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Understanding Pre-Registration Employment and Transition to Practice for the Newly Graduated Nurse

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master thesis

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Abstract

Background

Transition from nursing student to a registered nurse is fraught with difficulties such as gaining acceptance and knowledge on the unit, and obtaining comfort and confidence. Approximately 20% of newly graduated nurses (NGNs) leave the profession in the first year often due to difficulties in the transition phase. The focus of this research was understanding direct paid pre-registration employment and transition to practice for the NGN.

Methods

A study with a descriptive qualitative design was conducted. Nine participants, between three months and one year after completing their nursing program, were interviewed. Thematic analysis was conducted on the data.

Findings

The main themes emerging from the data were support, vulnerability, de-stress, becoming comfortable, and gaining confidence.

Contribution to Nursing Practice

Interviewing NGNs with paid pre-registration employment will assist employees’ understanding of the transition experience of new graduates, which may assist with retention of new hires.
Acknowledgements

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Dedication

I would like to dedicate this work to my family. I could not have finished without your continued love and support. First and foremost, my husband Patrick, my children Tamazene, Amanda (Diaadin), Jonathan, and David, as well as my grandchildren Yoseff and Amina. Thank you for your understanding and always being there for me.
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<tbody>
<tr>
<td>AHS</td>
<td>Alberta Health Services</td>
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<tr>
<td>CNE</td>
<td>Clinical Nurse Educator</td>
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<tr>
<td>GN</td>
<td>Graduate Nurse</td>
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<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
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<td>NA</td>
<td>Nursing Assistant</td>
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<td>NGN</td>
<td>Newly Graduated Nurse</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>UNE</td>
<td>Undergraduate Nurse Employee</td>
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</table>
Epigraph

Times of transition are strenuous … They are an opportunity to purge, rethink priorities, and be intentional about new habits. We can make our new normal any way we want.

Kristin Armstrong
Chapter One: Introduction

Many newly graduated nurses (NGNs) have a difficult time in the transition phase from nursing students to registered nurses (RNs) (Anderson, Hair, & Todero, 2012; Cantrell & Browne, 2005; Casey, Fink, Krugman, & Propst, 2004; Duchscher, 2008; Kamboj, 2013; M. Kramer, 1974; Morrow, 2009; Rheame, Clement, LeBel, & Robichaud, 2011; Romyn et al., 2009; Rush, Adamack, Gordon, Lilly, & Janke, 2013; Welding, 2011; Winfield, Melo, & Myrick, 2009). Anderson and colleagues (2012) mentioned that some researchers studied the impact of different programs that assisted with the difficulties in this phase such as preceptorship, mentorship, and nurse residency programs to name a few. Nursing students often seek employment in direct paid patient care roles prior to graduation to assist with the difficult transition to RN (Phillips, Esterman, Smith, & Kenny, 2013; Phillips, Kenny, Smith, & Esterman, 2012). Some direct patient care roles that may transition to the RN role in the Calgary health region are undergraduate nurse employees (UNEs), licensed practical nurses (LPNs) and nursing assistants (NAs). Melrose and Gordon (2008) noted that LPNs had a difficult time with the transition to RNs even though they had previous employment in a regulated profession.

One factor that seems to assist NGNs with the transition process is employment in direct paid pre-registration patient care roles prior to graduation from a nursing program (Cantrell & Browne, 2005; Collins, 1991; Harkins, Schambach, & Brodie, 1983; Phillips et al., 2012, 2013). As a staff nurse, nurse clinician, and an educator on an acute care unit, I have been involved in assisting numerous NGNs. Anecdotally, in my experience, NGNs...
who have previous paid pre-registration employment in a health care position seem to have an easier transition from being nursing students to RNs.

I conducted a study with a descriptive qualitative design, which helped me understand paid pre-registration employment and transition to practice for the NGN. Newly graduated nurses who previously worked as undergraduate nurse employees (UNEs), LPNs, and NAs were interviewed, which assisted with exploration of the transition experience. I present information that should assist management and on-site nursing staff that is specific to the orientation needs of NGNs. The data I obtained from this study will be presented to key stakeholders, such as nursing students, NGNs, educators (both in nursing programs and acute care), managers, and human resources personnel, to inform practices and provide insight into how NGNs viewed their transition phase.

**Background**

Transitions in everyday life are constant, such as being born, becoming adults, finishing school, entering the workforce, and changing jobs. Bridges (2004) stated that an unwillingness or inability to leave the old self behind and holding on to past experiences caused stagnation and a failure to transition was described as “just a rearrangement of the furniture” (p. xii). Newly graduated nurses must be willing to “let go” of nursing student roles before they can start to transition to employment as graduate nurses (GNs) and eventually RNs.

Etymologically, transition meant to “go across or over” (etymologic dictionary, n.d.). Transition is the ability to learn and adjust to a new culture or workplace and can be described as “life in an uncomfortable world” (Perrone & Vickers, 2003, p. 72); it is a
“rite of passage” and requires “fitting in” (Phillips, Kenny, Esterman, & Smith, 2014a, p. 107). Newly graduated nurses must leave the comfortable student role they have been accustomed to and go into an unfamiliar territory for a transition to occur. Even though nursing students have experience in the acute care hospital environment, they are leaving the more familiar academic environment where they usually have a support person, such as a nursing instructor or preceptor, and enter employment on a nursing unit where they do not always have a consistent support person.

When nursing students graduate, feelings of ambivalence are common (Casey et al., 2004). Newly graduated nurses are excited as they enter a new stage in their lives but they are often inundated with feelings of fear, stress, and anxiety, which can be related to being accepted into the culture of the nursing unit as well as working independently without academic support (Andrews, 2014; Cantrell & Brown, 2005; Phillips et al., 2014a). When nursing students progress through their practicums, they have different experiences working with a variety of patients and nurses. Positive experiences assist with a decrease in fear, stress, or anxiety of entering the workforce but unfortunately, negative experiences make it a more difficult time period (Levett-Jones & FitzGerald, 2005; Morrow, 2009).

