaching me. I think she was very patient."

> My preceptor helped a lot. I hear her in my head telling me like, 'Hey did you do this?' She was very thorough, but it was a good experience with her. I could ask her anything and she would tell me how to do it.

Occasionally NGN-preceptor relationships are less than positive. Some units are very busy or do not provide a consistent preceptor assignment. In addition, some preceptors are

critical, heavy-handed, or simply tell NGNs what to do rather than encouraging them to think for themselves. This leaves NGNs feeling insecure and confused, leading to a perception of gaps in the knowledge they are supposed to obtain.

> It was my understanding going into the program you would be one on one (with a preceptor). You would take one patient, two patients, and work your way up. It never worked that way in our facility. My first day on the floor with my preceptor, he had six patients, and all I did was… I was a gopher. I had one, two, three, maybe four different preceptors on days. We had conversations with our educator, things were supposed to change. They never changed.
>
> My first preceptor, even though she was younger than me, she had kind of a dominance aura about her. She was kind of like a demanding respect type. So instead of feeling like I had a partner, it was more like 'yes ma'am...no ma'am'. She had this kind of intimidating factor about her like, 'Ahhhh… is she going to think I am stupid if I asked this?' But I gotta ask somebody, so I gotta ask her. It was hard.

As this NGN explained, being bounced around in her preceptor assignment, created barriers to developing trust in their preceptor-preceptee relationships:

> I got bounced around so I would have maybe this individual one day and then two days later when I came in again I would wind up having another individual. The hardest thing was them knowing where you are and then

> trusting you. Some of them would be a little overbearing and they would kind of not let you be a nurse and think for yourself.

At this stage in their independent practice, six to nine months out of nursing school, NGNs are very dependent on their work relationships. They value teamwork as a technique to provide good patient care and as a means to obtain immediate help when they need it. NGNs appreciate when a co-worker with more experience or power notices that they need help and provides it or gives the NGN a patient assignment consistent with their abilities. When this occurs, NGNs experience a sense of relief, security, and belief that others care about what is happening to them. The opposite of this situation is when the NGN needs help but feels no one is there.

"The good part is some people see that you are a new grad. They don't want to overload you and they want to help you as much as possible so they're always looking out for you."

> I think the only difficult experience that I face is when you need some help and nobody is there. Where's the charge nurse? They're gone because they have patients. I don't like that. I want a strong charge nurse so that I know if I have to push that code blue button, or if I need any help doing this or that, they are going to be there for me.

Safe People

NGNs are still dependent on other nurses for information and help during this stage of their learning so they ask questions frequently. Based on the responses they receive, they quickly learn who is "safe" and who is not. A safe person does not judge them because they are still asking questions. Safe people freely suggest resources for information and offer help.

Unsafe people look down on NGNs for asking questions. They may lack patience if NGNs are slow to understand what they are told. They may covertly or overtly express an attitude of 'you should have known this already'. Unsafe people don't always provide the resources NGNs need and may not help them when they need it. Over time, NGNs develop an understanding of the norms, social groups, power, and politics of the unit. They learn how to act in order to fit in, and who is safe to ask.

> You kind of know how to act with certain people and you kind of know how to be with certain sets or groups of people. And I have, like, my people who are higher up that I can ask a good question and it will be a good answer.

"So you learn very quickly who you can talk to and who you can't. Who you vent to, who you don't. And who is going to help you with your patients, and who is not."

> In my area (OR), they really just want you to shut up, sit back and listen, and watch. They don't want you asking all these questions because it's hard enough for them to do their job without somebody asking them questions. In this environment, you'll make people mad and then they won't want to teach you because they'll think you are a 'know it all.' I had to get used to writing my questions down and saving them till the end.

A power and knowledge differential exists between experienced nurses and NGNs. Sometimes NGNs feel that experienced nurses look down on them or treat them differently than they might treat a peer with similar experience. This is called "eating your young", which is a term to describe bullying, harassment, or other forms of workplace incivility between nurses.

NGNs believe that newer experienced nurses don't usually eat their young, but older nurses might because they don't remember what it felt like to be new and not know anything.

"Everyone dreads being handed off to her, especially the new nurses. She has so much experience. She always tries to find something that you didn't do instead of accept all the things you have done."

"Some people are…more crabby and they forget what it is like to be a brand new nurse. That is the biggest thing I have learned. I vow to never forget what it is like to be new. I'm serious."

Getting Bitten

NGNs experience difficult situations at work where they need the help of a charge nurse, manager, or physician. Some NGNs go to their superior for help with a difficult patient or a mistake/incident and receive indifference, rejection, or hostility. This leaves the NGNs in a vulnerable position where they are uncertain about making decisions but must do what they think is best. As a result of this experience, NGNs may perceive an ongoing interpersonal conflict or experience ongoing reprisal from that individual(s). When this happens, their already high stress level climbs higher, and patient care is compromised.

> I went to the charge nurse to tell her what happened (that my patient had fallen) and she stuck her hand up in my face and said 'I already know… don't even talk to me!' I had to explain to upper management what happened. Then they went back and talked to her and then it came back around and bit me because now every time I work with that charge nurse it turns into a conflict of some type, getting a crappy assignment or difficult

patients. It was a terrible experience, I cried for many days after that. But I learned several lessons that I won't forget (*shakes head negatively*).

I did have my rite of passage…a cardiologist yelled at me once. He was yelling at me like he was disciplining his son or daughter. Like, 'This is unacceptable. Are you even the nurse taking care of this patient?' And I was like 'I'm so sorry sir.'…You know eventually I was just like thinking 'Fine, beat me down, I need to get back to my patients. I'm not going to argue with you.' Instead I said 'Ok sir, ok. So do you still want these meds?'

Cluster Three: Finding My Flow

The first few weeks of independent practice are scary for NGNs who are overwhelmed by the enormity of the job before them. They become focused on survival in their new role. They feel terrified by anticipated experiences they must confront, such as their very first day working solo or admitting to patients they are a new nurse. NGNs also experience dread at the thought of making a mistake or dealing with a big event, such as their first patient code. They are pleased with themselves when they detect a deteriorating patient and act appropriately. One of their biggest challenges is organizing their day efficiently in order to get things done, so this cluster is called Finding My Flow. The cluster includes flying solo, organizing myself, and getting it right.

Flying Solo

The first weeks of independent practice after precepting is over are nerve-wracking for NGNs. They have been anticipating and working toward the goal of working by themselves since they first started nursing school. Some NGNs are given advance notice that their first day

of independent practice is coming, which allows them to anticipate the transition. Other managers tell the NGN they will be working alone the shift before they go solo or when they arrive for work that day. This creates additional anxiety for the already nervous NGN.