Newly graduated nurses have difficulty in the transition phase with development of their time management skills, confidence, and comfort levels (Phillips et al., 2014a) but some have a more difficult time than others. M. Kramer (1974) mentioned the transition phase was a complex but expected period of emotional, physical, social, and development growth of NGNs. Various authors mention that the transition phase is the movement or change from nursing student to the first year after starting employment
Anderson et al., 2012; Chen & Lou, 2013; Ellerton & Gregor, 2000; Morrow, 2009; M. Kramer, 1974; Spiva et al., 2013). For the purposes of this study, NGNs are those who are able to work as GNs or RNs, regardless of their previous employment roles, and have less than one year of experience in this new role.

Researchers indicate that many nurses leave the profession in the first one to five years after graduation (Anon, 2008; Block, Canadian Nurses Association [CNA], 2002; Claffey Korow, & McCaffrey, 2005; Nuttall, 2010) possibly due to stress and anxiety. Participating in post-graduate programs (i.e. preceptorship, mentorship, nurse residency programs) is one way for NGNs to reduce their stress and anxiety. Another way researchers discuss alleviating the stress and anxiety and enhancing the potential of new nurses is paid employment in acute care facilities prior to graduation from nursing programs (Cantrell & Brown, 2005, 2006; Cantrell, Brown, & Lupinacci, 2005; Collins, 1991; Nuttall, 2010; Phillips et al., 2012, 2013, 2014a; Phillips, Kenny, Esterman, & Smith, 2014b). Some of these researchers examined NGNs up to three years in post-graduate employment (Cantrell & Brown, 2005, 2006; Cantrell et al., 2005; Collins, 1991; Nuttall, 2010). Phillips and colleagues’ (2012, 2013, 2014a, 2014b) research included NGNs who were in their first year of work experience; their studies included those who graduated in 2010 and were recruited in August to November 2011 so some participants possibly had more than one full year of work experience depending on when they graduated and started their work experience.

Nursing students are exposed to various clinical practicums in their undergraduate programs. As students, NGNs have opportunities to work in different areas of nursing practice but are not allowed to do specialized clinical competencies (Alberta Health
services [AHS], 2013; College and Association of Registered Nurses [CARNA], 2005) such as central venous catheter care or patient controlled analgesics. Therefore, students are given opportunities to learn in different patient care areas but obviously will not become expert practitioners at the end of their nursing program. Newly graduated nurses need to continue their learning as they transition, develop skills, and start to understand the patient population in the area where they choose to practice (Casey et al., 2004).

Nursing students often have an instructor available who assists with any issues, concerns, questions, and skill acquisition during their undergraduate programs when they are on direct patient care units. The instructor helps to protect the student and assists with gaining confidence, competence, and comfort (Morrow, 2009). When NGNs transition into employment as GNs without this familiar support, they often have fear, stress, and anxiety about working independently (Anderson et al., 2012). Even though nursing students, in their final preceptored practicum, have more responsibilities, learn to manage a full patient load, and gain knowledge and skills, they still cannot complete all tasks and always have someone to support them. When NGNs are on their own they still have transition stress, which can be due to factors such as lack of experience, time management, and decreased confidence (Chen & Lou, 2013; Kowalski & Cross, 2010).

Another reason NGNs have difficulties in the transition phase is they often are only able to focus on a small portion of the patient and the patient’s illness (Ebright, Urden, Patterson, & Chalko, 2004; Ellerton & Gregor, 2000); they focus on the tasks rather than prioritizing the patients’ needs (Kombaj, 2013; D. Kramer, Lindgren, High, Ocon, & Sanchez, 2012). Newly graduated nurses in comparison to senior nurses on the unit, lack nursing care experiences and therefore require time to find policies and
procedures, are unfamiliar with many patient diagnoses, and often focus on time management (Ellerton & Gregor, 2000). Morrow (2009) noted NGNs were unable to see all the nuances of patients and their illnesses because of decreased clinical experiences in various clinical situations. All of these factors make it difficult for NGNs to focus on the “big picture” and so minor tasks often become easy to focus on as confirmation and a sense of accomplishment; NGNs are easily able to “mark” these tasks off as they finish them.

Adult learners have active involvement in their learning experiences (Nutall, 2010) and acquire knowledge in various ways. Aleco (2009) discussed “active learning,” which is when NGNs gained experience through exposure to various patients, disease processes, and clinical situations. This active learning occurs as nursing students are given exposure to patients and experiences in their clinical practicums. Knowledge does not come from textbook learning alone but also from experiences (Kombaj, 2013; D. Kramer et al., 2012; Nickel, 2007). Nursing students gain beginning knowledge from their textbooks and classes but continue their learning as they move through different experiences in their clinical practicums. Nickel (2007) discussed cognitive apprenticeship, which allowed NGNs to use personal learning and allowed assimilating experienced nurses’ experiences, which enhanced their own learning. Newly graduated nurses require exposure to various experiences, as well as time to watch and discuss these experiences to increase their learning, competence, confidence, and decrease their fear, stress, and anxiety. The CNA (2004) stated that lifelong learning was an important component of nursing. Therefore, learning continues as NGNs enter the transition phase and advance throughout their careers.
Transition to graduate nursing practice is challenging due to the change in “identity, roles, and responsibilities” (Adam, Strong, & Chipchase, 2012, p. 568), which can be part of the re-structuring of NGNs self-concept (Bridges, 2004, 2009). Difficulties with transition can be due to “heavy workloads, inadequate staffing numbers and skill mix, inappropriate allocation of high acuity patients, and unprofessional behaviours of violence, bullying, undermining, and victimization” (Phillips et al., 2014a, p. 107). Two important elements of the transition period for NGNs are navigation of the system (i.e., layout of the nursing unit, hospital structure) and socialization. Kilpatrick and Frunchak (2006) described socialization as the “process of acquiring knowledge and skills as well as the norms and values of the professional culture” (p. 239). M. Kramer (1974) labelled the transition phase “reality shock” and described it as a time when NGNs, who felt prepared for work in the “real world,” entered the profession and realized that they were not as equipped as they anticipated they would be. Hiring nursing students as UNEs and NAs may alleviate some of their stress and anxiety as well as allow opportunities to learn and assist with navigation of the system and socialization when they transition to RNs.

**Problem Statement**

If NGNs are not supported in the transition phase, they may leave their first jobs and possibly the profession (Duchscher, 2009; Lindner, 2014; Morales, 2014; Moriarty, Manthorpe, Stevens, & Hussein, 2011; Phillips et al., 2013; Spiva et al., 2013) as indicated earlier. Approximately 20% of NGNs leave the profession in the first year (CNA, 2002) and 35-65% within the first five years (Anon, 2008; Block et al., 2005; Nuttal, 2010). Roughly one-third of nurses in the United States (US) who take the National Council Licensure Examination (NCLEX) work as RNs, the other two-thirds
either continue with further education or leave the profession completely (Nuttall, 2010). Numerous authors (Anderson et al., 2012; Block et al., 2005; Cottingham, DiBartolo, Battistoni, & Brown, 2011; Hoffart, Waddell, Young, 2011; Rush et al., 2013; Spiva et al., 2011; Winfield et al., 2009) noted that the cost to orientate one NGN to the workplace in US dollars was estimated at $40 000 to $60 000 and greater than $100 000 in specialized areas. Part of this cost includes the salary for classroom and unit orientation (Friday, Zoller, Hollerbach, Jones, & Knofczynski, 2015). There are also some hidden costs of nursing turnover such as recruitment, unit and hospital initiatives, and loss of productivity (Cottingham et al., 2011). I was unable to find Canadian costs of orientation even with an extensive search of the literature. For retention and cost reasons alone, it is important to support NGNs as they transition from nursing student to post-graduation employment.

**Purpose of the Study**

The purpose of this study was to understand paid pre-registration employment and transition to practice for the NGN. Acute care was chosen as the setting because the majority of NGNs began their nursing careers in this environment (CNA, 2010; Ellerton & Gregor, 2000; McCalla-Graham & De Gagne, 2015). Therefore, NGNs who were employed as UNEs, LPNs, or NAs while students were interviewed for rich descriptions of their transition experience.

**Researcher’s Perspective**

I worked as an UNE and started my nursing career on the acute care unit where I had my final nursing practicum as a student. When I worked as an UNE, I started developing the time management skills required to carry a full patient assignment as well
as began looking for the nuances and differences between patients and their diseases. I also began developing advanced assessment skills, learned what questions might be asked of me by my fellow nurses and physicians, and ensured that I was able to answer them appropriately. As an UNE, the other nurses were willing to answer my questions and helped me with development of my skills. I started learning how to work independently and used the resources available to me on the unit.

In my opinion, direct paid pre-registration employment in a health care facility assisted me as I completed my final practicum as a nursing student. By completing my final practicum on the unit where I started working as a GN, I knew whom to approach for assistance, where I could find the policies that were pertinent to the unit, what some of the main diagnoses were, and started to assimilate to the culture of the unit. I began to feel comfortable and accepted as a GN on the unit. I felt I had decreased stress and anxiety as well as increased comfort and confidence as I transitioned from a nursing student to a GN. I understand that my beliefs may cause bias, which is why it is important that I identify them. I was cognizant of my possible biases during data collection. One of the ways I addressed my biases was that I kept a journal to outline how I viewed responses from interviewees as a student researcher, nurse, and an educator. Additionally, I ensured that I did not interview any participants who worked on my unit or whom I had been involved with as an educator, either in a teaching or supervisory role.

**Summary**

The transition phase for NGNs can be a difficult time. Strategies have been developed to assist with this transition period. One way that researchers have studied the transition experience is from the perspective of paid pre-registration employment but
there was minimal information in the literature from participant’s voices about the first year of their experiences. A descriptive qualitative study was conducted which assisted with understanding from the participants’ perspective if paid pre-registration employment influenced the transition phase.
Chapter Two: Literature Review

Numerous authors discuss the difficulties NGNs have in the transition phase (Anderson et al., 2012; Chen & Lou, 2013; Duchscher, 2008, 2009, 2012; Ebright et al., 2004; Ellerton & Gregor, 2000; Kowalski & Cross, 2010; M. Kramer, 1974; Morrow, 2009; Spiva et al., 2013). Many researchers discuss how pre-registration employment in acute care influences the transition phase of NGNs (Cantrell & Brown, 2005, 2006; Cantrell et al., 2005; Collins, 1991; Nuttall, 2010; Phillips et al., 2012, 2013, 2014a, 2014b) but very little is known about how working in direct paid patient care roles prior to completion of a nursing program affects the first year of practice post-graduation from nursing programs.

In this chapter, I included information about a concept analysis of the term transition, using Rodgers’ (1989) concept analysis framework. Completion of this concept analysis assisted with understanding how transition was described in the literature. I also included information from a systematic search undertaken to complete a concept analysis of transition as preliminary work to this specific study. This concept analysis was a prelude to my thesis work and was important to develop the research question and guide the study.

Concept Analysis of Transition

To assist with understanding of transition, I completed a concept analysis, as a masters’ student, using Rodgers’ (1989) concept analysis framework. I used the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL [Ebsco]), Medical Literature Analysis and Retrieval System (MEDLINE [Ovid], Psychological Information (PsychInfo), and Educational Resources Information
Centre (ERIC), for this literature search. The terminology I used was *transition, change, evolution, conversion, shift, move, or alteration.* I then searched this terminology with *neophyte, new graduate, or novice.* I included thirty articles in the concept analysis from various countries, which showed transition was a global phenomenon.

Transition is not always a logical, linear process but is often cyclical as knowledge and skills are gained in different areas of nursing practice at various rates. There were many different aspects or attributes of transition and each NGN, dependant on their previous experiences, moved from a beginning to proficient stage (Benner, 1982) more quickly with some skills than others. Nursing is a constantly changing profession so NGNs need to continue with their learning as they proceed in their profession (CNA, 2004). Each NGN approaches the transition phase in diverse ways and has different intricacies but there are some constants in this transition.