"And then they said, 'Ok now you're ready for independent practice. You're on the schedule by yourself tomorrow.' And I'm just like, 'Oh my gosh! Here it comes! Am I ready, am I ready, am I ready?!?'"

"It was terrifying. Because I went in one morning and I didn't know I would be doing something by myself. And so it was just kind of, 'Oh, ok, this is happening today and I didn't know.'"

Up to this point, NGNs have been working with their preceptor as a team. Finally, they are working by themselves, which is both exciting and scary. They worry that they will not be successful. At first, identifying themselves as "the nurse" when they are working alone may feel strange. Admitting that they don't have very much experience to patients and families is difficult to do and leaves them feeling self-conscious.

> The first week I was on my own I was thinking, you know, 'How many things was my preceptor doing behind my back to help me?' Because I felt like the wheels were falling off. Like my hair was on fire. I was running around and I was like, there is no way I was doing all of this on my own before.
>
> I would walk into a room and be like, 'Hi I'm ___ and I'm going to be one of your nurses today.' And then I was like, wait a minute, I am your <u>only</u> nurse today. I'm it (*laughs).* I'm all you have, so sorry! (*more laughter*).

In addition to working independently, NGNs may also be faced with becoming accustomed to working nights, working on a different shift than their preceptor, or being scheduled on a pattern of shifts with which they are not familiar. This is an additional source of stress for NGNs in the first few weeks of practice because they must learn to access new resources.

> I cried after my first night shift. In fact for about the first week I cried. I'm a very old soul. I go to bed at 9 PM and I wake up early in the morning. It was very hard for me to transition to staying up all night long. About the third week when I was on my own, that was whenever I was fully awake at night. I was not asleep in the med room like I was that first night.
>
> Our unit makes you train on days. At the end of the internship I stayed on days for three weeks working on my own. And then I was sent to nights (with no preceptor or orientation shift). The only scary part about that was I didn't know anyone, so I didn't know who I could go to for help. I knew the charge nurse would help me but I didn't know anything about her. I knew her name. That's it.

Organizing Myself

NGNs learn that nursing is a complex job with time-consuming multi-step tasks. Now that they are working independently, they must develop their own style of nursing for efficient time management and patient interaction. NGNs are also surprised by how much of

their time is spent documenting patient care as a nurse. They struggle with finding the right time during the shift to chart and with charting all of the required things in the right places.

> It was very exciting to get my own rhythm going (working independently).
>
> It's nice to find your own organization style and say I'm going to do this first and I'm going to do this next. When you are with a preceptor you kind of…you're going with their flow. They're so used to doing things their way. And so it's hard to find your flow whenever you are riding on someone else's flow.
>
> I was surprised at how much charting there is and how much time I spent on the computer, and not at the bedside...that was my biggest shock. It's constant charting. How do I support a mom and labor and still get all of my things done that I have to do on my side of it? Because I want to be there and be present for them, you know, and do all of the things I've been trying to do. But I have to hit all of these checkmarks too.

Another challenging aspect of time management for NGNs is coordinating patient care. They must remember whom to call when they need something and how to access resources in the hospital for their patients. Because they are continuing to refine their prioritization skills, they may struggle with delegating to others. They verbalize uncertainty about when to spend quality time with patients versus knowing when to move on to the next task.

> At first it was just like constant stress and it was more calling and being the middleman then I thought it would be. So that's the one thing that

caught me off guard is being the middleman that much. Like, you have to make sure did my consult come in?

"You know, time management, stress management, people management. There is a whole just managing. Managing everything is its own challenge."

I think my biggest challenge is delegating because I worked in this unit as a tech. So these are all my peers. And so it's really hard to delegate to them. Little things like "Oh hey can you wheel this patient outside?" Hmmmm…. because it's definitely things I can do myself, but if I do that then I really get far behind and I can't take care of what I need to.

Getting It Right

NGNs fear making mistakes at work. Making a mistake could be as simple as not following an established order of steps for a task and then feeling embarrassed or needing to apologize when others notice it. NGNs also fear making a mistake that could result in harm to their patients because they are not yet fully competent in their role. This is more likely when they are experiencing a situation that is novel, complex, or involves a change in the patient's condition that they did not recognize. If a situation they experience results in a negative outcome for themselves or the patient, some NGNs may choose to actively avoid the same situation in future shifts.

And when to call PACU (as an OR nurse)…not too early…not late. I may have accidentally forgotten to call them earlier this week and then just walked in (with a patient). *(Laughs nervously)* And they just looked at me and I thought, oh, I forgot to call. Because the looks on their faces and

> I was like… oh I messed up… and I mean… it happens… but I felt so bad!
>
> I guess I didn't know that the acuity was that high. I went in there one time and the kid was fine. And then he had a seizure but he didn't have an IV and the physician hadn't got in there to see him yet. It was just like a big thing that he hadn't really been taken care of. And still to this day, I'm kind of like, eh about getting pedi patients.

As new nurses in independent practice, NGNs also dread anticipated difficult "first" experiences, for example a patient coding or a nurse delivery. They are aware that these "firsts" will happen eventually and feel that they cannot be prepared enough to manage these events like experienced nurses do. They may feel alone in these experiences because it is "their patient" and they feel responsible, even though a team is with them. After these experiences occur, most NGNs feel relief and focus on how they will manage the experience differently the next time it occurs.

> I have done one nurse delivery where the doctor didn't make it. It was amazing, and scary, and terrifying, and awesome at the same time. It was a precipitous delivery. The baby was coming out. I had no time to ask for help. As soon as the baby was out I was like 'help' (*faintly spoken*) and everybody came running.
>
> They gave me a stat C-section. I was like… I'm not ready! I didn't bring my C-section notes! I remember saying 'Guys this is my first day by myself…' And they all responded with basically, 'It's ok, we're going to

> help you'. I had a team helping me, but it still felt chaotic and alone because it was so sudden and it was my first night there and my first patient.

An important skill for NGNs is recognizing that something hasn't been done that needs to be or that something is about to go wrong. This implies becoming aware of professional instincts or noticing gut feelings, choosing to act on them, and averting a problem for the patient. To act on their developing professional instincts involves taking a risk. They must ask a nurse with experience, a charge nurse, or a physician to assess the situation. They could be right and the patient receives the additional care they need, but they could also be wrong in their assessment and feel embarrassment.

> I caught his blood pressure was 90 and his lactic acid was high. Wasn't his temperature a little wacky this morning too? I pointed it out (to my charge nurse) and we called the RRT nurse. Then my supervisor recognized me in a meeting. So I was proud of myself for that one.

NGNs feel pride when they are able to recognize a patient problem or listen to their gut and successfully act on these instincts, as explained by this participant:

> I called the doctor at three in the morning, which is tough. But he came in, he agreed and we proceeded. Afterwards he said: 'You made the right decision calling me and asking me to come in'. It makes you feel really good when the doctor says 'Hey that was the right thing to do.'