The attributes of this concept of transition were stress, anxiety, uncertainty, insecurity, as well as requiring time and support (Reimche, 2014). Consequences of a successful transition were confidence, competence, independence, and acceptance (Reimche, 2014). A successful transition was related to increased retention of NGNs on the unit (Phillips et al., 2013; Ulrich, Krozek, Early, Ashlock, Africa, & Carman, 2010). Alternatively, consequences of a negative transition were dissatisfaction and attrition (Grindel & Hagerstrom, 2009).

**Search Method for Thesis**

I conducted a literature search for my thesis in January, 2015, in consultation with the University of Calgary librarian, that located 311 articles about the transition experiences of NGNs who had pre-registration employment in direct patient care roles.
prior to completion of their nursing programs. The databases I used in this search were:
CINAHL – 229 articles, MEDLINE – 49 articles, Excerpta Medica Database (EMBASE) – eight articles, ERIC – four articles, Proquest Thesis and Dissertations – 20 articles, and the Cochrane Database of Systematic Reviews – one article. My search included the following terms either alone, in combinations, or synonyms of newly graduated nurse, undergraduate nurse employee, licensed practical nurse, nursing assistant, student employment, and transition (for a copy of the MEDLINE search and synonyms used see Appendix A). I did not apply any limits or filters to this search, including year of publication or language however, only English articles were found and used. I removed thirty-six duplicates. I read a total of 275 titles and abstracts; 258 were excluded since the authors did not discuss pre-registration employment or support programs after graduation. I then read seventeen articles and three of these were excluded as they discussed programs, orientation, and differences between advanced degree nurses and LPNs. My final selection included 14 articles which included qualitative, quantitative, and mixed methods studies, as well as one program description and one program development. I have provided a copy of the study flowchart in Appendix B.

Literature Results

I have included three different sections in this literature review. First, I present three different transitional theories. Next I provide comments specific to transitional programs. Finally, I include information about pre-registration employment of NGNs.

Transitional Theories

The viewpoints of three researchers who developed transitional theories will be described to help with understanding how transition was viewed in the literature. Two of
these theorists were nurses who described the transition phase from a nursing standpoint and the last theorist discussed it from a business or change management viewpoint.

**Kramer.** In her seminal work, *Reality Shock*, M. Kramer (1974) discussed four transitional phases for NGNs. The honeymoon phase occurred when NGNs saw the world through “rose colored glasses” (Schmalenberg & M. Kramer, 1976, p. 38) and believed they could change the world. The shock or rejection phase occurred when there was dissonance between the beliefs taught in school and the values in the workplace (M. Kramer, 1974; Schmalenberg & M. Kramer, 1976). A balanced view of these beliefs was noted in the recovery phase (M. Kramer, 1974; Schmalenberg & M. Kramer, 1976). Finally, the resolution phase was where inconsistencies of school and work were integrated and NGNs became “competent, organized, [and] efficient nurse[s]” (Schmalenberg & M. Kramer, 1976, p. 40).

**Duchscher.** Duchscher (2008, 2009, 2012) identified three phases of transition. “Doing,” occurred when NGNs focused on the tasks and often lived in their own “private bubble” (Duchscher, 2008, p. 445). The first phase was a highly physical, emotional, and intellectual time and included the process where NGNs gained knowledge in a complex, and constantly changing environment (Duchscher, 2008, 2009, 2012). The second stage, “being” was described as obtaining balance (Duchscher, 2008, 2009, 2012); during this phase NGNs started to gain social and cultural knowledge in their environment (Duchscher, 2012). In the third phase, “knowing,” NGNs started to feel competent, confident, and comfortable in their jobs (Duchscher, 2008, 2009). During the third stage,
NGNs recognized who a nurse was and who they were in the profession (Duchscher, 2012).

**Bridges.** Bridges (2004, 2009) discussed a three-stage transitional process from a change management viewpoint. In the first stage, anyone in transition was required to “let go” of the past and their previous identity before they re-constructed their new identity (Bridges, 2009; Bridges & Mitchell, 2000). Therefore, the first stage is where the familiar past is left behind and NGNs move into an unfamiliar place. The second or neutral phase occurs when the comfortable past is gone but the future is still unattainable (Bridges, 2009; Bridges & Mitchell, 2000). The neutral phase is necessary to allow NGNs to question, develop critical thinking, and where the true transformation from students to RNs happens. The third phase occurred when a new reality was obtained (Bridges, 2009; Bridges & Mitchell, 2000); NGNs started to act differently and a new conceptualization of being RNs was realized in this phase. If NGNs do not let go of their student philosophy, take time in the neutral phase, and act in a different way, they do not have a successful transition.

**Comparison of Transitional Theories.** Each of these three theorists (Bridges, 2004, 2009; Duchscher, 2008, 2009, 2012; & M. Kramer, 1974) discussed how transition required time to move from one step to another, it was not instantaneous. The three transitional theories presented here included a period of feeling uncomfortable or unfamiliar and moving through each stage until they became competent and confident in their new role. Both M. Kramer (1974) and Bridges (2009) discussed a period where the person in transition was either in a flux or was not moving; M. Kramer (1974) called this the recovery phase and Bridges (2009) termed it the neutral phase.
M. Kramer (1974) wrote about transition from a relational perspective. This is seen by the NGN entering a “honeymoon phase” and then questioning how this relationship works until they come to a new understanding of how a nurse in an organization becomes part of the culture. Alternatively, Duchscher (2008, 2009, 2012) talked about transition from an action point of view starting with how the NGN saw life from a micro perspective. The NGN can only focus on a small part of the role of a nurse, and so is seen as “doing.” As NGNs progress through the stages, they become part of the nursing culture and can see from a macro perspective. Conversely, Bridges (2009) transitional theory required a person to “let go” of their past and then embraced each phase to properly transition into a new role.

Bridges and Mitchell (2000) mentioned the world was rapidly changing and transition was much slower than change. Transition is a concept throughout a person’s entire personal and professional life and not just specific to nursing. It is unclear how the transition to a competent and confident RN is different with paid pre-registration employment as UNEs, LPNs, and NAs prior to completion of a nursing program.

Therefore, I have chosen to complete this study to assist with greater understanding of this phenomena.

**Transitional programs**

A transitional program is a program where NGNs are given assistance in the transition phase from nursing students to RNs. Some components of transitional programs include pairing NGNs with experienced nurses, helping build relationships with nurses on the unit, and allow opportunities for questions and hands on learning (Anderson et al., 2012). Transitional programs are formal and supportive of NGNs in professional
growth, help with socialization to the unit and hospital, assist with patient safety, and
allow NGNs to gradually become competent registered nurses (Anderson et al., 2012;
Lindner, 2014). Examples of post-graduation transitional programs include preceptorship
(Blanzola, Lindman, & King, 2004; Reimche, 2013; Roziers, Kriacos, & Ramugondo,
2014; Winfield et al., 2009), mentorship (Anon, 2008; Block et al., 2005; Chen & Lou,
2013; Lantham, Ringl, & Hogan, 2011; Nuttall, 2010; Reimche, 2013; Romyn, 2009),
nurse residency (Anderson et al., 2012; Casey et al., 2004; Chen & Lou, 2013; Hoffart et
al., 2011; Hunsberger, Baumann, & Crea-Arsenio, 2013; Reimche, 2013; Romyn et al.,
2009 Rush et al., 2013; Welding, 2011; Williams, Goode, Krsek, Bednash, & Lynn
2007), as well as many site-specific, individualized programs (Anderson, 2012; Reimche,
2013). Numerous researchers (Anderson et al., 2012; Kowalski & Cross, 2010; Rush et
al., 2013; Ulrich et al., 2010) mentioned that the participants of these programs
demonstrated increased competence, confidence, and decreased costs of attrition of
NGNs was also discussed. Programs typically run for a minimum of three months to a
maximum of two years and gradually allow NGNs to assume a full patient care
assignment (Anderson et al., 2012), which assists with greater competence, confidence,
(Chen & Lou 2013; Halfer, 2007; Hunsberger et al., 2013; Ulrich et al., 2010; Welding,
2011), and comfort (Hunsberger et al., 2013; Rush et al., 2013; Spiva et al., 2013), as
well as a decrease in stress and anxiety (Anderson et al., 2012; Kowalski & Cross, 2010;
Rush et al., 2013).

**Direct paid pre-registration employment**

Early exposure to employment in health care promotes understanding of
organizational structure, application of knowledge and clinical skills, and motivates
undergraduates as they continue their learning (Kilpatrick & Frunchak, 2006). Melrose and Gordon (2008) stated that adults acquired knowledge when engaged in activities related to work and previous experiences, which led to an understanding of why paid pre-registration employment possibly assisted with the transition phase of NGNs. Direct paid pre-registration employment on a hospital unit allows students to take the knowledge from in their educational program, apply it to the “real world,” and recognize each patient is different and does not always follow the textbook examples (Aleco, 2009; Collins, 1991; Kilpatrick & Frunchak 2006; Nuttall, 2010) and assists with development of critical thinking skills (Nuttall, 2010). Therefore, working in direct paid patient care roles such as UNEs, LPNs, or NAs allows undergraduates to assimilate information from their programs into knowledge on the unit and assist with gaining competence, confidence, comfort, and retention.

**Extern programs.** Extern programs are a formal curriculum that allows nursing students paid employment in health care and assists with gaining experience, comfort, independence, and preparation for the RN role after completion of their nursing program (Cantrell et al., 2005; Starr & Conley, 2006). These programs are typically available in the summer months between the third and fourth year of undergraduate education (Cantrell et al. 2005; Starr & Conley, 2006).

Cantrell and Browne (2005; 2006) and Cantrell and colleagues (2005) conducted a three-part mixed methods study, which evaluated an extern program in the US. Cantrell and Browne’s (2005) participants had increased confidence, competence, socialization, and clinical skills during their transition phase. Cantrell and colleagues (2005) noted organizations with extern programs had higher retention rates and NGNs had increased
professionalism and socialization to the nursing role. The Joint Commission on Accreditation of Healthcare Organizations in the US (2002) stated that hospitals with decreased attrition of nurses (<12% vs. >22%) had lower patient mortality rates. Ulrich and colleagues (2010) and Welding (2011) noted that when attrition rates increased, more new nurses were required and subsequently there were often fewer experienced nurses on the units who assisted NGNs in the transition phase. Anderson and colleagues (2012) discussed that the impact of transitional programs showed benefits of assisting NGNs, which included increased patient safety, decreased attrition, and more experienced nurses on the units.

Phillips and colleagues (2012, 2013, 2014a, 2014b) conducted four studies in Australia and compared transition experiences of NGNs who either worked in retail stores (i.e. grocery stores, clothing stores) or were in extern programs during the final year of their nursing program. Retail experiences of students showed benefits such as “customer focus” (Phillips et al, 2014b, p. 535) which could be related to patient focus, ability to deal in complex situations, respect from colleagues, organizational orientation, and higher transition scores (less difficulties with the transition phase). Phillips and colleagues (2013) noted that NGNs who worked in health care had increased confidence and experience. Regardless of where undergraduate students worked, transition is difficult and all NGNs require support (Phillips et al., 2014a).

Collins (1991) stated that participants in extern programs showed increased ability to cope with the transition phase (Collins, 1991). Kilpatrick and Frunchak (2006) noted that extern programs, which included classroom components assisted in gaining knowledge and developing critical thinking. According to these researchers (Collins,
1991; Kilpatrick & Frunchak, 2006), it appeared that extern program participants had early assimilation of textbook knowledge, which assisted with understanding that continued learning in the nursing profession was a necessity.