Cluster Four: Being a Good Nurse

A final theme verbalized by NGNs is the desire to be a good nurse. NGNs believe that there is a good nurse ideal from the nursing knowledge they have acquired and observing other nurses as they work together. To NGNs at this stage, being a good nurse has several qualities. Good nurses are able to discern what is the right thing to do clinically for each patient during their shift. Good nurses know how to speak up for themselves or their patients when there is a need to do so. NGNs are still developing their ability to become a good nurse and feel pressure to prove this ability to others. At this point, becoming a good nurse is a work in progress. The themes in this cluster are giving good care, using my voice, and proving myself to others.

Giving Good Care

Giving good care is an idea created by NGNs that there is a right thing to do in each situation at work. They first learn what constitutes good care in nursing school, where there is often only one right or "best" answer for a test question. Giving good care is then further refined as they work with their assigned preceptors to learn their role as an RN. Finally, their beliefs about giving good care are put to the test when they begin to work independently. NGNs will choose their actions based on their beliefs about what is the right thing to do clinically and sometimes emotionally.

One example of good care is patient safety. "You just have to make sure that whatever you're going to do, that you don't know for sure, is going to be safe. As long as it's safe, it's probably OK."

> I was working with filters for the IV fluids. I had to change them twice to get them right. The parents felt like I wasn't giving good care. And I

think it was because I really didn't know what I was doing. I wanted to say, I am a good nurse and I can do this. I promise I'll love your baby. But that was hard.

NGNs also believe that giving good care includes the ability to build rapport with patients. Their good care is reinforced when they receive verbal recognition from patients and families. On satisfaction surveys that patients complete after they are discharged, patients identify nurses who gave them good care while they were hospitalized. When NGNs are recognized on these surveys, they feel a sense of wonder and are happy.

"I know that nobody wants to be (in the hospital), so how can I get a laugh out of them? You try to connect with them on a real personal level. That helps."

"I never realized they could be so grateful for what I did. I feel like I did not do that much but they feel like I saved their whole entire family. The feedback I get from them, it's pretty nice."

Using My Voice

Advocating for patients is an important skill for a good nurse. NGNs recognize the need to speak up for themselves or their patients, but they are still growing in this ability. Learning to use their voice includes the challenge of giving accurate and confident directions to patients and their families or to other staff members. They know that they must learn when to advocate for their patient to charge nurses, mid-level providers, and physicians. They must be persistent in asking questions to clarify content of which they are unsure. This ability to use their voice is developing and is sometimes successful, sometimes not.

For example, one NGN had to speak up for herself when she felt her workload was too heavy. 'I'm the only one that can tell you all this. I'm not ready for days and six patients. This is not what I signed on for. I am in trouble and this is not what I wanted.'

Another NGN got frustrated when, in her own opinion, she could not give good explanations to parents. "You know, I really struggle with explaining things to parents. When I don't explain things well, it really frustrates me. When I go home I'm upset about it."

A good nurse is always a patient advocate, as this quote illustrates:

I think that even though I am a new nurse, I like to pride myself in sticking to my guns and asking questions when I think something is wrong. I'm not afraid to speak up and let them know, even if it is the doctor. If it's wrong, then they can explain it to me and then I will know.

Proving Myself to Others

NGNs are aware that other co-workers, patients, and family members notice their lack of knowledge and experience and may judge them to be less than a 'good nurse.' This feeling of judgment or lack of trust causes NGNs to feel pressure to demonstrate their competence through their words and actions. This fear of others' judgment may also cause some NGNs to be reluctant to ask for help with patient care. They reason that if they need help, the people around them will think that they cannot handle it and they are not a good nurse.

The nurse ansethetist asked, 'What facility did you come from?' and I was like, 'Well I didn't *(laughs)*. This is my first job. I graduated in May.' And she said, 'I will keep that in mind from now on. You know, it is a

> good thing for you that it took me this long to figure it out.' I guess that made me feel a little bit better. But you know, I just hate that because I was like 'Oh, she could tell that I was new, you know?'
>
> We have some older nurses that have 20 years experience that do not remember what it's like to have six months experience. I want to be able to defend myself and not look stupid. They are measuring me with the same ruler they would measure themselves, and it isn't fair.
>
> Asking for help was something I had a hard time doing. I did not want them (my co-workers) to feel like 'Oh she cannot handle it.' You know it is a really hard place to be because you want help and at the same time you do not want them to think you can't cut it. But that is a fine line to walk because you really do not know that line very well.

Chapter Summary

This chapter presented the analysis of 15 interviews focusing on the lived experience of new graduate nurses who have between 6 and 9 months of nursing practice. The demographic characteristics of the sample were provided. The four clusters of: overwhelmed, relationships, finding my flow, and being a good nurse were introduced and their themes were explored. Participant quotes that supported the findings were selected to illustrate these themes.

Chapter 5: Discussion

The purpose of this study was to understand the lived experiences of NGNs with six to nine months of nursing experience. Four major clusters of themes emerged: overwhelmed, relationships, finding my flow, and being a good nurse. The findings are consistent with the researcher's expectations. Based on her clinical experience and as a nurse educator, issues of stress, relationships, and work organization are known to the researcher. Perhaps the only unexpected finding was the degree to which the NGNs internalize their limitations and blame themselves for working slowly or not knowing all details of patient care (see theme of being a good nurse). This chapter links the study findings to previous research on NGN's transition experiences. Connections are made between the study's findings and Duchscher's (2008; 2012) stages of transition theory. This chapter also contains study limitations, implications for clinical nursing practice, and recommendations for future research.

Significant Findings

Overwhelmed

The most significant finding in this study is that NGNs feel substantial distress as they continue in the transition to becoming an experienced nurse after the initial orientation and preceptorship is over. The learning curve at this stage is still steep, and they find themselves constantly thinking. Although they feel they know enough to provide care for basic or routine patients, they know they must stay ready to manage novel, urgent, or emergent situations for which they are not fully prepared. This finding is also reflected in a recent qualitative study, where NGNs with six to 18 months' experience described feeling fearful when caring for

critically ill patients, managing an overwhelming workload, or caring for unfamiliar patient populations (Guay, Bishop, & Espin, 2016).

NGNs in this sample are reporting high levels of anxiety and stress. This is consistent with previous studies ,which identified that work-related stress is at its highest levels at six months of practice, irrespective of what type of training program the NGN had or is experiencing (Bratt, 2009; Spector et al., 2015). NGNs in this study used the words overwhelmed, drowning, and fear of failure to describe a stress level that they have come to believe is normal for this stage of their career. High levels of work-related stress increase their risk for emotional exhaustion and burnout, and may contribute to the risk of job turnover. In a recent study, Laschinger and colleagues (2016) found high levels of burnout in a sample of 406 Canadian NGNs as evidenced by levels of cynicism and emotional exhaustion at one year of practice. Job turnover intentions of NGNs were strongly related to cynicism, ($r = .55$, $p < .05$) and emotional exhaustion ($r = .45$, $p < .05$).