**Undergraduate nurse employees.** Employment as paid UNEs allows exposure to the RN role, expands knowledge and skills in real world situations, and assists with socialization to the nursing profession (Kilpatrick & Frunchak, 2006; Phillips et al., 2012). In Alberta, UNEs have been hired for many years and assist with vacation planning and recruitment for the hospital unit and AHS (personal communication, L. Reyes, March 12, 2015). Anecdotally, many UNEs obtain employment as GNs on the same unit after graduation probably due to their experience and acceptance on the unit. Managers often feel the best NGNs to hire have previous employment on their specific units possibly because the manager acknowledges their work ethic and experience (Romyn et al., 2009). An UNE should always have a supportive RN (AHS, 2010), which helps provide safe care for their patients and assists with developing competency and time management skills (Gamroth, Budgen, & Lougheed, 2006). Gamroth and colleagues (2006) conducted a quasi-experimental study set in British Columbia, Canada that discussed a provincial program that was based on the Alberta UNE program. Participants showed increased competence, confidence, skills, organizational abilities, teamwork, and retention on the nursing unit. Thus, working as UNEs seems to assist with the transition phase. Additionally, as the Alberta UNE position is available, for more than 10 years in Alberta, to nursing students after completing greater than 450 hours of clinical practice, it also appears that AHS also agrees that nursing students working as UNEs is beneficial.
**Licensed practical nurses.** Some registered nursing students may be transitioning from the LPN role. Licensed practical nurses are regulated members of the health care team and follow the standards of practice as listed by the College of Licensed Practical Nurses of Alberta but may still have some difficulties in the transition phase to the RN role. Even though LPNs are able to look after the complex needs of their patients they typically care for a stable and primarily predictable patient population (Calgary Health Region, n.d.).

A qualitative study by Melrose and Gordon (2008) described the transition from LPN to RN and found that LPNs left a familiar, satisfying profession behind but had difficulty recognizing the differences in the RN role. Hutchison (2013) noted the main difference between LPNs and RNs was critical thinking development instead of just problem solving. Unfortunately, LPNs do not always recognize the role differences and lack critical thinking until they fully transition into RN roles. Spross (2014) and the CNA (2014) mentioned that work still needed to be completed to demonstrate role clarity between LPNs and RNs.

**Nursing assistants.** Nursing assistants provide direct paid care to patients and their specific duties encompasses activities of daily living, comfort, and safety of the patients or residents they are responsible for in their area of practice (AHS, 2002). Romyn and colleagues (2009) mentioned that NGNs who previously worked as NAs had easier transition phases because of increased confidence and comfort with personal care; these experiences allowed NGNs to focus on other learning. Harkins and colleagues (1983) discussed a 12-week rotational program where undergraduate students were hired as NAs. The study participants discussed learning experiences, difficulties, and presented
what they had learned, which assisted with developing knowledge, experience, critical thinking, and leadership skills. For more information of the literature results see Appendix C.

**Gaps in the Literature**

There were many programs discussed in the literature, which assisted NGNs when they entered the workforce (Anderson et al., 2012; Reimche 2013) but there was a lack of literature about how paid pre-registration employment in direct patient care roles influenced the transition phase. Some forms of pre-registration employment, in direct paid patient care roles, for NGNs are externs, UNEs, LPNs, and NAs. I was only able to find a total of 14 research studies that discussed these roles. Twelve of the studies I found in the literature search were research based (Cantrell & Brown, 2005, 2006; Cantrell et al., 2005; Collins, 1991; Gamroth et al., 2006; Hutchison, 2013; Melrose & Gordon, 2008; Nuttall, 2010; Phillips et al., 2012, 2013, 2014a, 2014b), one discussed program evaluation of an extern program (Kilpatrick & Frunchak, 2006), and one discussed program development for nursing students to work as NAs in the summer (Harkins et al., 1983). The purpose of this research was to understand paid pre-registration employment and transition to practice for the NGN. I was also interested in understanding from the participants’ viewpoint if this paid pre-registration employment decreased their fears, stress, and anxiety and increased their comfort and confidence in their competency as new RNs.

There was minimal documentation about the origins of the Alberta UNE position except a few internal documents, which mainly provides job description and hiring information (AHS, n.d. b; AHS, 2010) as it assists with staff and reduces costs in the
health care system (personal communication, Dr. S. Hirst, June 2, 2015). In Alberta, the UNE role is a direct paid pre-registration employment position but there is no documentation about how this position may assist in the transition phase of NGNs. Gamroth and colleagues (2006) mentioned an undergraduate employment project that was specifically developed in British Columbia. The UNE role should assist with comfort and acclimatization to the nursing unit prior to graduation. In this research study I interviewed nine participants, six of these participants were UNEs, to determine if working in this position assisted with the transition phase of NGNs.

Phillips and colleagues (2012; 2013; 2014a; 2014b) research included NGNs with paid pre-registration employment. There was minimal information about the actual previous health care positions of these participants. Therefore, it is difficult to determine if the participants were actually in direct patient care roles.

Some researchers (Cantrell & Brown, 2005, 2006; Cantrell et al., 2005; Collins, 1991; Nutall, 2010) interviewed participants up to three years after graduation from their nursing programs. Some of Phillips and colleagues’ (2012, 2013, 2014a, 2014b) participants may have been in their first year of nursing but also could have been up to 18-months post completion of their nursing program. As the first year of employment as RNs seems to be the most difficult time of transition (Anderson et al., 2012; Chen & Lou, 2013; Ellerton & Gregor, 2000; Morrow, 2009; M. Kramer, 1974; Spiva et al., 2013) it is beneficial to interview participants with less than one year of experience post program completion.
Summary

Transition to registered nursing practice for NGNs can be a difficult and complex phase. One way that may assist NGNs in the transition phase is paid pre-registration employment in a direct patient care role in an acute care facility, prior to completion of their nursing programs. A concept analysis of transition that was previously completed was discussed. There was a lack of literature, both Canadian and international, about understanding, from the participant’s perspective, the first year experiences of NGNs. The main topics found in the literature were transitional theories, transitional programs, pre-registration employment of NGNs, UNEs, extern programs, LPNs transitioning to the RN role, and being employed as NAs prior to nursing program completion.
Chapter Three: Method

In this chapter, I use a qualitative research approach, which helps with understanding paid pre-registration employment and transition to practice for the NGN. I also provide rationale for choosing a descriptive qualitative design to describe NGNs transitional experiences. Additionally, I include information about the research context, a description of the sample, methods of data collection, the data analysis, ethical considerations, and limitations of the study.