NGNs describe ways that work-related stress intrudes into their personal lives. During their off time, NGNs are exhausted. They think about work and what they could have done differently, and worry about the outcome of patients they have cared for. They may cry while driving to or from work and they dream about work-related experiences. Adjusting to the physical demands of working long hours and night shifts continues to be challenging. These findings are similar to previous studies which described NGNs' difficulty with becoming physically acclimated to the demands of the job, and coping with emotions and thoughts about work that affect them in their off hours (Ashton, 2015; Walker et al., 2013). It is clear that NGNs at this stage of transition are still feeling overwhelmed. The experiences of NGNs in this

study offer support for the previously established claim that transition programs that are less than one year in length may not provide sufficient support or time for new graduates to adjust (Krugman et al., 2006; Williams et al, 2007).

These findings of knowledge insecurity, feeling overwhelmed by work-related stress, and taking the job home were not unexpected findings based on the review of the literature and the previous work experiences of the PI. The continuing cognitive and emotional distress revealed by participants in this study at six to nine months of nursing experience is the NGNs most pressing concern and is of importance to those who wish to assist them with transition.

Relationships

NGNs in this study recognize the importance of relationships at work, starting with their assigned preceptors. They describe a consistent and positive preceptor–preceptee relationship in training as being essential to initially preparing them for independent practice. This confirms earlier research regarding the importance of the role of the preceptor (Baxter, 2010; Fink et al., 2008; Thomas et al., 2012). This finding also seems congruent with the findings of Guay and colleagues (2016) where NGNs indicated that the early months of independent practice were perceived as the most challenging because they had to learn to survive without their preceptor's guidance. NGNs in this study verbalized their relief and appreciation when co-workers and charge RN's recognize that they are still "new" and notice if they need help. Teamwork is essential in nursing and NGNs feel apprehensive when they believe help is not immediately available if needed. This supports the findings by Dyess and Sherman (2009), who indicated that NGNs experienced feelings of professional isolation and being overwhelmed, especially when no one noticed that they were having problems.

NGNs have questions and must actively seek answers from people on their shift whom they believe will be safe. Because they have already experienced workplace incivility, they fear being judged negatively for their lack of knowledge by experienced nurses, charge nurses, or physicians. Fear of judgment by others leaves NGNs feeling vulnerable and choosing to engage in solitary decision making because they are afraid to reach out for additional help. This problem is not unique to nursing in the United States. Canadian nurses, with less than two years of experience, indicated that they needed to be able to seek feedback as an NGN without fear of being ridiculed by experienced RNs (Regan et al, 2017). In a qualitative study of Australian NGNs with 12 months' experience, unprofessional workplace behavior was identified as one of the most frequently experienced stressors during their first year of practice, negatively impacting their perception of a successful integration into the workplace (Walker et al., 2013). The importance of relationships at work, the continued dependence of NGNs on others, and the relative vulnerability of NGNs in these relationships were expected findings based on the review of the literature and the previous work experiences of the PI.

Finding My Flow

NGNs describe their initial shifts working autonomously as landmark events. They are now flying solo and assuming independent responsibility for the RN role. NGNs must learn to access and use their available resources. Organizing themselves to provide care efficiently for multiple patients and to document their activities is challenging, as hospitalized patients have complex needs. Finding their own organizational style or work flow is a process that takes time and is refined by having positive and negative experiences. This is congruent with previous studies that describe NGNs as focused on tasks and performance, identifying concerns in the

areas of time management, and lacking knowledge and self-confidence (McCalla-Graham & DeGagne, 2015; Penphrase, 2012).

In this study, NGNs shared that they feared making mistakes. Mistakes could be as simple as not charting something correctly or forgetting the steps of a task or process. They are also understandably apprehensive about making mistakes in managing the big events (patient falls, code blue, nurse-assisted delivery) that they know are going to happen to them sooner or later. NGNs know that they are inexperienced in clinical decision-making skills. They must learn to detect and act on their professional instincts as they are building self-confidence. The themes associated with finding my flow were expected findings based on the literature review and the personal and professional experiences of the PI.

As Etheridge (2007) suggested, the self-confidence of NGNs may be tenuous as they begin working alone. Ortiz (2016) noted that feelings of professional confidence in NGNs fluctuate throughout the first year of practice. Making mistakes and poor communication experiences with colleagues decreased professional confidence (Ortiz, 2016). In a qualitative study focused on NGN's management of deteriorating patients, Della Ratta (2016) explained that they are unable to manage the ambiguity of decision-making because of their inexperience in problem solving in these situations. The NGNs' experience of performance success or failure during these encounters influenced their view of themselves as nurses and impacted their transition (Della Ratta, 2016).

Being a Good Nurse

At this stage in the transition to becoming a nurse with experience, NGNs placed value on giving what they felt to be good care. Good care consists of actions that NGNs' believe are

the “right thing to do” either clinically or emotionally. In addition, good nurses are able to build rapport with their patients and families. They are pleasantly surprised and happy when they receive either verbal or written recognition from patients who were pleased with their care.

NGNs are also learning to use their voice. They are trying to be more persistent and careful in the way they ask questions of peers. They are finding ways to speak up for their patients and themselves. They are beginning to feel confident when talking with families or giving explanations. This is consistent with Schoessler & Waldo’s (2006) findings where NGNs struggled with effective communication with physicians in order to advocate for patients and feared being presented with questions from physicians and patients/families that they were unable to answer. Ortiz (2016) also noted the importance of communication for NGNs. When communication with others does not go well, feelings of self-confidence may drop for NGNs.

NGNs feel a need to prove themselves to others. They intuitively feel that their lack of knowledge and experience (compared to nurses with experience) somehow equates to not being a good nurse. They express a sense of internal pressure to prove what they know, and develop a mindset that to ask for help means others will think they cannot handle it. The idea that a lack of experience creates a feeling of not being a good nurse, and that they perceive this to be an acceptable reason to be looked down upon by others, is an unexpected and important finding in this study. It means they are equating inexperience with bad nursing, which is a harsh self-judgment. Additionally, they are blaming themselves for uncivil behavior by colleagues, which could lead to excessive anxiety and negative mental health outcomes. It is concerning that some NGNs choose to not ask for help, or do not reveal they are experiencing difficulty at work, because those choices may put patient safety at risk.

Study Framework: Stages of Transition

According to Duchscher (2008; 2012), NGNs with four to eight months of experience belong to the *being* stage of transition. This stage is characterized by a consistent and rapid advancement in NGNs thinking, knowledge level, and skill competency. The *being* stage is also known as transition crisis and is characterized by five concepts. Searching, questioning, and doubting occur in the earlier months, while the examining and revealing concepts occur near the end of this stage, according to the theory. NGNs in this study shared experiences that were primarily reflective of the searching, questioning, and doubting, which support those concepts in the theory.

Duchscher (2008; 2012) believes that searching reflects NGNs' experience of looking for a sense of balance in a life that feels out of control. She notes that feelings of confusion, doubt, frustration, and anxiety are common and continue from the first stage of NGN transition. NGNs are experiencing a cumulative exhaustion from all of the energy they have expended to learn and perform the role of a nurse. NGNs cope with this physical and emotional exhaustion by sleeping more and isolating themselves from others. This withdrawal allows them to protect their energy and re-gain a sense of control over their lives. Searching is similar to the experiences of NGNs in this study who report struggling with knowledge insecurity, high levels of anxiety, and taking the job home.

Duchscher's (2008; 2012) questioning concept describes NGNs discovery that nursing, like every other profession in the world, is about working for a living. NGNs are tired of the constant stress and are looking to escape the continual learning, growing, and changing required at this stage of the transition. Questioning includes NGN thoughts of looking to the past because

it is perceived to be an easier time than what they are experiencing now. The past is comforting because it represents familiarity, consistency, and predictability. NGNs in this study shared that they look back to their recent past experiences in nursing school as an easier time or daydream about future options such as planning to transfer to a new unit or pursuing their next academic choices.

The concept of doubting demonstrates the fragile sense of trust NGNs have in themselves as nurses to make safe decisions. This is reflected in statements made by NGNs such as: "Did I make the right choice?" or "Is this unit right for me?" NGNs may question whether or not they should ask for help. At this stage, when NGNs consult with peers, it is more likely to validate their thinking or plans for patient care rather than to simply ask them what to do. This theme also reflects the insecurity NGNs feel regarding whether they will recognize a problem or know what to do. NGNs in this study often questioned or second-guessed themselves. They wondered if they would survive the first year. They doubted if this was the right unit for them. They struggled with knowing if and when to ask for help. They shared their experiences with trying to give what they felt was good care, and trying to get it right by detecting early changes in their patient's condition.

Duchscher (2008; 2012) describes the concept of examining as an increasing awareness for NGNs of the difference between what is taught in nursing school versus what is done in clinical practice. Real-world nursing practice is not perfect. This creates cognitive dissonance for NGNs who are independently choosing what is good and bad nursing practice in themselves and noticing it in others. They may focus on how to do things better while not cutting too many

corners. In this study, giving good care may be a reflection of one aspect of Duchscher's examining concept.

The final concept of the *being* stage is revealing (Duchscher 2008, 2012). NGNs in this stage experience fewer emotional highs and lows at work and more days that are moderate or neutral. They experience a growing confidence about what they do know and less anxiety about what they don't know. At this stage, NGNs expend less cognitive and emotional energy at work. They think less often about work and have more ability to relax on their days off. In this study of NGNs with six to nine months of experience, there was little evidence of the characteristics of revealing.

Overall, the findings of this study support the conceptual process of Duchscher's *being* stage of transition, which is occurring when NGNs have between four and eight months of experience. However, the themes of flying solo, organizing myself, and proving myself found in this study may be more reflective of the performing concept. This concept reflects NGNs' concerns with accomplishing the tasks and skills that are required of nurses. It includes the idea that others are watching and potentially judging your choices and actions. Duchscher (2009, 2012) places the concept of performing in the *doing* stage, which occurs when NGNs have zero to three months' experience. This study demonstrated that concerns regarding flying solo, self-organization, and proving themselves continued to be important to NGNs with six to nine months of experience.

Factors that are external to NGNs can influence the transition to practice. Past work experiences, variations in length and content of orientation, and relationships with preceptors and experienced colleagues can all have an influence on NGN's transition to practice. This study

demonstrated the importance of positive work relationships and teamwork to NGNs with six to nine months of experience and exposed their fears of not receiving support when they need it or of experiencing workplace incivility. Duchscher's (2008; 2012) stages of transition theory does not clearly depict external factors that can potentially affect NGNs during their first year of practice.

Study Limitations

The study has several limitations to consider. The participants, recruited by network and snowball sampling, were working in a variety of different units. Although commonalities exist among acute care nurses working in different areas, a more focused study on the experiences of just critical care or operating room NGNs may have yielded different results. In addition, the sample is working in medium and large private hospitals in a large metropolitan area of the southwest. NGNs working in medium and large urban hospitals may have different experiences than those working in public and/or rural hospitals. The recruitment techniques and the subjective nature of phenomenological research limit generalization of the findings.

In phenomenology, participants are considered to be experts on their personal views and lived experiences. Some participants may have been hesitant to share their experiences or held back some of their thoughts and opinions because they did not know the primary investigator (an experienced nurse). NGNs are working with more experienced peers whom they fear will view them poorly or treat them differently if they reveal a weakness or lack of knowledge. NGNs in this study may have experienced a similar fear and reluctance in their disclosure with the primary investigator, possibly injecting a social desirability bias in their responses.

The primary investigator has previous work experience with NGNs as a nurse educator in hospital settings. These prior experiences influence the primary investigator's beliefs and values about NGNs and may create a confirmation bias in the interpretation of the data. In addition, the primary investigator is a novice at qualitative interviewing and data analysis, which is a potential limitation of this study.

Implications for Nursing Practice

At this stage in their transition, it is clear that NGNs need more support. It is important to take a critical look at what support is currently in place for NGNs in their work environment to see where improvements can be developed and implemented. Educators, managers, and fellow nurses each have a role to play in assisting NGNs to transition successfully through this period of six to nine months of experience. In addition, support for NGNs as they transition to practice is not limited to the hospital environment. Suggestions are also made for nurse educators in academia as they prepare pre-licensure students for their role as registered nurses.

Hospital-Based Educators

Hospital-based educators need to review training programs with unit managers and nursing staff to determine what knowledge and skills are priorities for NGNs to learn at the beginning of their practice, in order to provide safe care for the types of patients most commonly encountered in their assigned area. Instruction regarding documentation in hospitals' electronic health record typically occurs within the first week of hospital orientation for all nursing staff. Educators should consider how to integrate documentation and self-organization skills at multiple points in the first three months of training in order to help the NGN be more efficient during their first few months of independent practice. NGNs fear not recognizing patient decline

in a timely fashion and they worry about asking for help. Educators can review initial training content to ensure this is reinforced, with opportunities to practice ways in which to communicate their concerns to others who can help them. NGNs are facing a stressful year of transition to becoming an experienced nurse. Training programs for the first three months of practice should include an evidenced-based discussion about the transition process and the importance of NGNs creating and implementing a plan for stress management for their first year of practice.