Rationale for A Descriptive Qualitative Study

Rodgers (2005) noted that epistemology was the theory of knowledge. Whereas, ontology was the nature of reality and what exists in the world or how each person understood their reality (Rodgers, 2005). For example, if people see a river in a different way, does that mean that it is not the same river when they describe it to you or just their reality is different from others? Kincheloe and McLaren (2005) stated that “all observers view an object of inquiry from their own vantage points in the web of reality, no portrait of a social phenomenon is ever exactly the same as another” (p. 319). Therefore, how the researcher understands reality, one’s own assumptions, and characteristics influences every aspect of the research (Denzin & Lincoln, 2005). Qualitative researchers are interested in what the nature of reality is for the participants that have been exposed to the phenomena of interest (Creswell, 2007; 2012) and need to ensure that the researcher preserves the participants’ view of reality (Struebert, 2011).

Researchers use various methods for a systematic way of gathering data, performing analysis, and generating knowledge (Streubert, 2011). Loiselle, Profetto-McGrath, Polit, and Beck (2011) mentioned that there were two main approaches to
research, the quantitative approach which is informed by the positivist viewpoint and deductive reasoning and the qualitative approach which is informed by the naturalist approach and focused on the participant’s perspective. The study of qualitative research should be focused on gaining meaning, understanding, and perception from the research participants; alternatively, quantitative research focuses on an objective perspective (Creswell, 2007; 2012).

Qualitative researchers use rich descriptions and interpretations of participants, which allows for greater understanding of the phenomenon of interest (Sandelowski, 2000; Sandelowski & Barroso, 2007). Lincoln and Guba (1985) mentioned that to understand a specific phenomenon, the questions must be asked and answered by those exposed to the phenomena of interest. Gadamer (1976) mentioned that qualitative researchers did not necessarily search for a question but often through their own experiences a question “addressed” the researcher. Therefore, as a clinical nurse educator (CNE) who has previous direct paid pre-registration employment as an UNE, is currently a CNE, and assists NGNs in an acute care facility, this question “addresses” me. In my career, I noticed that NGNs who previously worked in direct paid pre-registration employment roles seemed to have an easier time in the transition phase. Therefore, I felt it was necessary to interview NGNs with previous employment as UNEs, LPNs, and NAs. The qualitative approach was used, which helped with understanding NGNs perspective of direct paid pre-registration employment and transition to practice.

Philosophical Assumptions of Qualitative Research

Creswell (2007; 2012) and Streubert (2011) mentioned qualitative research approaches are varied and each one required different ways of data collection and
analysis. Polit and Hungler (1995) as well as Lincoln and Guba (1985) mentioned that the study of qualitative research focused on the naturalistic paradigm where each participant had different subjective experiences. Qualitative researchers should focus on exploring, discovering, and understanding how people experience and interpret the phenomena of interest (Sandelowski, 2000; Struebert, 2011). The study of qualitative research should be a systematic, subjective approach to understanding the phenomena of interest (Burns & Grove, 2001).

Bloomberg and Volpe (2012) mentioned that the approach of qualitative research was determined by how researches interviewed, analysed, and were sensitive to the culture and history of the participants. Struebert (2011) stated an important factor that determined the qualitative research design was what made sense to the researcher’s area of interest.

**Descriptive Qualitative Research**

Sandelowski (2000) noted that the descriptive qualitative design was the least theoretical of all qualitative approaches as the research should follow the tenets of naturalistic injury. Sandelowski (2000) also mentioned that even though the descriptive qualitative design was “different from phenomenologic, grounded theory, ethnographic, and narrative studies, they may, nevertheless have hues, tones, and textures from these approaches” (p. 337). Zoroya (2014) stated that a descriptive qualitative design was focused on amalgamating data into everyday language, which assisted with enhanced understanding of the phenomena of interest. Descriptive qualitative researchers should not use highly abstracted words (Sandelowski & Barroso, 2007) but should “seek descriptive validity, or an accurate accounting of events that most people (including
researchers and participants) observing the same event would agree is accurate… or an accurate accounting of the meanings participants attributed to those events” (Sandelowski, 2000, p. 336). Zoroya (2014) and Sandelowski (2000) discussed that when researchers used a descriptive qualitative design, the analysis was less interpretive, conceptualized, or abstracted and was more closely associated with the participants’ descriptions.

Descriptive qualitative researchers “collect as much data as they can … to capture all of the elements of an event that come together to make it the event …” (Sandelowski, 2000, p. 336). Polit and Hungler (1995) stated it was important that researchers described and documented rather than just explained the phenomenon of interest. The study of descriptive qualitative research allowed for data that was relevant to educators and policy makers (Bogda & Bilken, 2007; Sandelowski, 2000). As the main focus of my study was to gain understanding from the participants’ viewpoint, the descriptive qualitative design was appropriate. I used a semi-structured interview, which helped to garner rich descriptions and interpretations of the culture, language, and in depth practices that helped NGNs to become fully functioning members of the unit and hospital.

**Research Context**

As the majority of NGNs began their nursing career in acute care (CNA, 2010; Ellerton & Gregor, 2000; McCalla-Graham & De Gagne, 2015), participants who worked in this setting were chosen for the research study. In the past, nursing students were exposed to an apprenticeship model where they were immersed in the hospital environment from the start of their training so the transition phase post-graduation was not as prominent as today (Andrews & Wallis, 1999; Stacey, Pollock, & Crawford, 2015;
Wangensteen & Johansson, 2008). More recently, other methods of supporting NGNs in the transition phase include post-graduate programs such as preceptorship, mentorship, and nurse residency programs. Many of these programs have educational and practical components as well as experienced nurses who are available and assist NGNs as they gradually obtain knowledge and experience (Anderson et al., 2012; Hunsberger et al., 2013; Reimche, 2013).