In addition, training programs need to be evaluated to better assist NGNs at six to nine months of practice. At the beginning of their second six months of practice, NGNs have different training needs than when they were first hired. However, many hospital-based training programs for NGNs end between 12 and 20 weeks, based on their unit's typical patient diagnosis and acuity. Hospital-based educators need to collaborate with managers, nurses, and NGNs to determine what content can be taught and practiced in the second six months of practice. The use of lectures to teach new content should be minimized, and simulation scenarios or unfolding patient case studies that require clinical reasoning to assist NGNs to grow in their knowledge and experience should be employed. At this stage, NGNs may need additional communication skills for difficult interactions with peers or high-stakes situations with charge RNs or physicians. These skills can be offered along with opportunities to practice them using role play. NGNs need the continuing support of hospital educators at this stage, when it is still common to feel overwhelmed with complexity of nursing care, experiences with workplace incivility, and the ongoing transition to becoming an experienced nurse.

Unit Managers

According to the AONE (2010), the unit manager is the key driver for ensuring a successful experience of NGNs as they transition to practice. Once NGNs are working independently, it is recommended that managers implement brief meetings with NGNs on a set schedule of twice a month in the first three to six months of independent practice, and then if mutually agreed upon, monthly for the remaining months of the year. Meeting routinely helps to foster a relationship between the manager and the NGN. When a relationship is present, it can facilitate a more transparent conversation about how things are going.

For NGNs who are between six and nine months of experience, managers can review the types of patients they have provided care for thus far, and identify a proactive plan for where they still lack knowledge and experience. They can ask NGNs how relationships are going with unit staff and physicians. Self-organization and providing good care are fundamental concerns for NGNs. Managers are well-positioned to help with these and other issues, and can identify barriers to NGNs transition and assist with solutions. It is important for managers to normalize what NGNs are feeling and encourage their accountability for their own self-care and stress management as their transition to professional practice continues. During these conversations, managers need to assess NGNs for feeling overwhelmed or their stress levels related to work, and offer information about how to access employee assistance programs offered by their company, if needed.

Managers and charge nurses can offer support to NGNs by recognizing the importance of relationships. One way to do this is to emphasize the importance of scheduling the independently practicing NGN to work with individuals with whom they have a positive working

relationship. The goal of this intentional scheduling is so NGNs feel there is someone "safe" they can ask questions of while they are working alongside them. The addition of mentor programs to run concurrently with existing orientation methods (internships and residency programs), or to extend beyond the end of initial orientation and training, are associated with best practices for NGN transition programs (Rush et al., 2012).

Charge nurses who round more frequently on NGNs during their shift may be likely to detect whether NGNs need assistance and can reinforce that asking for help is not considered to be a weakness. This may foster a sense of "someone is looking out for me" in NGNs. Charge nurses should also be encouraged to be more mindful of the acuity of patient assignments given to the NGN for the first six months of independent practice, making an active choice to give lower acuity patients and consistent diagnoses assignments to NGNs where possible. Duchscher (2012) suggests that NGRNs who lack "consistency, predictability, familiarity, and stability" (p. 91) in their patient and unit assignments are at risk for experiencing regression and a more intense and extended transition experience. The AONE (2010) recognizes that encountering nursing's complexity and assuming the role of the nurse are major life events for NGNs and recommends the nurse manager assist with the reduction of work environment stressors.

Experienced Nurses in Hospitals

A key finding from this study was the importance of NGNs having safe relationships with experienced nurses, nurse leaders, and physicians. NGNs in this study have experienced workplace incivility and they fear being judged negatively for their lack of knowledge. Uncivil behavior in healthcare influences individual and unit morale, increases staff turnover, and may place patient safety at risk (Warrner, Sommers, Zappa, & Thornlow, 2016). Experienced nurses

need training to increase their awareness of uncivil behavior in themselves and others, and to understand how it affects NGNs and the unit. This training should include positive ways for experienced nurses to express their concerns to NGNs which are respectful and encourage additional dialogue. Preceptor training should include additional information on recognizing uncivil behavior directed specifically towards NGNs, and guidance for how to manage the experience. Nurses with experience must intentionally choose to avoid uncivil behaviors, realizing their power to positively affect the work culture of their unit and the transition of NGNs. The goal is to establish a unit-based culture where this is not tolerated, and where a culture of mutual respect exists. If nursing is about caring for others, then uncivil behavior towards NGNs and co-workers is antithetical to nursing.

The findings of this study can be utilized to create hospital-based policies regarding the transition of NGNs. It is recommended that the policy be based on Duchscher's suggested time-divisions for the first year of transition to practice with specific recommendations for hospital-based educators and unit managers. For example, this policy could require that hospital-based educators provide continued training and debriefing specific to the assessed needs of NGNs in the being and knowing stages of transition. A recommendation from this study is that unit managers should schedule ongoing meetings with their NGNs after their initial training time is complete to assess the needs of NGNs and provide support. A policy could standardize the frequency, suggested content, and documentation of manager / NGN meetings during the first year of practice.

Nurse Educators in Academia

In addition to established educational objectives and clinical experiences, nurse educators in academia can influence the transition to professional practice in several ways. Undergraduate courses at each level should be evaluated for inclusion of real-time documentation, time management techniques, and stress reduction skills where relevant to that course material. Current research evidence regarding the transition to professional nursing practice can be intentionally integrated into undergraduate programs at several points during the curriculum. Content to consider for nursing students should include the length of time to transition to professional practice, the knowledge insecurity and steep learning curve experienced by NGNs, the potential for workplace incivility, and the importance of developing communication skills to use with high-stakes conversations. Nursing students learn that achievement of the next level means meeting deadlines and milestones, such as the end of a semester, graduation from school, passing NCLEX, and obtaining their first position as a nurse. Nurse educators in academia are uniquely positioned to help students develop the expectation that becoming a competent nurse is an ongoing process that develops during the first year of practice, rather than an event or a specific time-related milestone.

Implications for Future Research

Nurses universally acknowledge the difficulties encountered in the transition to becoming an experienced nurse. To influence the quality of this transition, there are areas in which additional research is needed. Currently, no qualitative studies have been published that focus on the lived experience of NGNs at 9 to 12 months of practice, consistent with Duchscher's stages

of transition theory. Understanding how NGNs transition experience continues or even concludes during this time would be helpful.

Although experienced nurses understand that the transition from NGN to experienced nurse takes about a year, there are currently no published studies regarding the expectations of nursing students regarding this experience. A comparative descriptive study is recommended to assess pre-nursing and senior level students' understanding and expectations regarding the transition time needed to become an experienced nurse. This information regarding the expectations of pre-nursing and nursing students can assist nurse educators in academia to develop transition-related curriculum that meets the needs of their students.

In this study, NGNs with six to nine months of experience are clearly experiencing high levels of stress and emotional distress related to work. Currently there are no published studies that longitudinally explore the stress levels and emotional states of NGNs. It is recommended that a longitudinal study be conducted with a cohort of NGNs working in a variety of settings that measures anxiety, depression, quality of life, and turnover during the first 12-18 months of practice. This data could also be used to plan an interventional study for a new cohort of NGNs.

One focus for an interventional study could be to teach stress-reduction strategies to NGNs for use during their first year of practice. Mindfulness-based stress reduction training is an innovative stress-reduction strategy that focuses on improving the individual's awareness of the moment (Kemper & Khirallah, 2015). It involves developing the ability to increase an individual's awareness of their current thoughts, feelings, and bodily sensations with kindness and understanding. In a study where mindfulness techniques were taught to experienced Australian critical care nurses over a five week period, participants reported a decrease in

perceived stress ($r = 0.50$; $p < .001$), anxiety ($r = 0.38$; $p < .001$) and depression ($r = 0.37$; $p < .001$) (Lan, Subramanuan, Rahmat, & Kar, 2014).

In a pilot study by Chesak and colleagues (2015), a single 90-minute mindfulness-based stress reduction training was offered as part of hospital orientation for nurses in transition. Although statistically significant improvements were not achieved, resilience levels improved from baseline, and stress and anxiety levels decreased when measured 12 weeks later. It is recommended that mindfulness-based stress reduction training could be incorporated into a hospital NGN training program using multiple sessions to teach the skills in the first weeks of training with follow-up sessions to reinforce and practice learned material offered monthly through the remainder of the first year of practice (Kemper & Khirallah, 2015). Assessment of NGN levels of anxiety, stress, depression, or resilience could be measured at multiple points during their first year of practice to assess the influence of this type of training,

A second opportunity for an interventional study is with experienced nurses. Experienced nurses may not uniformly be aware of what behaviors are considered to be uncivil in the workplace. Nurses with experience may also perceive and manage workplace incivility differently than NGNs. An educational intervention directed at nurses and staff working within specific units may help to elevate awareness of uncivil behavior and reduce the incidence of their occurrence (Lasater, Mood, Buchwach, & Dieckmann, 2015). Offering information to nurses about how workplace incivility affects morale, turnover, and patient safety, including the impact of incivility on NGNs, may help to create a change in a unit's culture. Offering annual training to newly hired nurses and refresher sessions for experienced nurses who have had training may help to reinforce the desired change in attitudes and behavior.

Conclusion

The phenomenological approach was an appropriate research design for this study, because little information exists about the lived experience of NGNs with six to nine months of practice. At this stage in their transition to becoming an experienced nurse, NGNs wrestle with knowledge insecurity and effective time management. They are overwhelmed and feel like being stressed all the time is a new normal that they must adjust to. Creating and maintaining workplace relationships is necessary for survival and safe patient care. These relationships can also be complicated because some nurses with experience are critical of NGNs. Because of their relative inexperience at this point in their transition, NGNs are dependent on the help of seasoned nurses and are vulnerable to workplace incivility. As a result, NGNs are uncertain about when they should ask for help for fear that these nurses will think they can't manage the responsibilities of being a nurse. NGNs with six to nine months of work experience want to be a good nurse and give good care to their patients, but need more support from hospital-based educators and managers.

Although several qualitative studies exist that ask nurses with one to two years of experience what their perspective was on their first year of practice, this is a retrospective approach. Their perspective on what they may have felt six to 12 months ago could be altered or changed as time passes and NGNs gain experience. Asking nurses with six to nine months of nursing practice what their lives are like right now provides authentic insight into their current lived experiences and offers a better understanding of what nurses at this stage are going through as they continue through the transition from NGN to experienced nurse.

This chapter presented a comparison of this data to previous studies, and the ways in which the findings support the theory framework. Study limitations and implications for nursing practice and future research were provided.

Appendix A

Recruitment Text

Recruitment Text

For use with e-mail:

Hello,

My name is Regina Urban and I am a PhD candidate in Nursing at the University of Texas at Arlington. I am conducting a study to describe the experiences new graduate nurses are having during their first year on the job. I would like to invite you to take part in an interview that asks you about your experiences as a new graduate nurse with 6-12 months of experience working in an acute care setting.

You are eligible to participate if you have:

- Graduated from a BSN or ADN program and started working in an acute care setting.
- Completed your active precepting and are working independently on your assigned unit.
- Have no previous experience working in healthcare as an EMT or LVN.
- Have no previous experience working in a professional position (for example, as a teacher or manager).

Data collection consists of one interview of approximately 30 to 60 minutes. The interview will take place in a setting of your choosing and will include some brief demographic questions such as your age, gender, and the type of unit on which you work, and some open-ended interview questions like:

- Tell me about what it is like to be a nurse with six to nine months of experience?

- Tell me about the training that the hospital offered you when you first started in your position?

The results of this study could assist future nurse educators, staff developers, and managers who are working with nurses during their first year of practice.

More information on the study and your rights regarding participation, withdrawal, and confidentiality are outlined in the attached consent form. For additional information, or to participate in an interview, please contact me at:

Regina Urban

rurban@uta.edu

817.925.3234

Appendix B

Informed Consent

PRINCIPAL INVESTIGATOR

Regina Urban, PhD Candidate, MSN, RN-BC, CCRN, CNE, University of Texas at Arlington College of Nursing and Health Innovation. Contact Phone: 817.925.3234. Email: rurban@uta.edu

FACULTY ADVISOR

Donelle Barnes, PhD, RN, CNE, University of Texas at Arlington College of Nursing and Health Innovation. Contact Phone: 817.272.0108. Email: donelle@uta.edu

TITLE OF PROJECT

New Graduate Nurses and Transition to Practice

INTRODUCTION

You are being asked to participate in a research study about the lived experience of new graduate nurses at six to twelve months of practice. Your participation is voluntary. Refusal to participate or discontinuing your participation at any time will involve no penalty or loss of benefits to which you are otherwise entitled. Please ask questions if there is anything you do not understand.

PURPOSE

The specific purpose of this research study is to understand what it is like to be a new graduate nurse working independently with six to twelve months of experience. The first year of nursing

is a year of transition, and not much is known about how nurses may think and feel about nursing during this specific time frame.

DURATION

You will be asked to participate in a face-to-face individual interview, where you will be asked questions about what it is like to be a nurse during this time period in your career. The interview will last approximately 30 to 60 minutes.

NUMBER OF PARTICIPANTS

The number of anticipated participants in this research study is 25.

PROCEDURES

The procedures which will involve you as a research participant include participation in a face to face interview where you will be asked questions about what it is like to be a nurse during this time period in your career. This interview uses the same list of questions for each participant. The interview will be audio recorded. After the interview, the recordings will be transcribed, which means they will be typed exactly as they were recorded, word-for-word, by the researcher. The transcription files will be used for data analysis for the research project. The recordings will be destroyed after transcription.

POSSIBLE BENEFITS

There are no direct benefits for participating in a research study. There may be a benefit for you to think and speak reflectively on your experiences in nursing over the past six to twelve months. Sharing your experiences with the researcher may eventually assist others (educators, managers) who have an interest in working with new graduate nurses to know how to work with them more effectively during this time period of their career.

POSSIBLE RISKS/DISCOMFORTS

Thinking reflectively on your experiences may cause you to experience strong emotions (both positive and negative) and the length of the interviews (30 to 60 minutes) may be potentially fatiguing. You have the right to quit the interview at any time at no consequence and may do so by informing the researcher.

COMPENSATION

You will receive a $15.00 Starbucks or Target gift card as a participation gift after you complete the interview.

"The Internal Revenue Service (IRS) considers all payments made to research subjects to be taxable income. Your personal information, including your name, address, and social security number, may be acquired from you and provided to UT Arlington's accounting office for the purpose of payment. If your total payments for the year exceed $600.00, UT Arlington will report this information to the IRS as income and you will receive a Form 1099 at the end of the

year. If you receive less than $600.00 total for payments in a year, you are personally responsible for reporting the payments to the IRS."

ALTERNATIVE PROCEDURES

There are no alternative procedures offered for this study. However, you can elect not to participate in the study or quit at any time at no consequence.

VOLUNTARY PARTICIPATION

Participation in this research study is voluntary. You are free to withdraw consent and to discontinue participation at any time without penalty. If you do not complete the entire interview, you will not receive the participation gift (gift card).

CONFIDENTIALITY

Every attempt will be made to see that your study results are kept confidential. A copy of this signed consent form and all data collected [including demographic information and transcriptions] from this study will be stored in the College of Nursing and Health Innovation at the University of Texas at Arlington for at least three (3) years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a participant. Additional research studies could evolve from the information you have provided, but your information will not be linked to you in anyway; it will be anonymous. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research

have access to the study records. Your records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above. The IRB at UTA has reviewed and approved this study and the information within this consent form. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, the University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law.

CONTACT FOR QUESTIONS

Questions about this research study may be directed to Regina Urban 817.925.3234 or rurban@uta.edu / Dr. Donelle Barnes 817.272.0108 or donelle@uta.edu]. Any questions you may have about your rights as a research participant or a research-related injury may be directed to the Office of Research Administration; Regulatory Services at 817-272-2105 or regulatoryservices@uta.edu.

CONSENT

By giving your verbal consent at the start of the interview in a non-personally identifiable manner, you confirm that you are 18 years of age or older and have read or had this document read to you. You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you give your verbal consent, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By giving your verbal consent, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

Appendix C

Demographic and Interview Questions

Demographic and Interview Questions

The purpose of this study is to describe the characteristics of transition period as experienced by new graduate nurses during the first six to twelve months after they have completed their initial training with a preceptor.

Interview Opening: *Thank you for agreeing to help me with my research project for my dissertation. I am especially interested in working with new graduate nurses after I am done with my PhD program, so I really value the time you are sharing with me.*

Demographic Questions

1. What was your initial date of employment with your current employer?
2. Did you sign an employment contract with your employer? If so, how long is your contract? _____
3. This means you have been working now for a total of _____weeks / months?
4. What type of hospital are you working for currently: private / public? Large / small?
5. What type of unit are you working on currently (med-surg, telemetry, ED, etc.)? How many beds does it have?
6. Which shift do you work? _____
7. How many hours a week do you work? _____

8. Tell me how approximately many weeks you were actively working with or assigned to a preceptor before you were allowed to work independently? _____

9. What is your current age? _____

10. What ethnic group / racial group you would describe yourself as?

- Hispanic
- Asian
- African American
- American Indian
- White
- Other: _____

11. What gender are you? Male / Female

12. What type of program did you graduate from? ADN / BSN

Interview Questions

1. Tell me about what it is like to be a nurse with _____ months of experience?
    - Probe: What do you think are your biggest achievements?
    - Probe: What do you think are your biggest challenges / concerns?

2. Tell me a little bit about some of the positive experiences you've had so far in your nursing career since you have been working independently?
    - Probe: What are you excited about? Proud of?

3. Tell me about the training that the hospital offered you when you first started in your position?
    - Probe: What was your relationship like with your preceptor? Did you have more than one?
    - Probe: Did you go to classes? What kind did they offer?
    - Probe: How long was your total time being trained?
    - Probe: What was it like for you when training was initially over and you were "on your own"? How did you feel?
    - Probe: How does it feel now for you to be out on your own?
4. How do you feel about (or like) the unit that you are working on right now?
    - Probe: Was it your first choice?
    - Probe: The type of patients you are working with?

- Probe: The people you are working with? Do you feel socially connected to your co-workers?

5. Give me an example of a difficult experience that you have faced so far since you've been working independently?
    - Probe (patient related): What did you do to cope with that / deal with your feelings about that?
    - Probe (staff member related): How did you manage that? What was it like working with that individual again? How did you feel about the unit after that?

6. At this stage in your training, you are going through a transition from the new graduate role to the role of a competent nurse. Can you share with me three words that would describe the experience for you right now?
    - Probe: For example, "exciting" or "scary." Can you tell me a little more about what made you choose the word _____?

7. In your mind, I'd like you to picture what a nurse "looks like" that is comfortable, competent, and confident in her job. What does that look like to you at this point in your career?
    - Probe: Are you there yet?
    - Probe: If so….what makes you think so?

- Probe: If not…tell me why not and what do you think you still need to do to get there?

8. Do you think often about the future this point in your career? If so, what kinds of things do you find yourself thinking about?
   - Probe: Work-related? Professional development / Changes? Personal relationships or goals?

9. Researchers can choose to share the results of the study with the participants. If you are interested in reviewing the findings at the conclusion of the study, I will send them to you. Additionally, I may want to ask you a few more questions after I have interviewed other people. Can I contact you again? This is optional; not required. *(Only a verbal yes / no by the participant is required here.)*

Thank you so much for helping me with this project! I really appreciate your time and being allowed to explore your perspective on your experience as a new graduate nurse during this specific time in your transition.

Appendix D

Permission to Use Figure 1. Stages of transition theory.

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