Another method that assists NGNs in the transition process is exposure to the acute care environment as an employee and accepted member of the unit while they are nursing students (Cantrell & Brown, 2005; 2006; Cantrell et al., 2005; Collins, 2001; Nuttall, 2010; Phillips et al., 2012, 2013, 2014a, 2014b). Nursing students who work in direct patient care roles such as UNEs, LPNs, and NAs are already accepted members of the nursing unit, have started to adapt to the nursing environment, assume care for a patient assignment, and work with the medical issues inherent in the acute care population. Newly graduated nurses with direct paid pre-registration employment as students felt they gained knowledge both of the patients they were looking after as well as the nursing unit and culture; they felt closer to being “real nurses” and not imitators (Nuttall, 2010). Knowing what resources are available, who they can approach for assistance, and understanding the nursing culture on the unit assists with the transition phase for NGNs.

**Research Topic**

The primary focus of this research was to understand paid pre-registration employment and the transition experience of the NGN. Sub questions of the research were: What does the word transition mean to the NGN? Does employment in direct
patient care roles influence the transition experience? What supports does the NGN use to assist with the transition experience?

Definitions

Some terms used in this research study might be unfamiliar to the reader or used in different ways in the literature. To assist with clarity, definitions of NGNs, UNEs, pre-registration employment, and extern programs are included in this section.

Newly Graduated Nurse

Researchers identified NGNs as those who were in their first year of employment (Anderson et al., 2012; Chen & Lou, 2013; Ellerton & Gregor, 2000; Morrow, 2009; M. Kramer, 1974; Spiva et al., 2013). For the purposes of this study, participants were NGNs in their first year of employment post completion of their nursing program. Participants had completed at least three months of employment, which ensured they had completed unit and hospital orientation. Each participant had completed a Canadian nursing program, worked as a GN or RN, and was employed in Alberta. Criteria used were when NGNs completed their nursing program, instead of graduation, as some nursing students who finished their coursework were able to work as GNs or RNs but did not graduate for a number of months.

Undergraduate Nurse Employee

Undergraduate nurse employees are nursing students who have worked a minimum of 450 hours in a clinical placement prior to being employed as UNEs (AHS, 2010).
Pre-Registration Employment

Pre-registration employment describes NGNs who have employment during their nursing program as either UNEs, LPNs, or NAs prior to when they obtain GN or RN status. These positions are considered direct paid patient care roles.

Extern Programs

Extern programs are typically for nursing students in the summer between their third and fourth year of the nursing program. In this type of program, the undergraduate student is an employee who gains experience, comfort, and independence in preparation for the RN role after graduation (Cantrell et al., 2005; Starr & Conley, 2006). Extern programs are often used to assist with the transition phase and encourage students to return to the same environment or unit after they complete their nursing program (Harkins et al., 1983).

Participant Selection for the Research Study

A complete list of the selection of participants for my research is noted in this section.

The NGNs must:

- Work a 0.5 full time equivalent (FTE) for a minimum of three months in an acute care environment since completing coursework from a Canadian nursing program
- Work as a GN or RN
- Worked at least a 0.5 FTE for a minimum of four months in acute care during the nursing program in a direct patient care position.
- Worked as an UNE, LPN, or NA prior to graduation
- Work in Alberta
Waiting to write the Canadian NCLEX or written the Canadian NCLEX and either have results or awaiting results

Finished the educational program for a RN less than one year ago

Finished hospital orientation.

As an educator in the acute care system, I provide orientation to new staff on the cardiac units in the Calgary zone of AHS. Therefore, I did not interview any of the following potential participants to minimize possible coercion and decrease bias.

- Staff I instructed/ interacted with in a supervisory capacity
- Nursing students whom I taught.

**Acute Care Sites in Calgary**

The sites I used for my study were the four acute care hospitals in Calgary. I chose these sites as the main focus was understanding paid pre-registration employment and the transition experience of the NGN. In Calgary, some nursing students work as UNEs and NAs prior to completion of their nursing program. Also, some LPNs who enter in a bachelor of nursing program continue working as LPNs until they complete all the courses and practicums of their program.

**Participant Recruitment**

Ethics approval was obtained from the University of Calgary Conjoint Health Research Ethics Board (CHREB). Once this ethics approval was obtained, I gained AHS approval to place posters (Appendix D) at the four acute care hospital sites in Calgary. I obtained a purposive sample of participants. Participants contacted me by phone, text, or email in response to the posters. I did ask participants if they knew anyone else who would be interested in the study. If participants knew of anyone, I asked that they would
give the other individual my information but I did not contact any participants, they all contacted me. Creswell (2007) stated that a purposive sample was a group of participants who were selected because they were exposed to the phenomenon of interest (Creswell, 2007). I obtained consent from each participant prior to the interview. Calgary is the largest city in Alberta with approximately 1.2 million people (City of Calgary, 2016) and the hospitals in Calgary serve patients from southern Alberta, parts of British Columbia, and Saskatchewan. Each of the four selected acute care sites have similarities but there are distinct differences.

Foothills Medical Centre specializes in cardiovascular care, neurological care, burns, eating disorders, renal and renal transplant, and is the trauma centre for southern Alberta, parts of British Columbia, and Saskatchewan (AHS, 2015). There are 1095 inpatient beds (AHS, 2015). Peter Lougheed Centre specializes in vascular care and has 562 inpatient beds (AHS, 2015). Rockyview General Hospital specializes in urology, psychiatric care, and ophthalmology and has 617 inpatient beds (AHS, 2015). South Health Campus specializes in outpatient clinics but also has 269 inpatient beds (AHS, 2015).

Sample

Sandelowski (2000) and Zoroya (2014) mentioned that one method of data collection for a qualitative researcher was a purposive sample, which allowed for rich data from the participants. I interviewed nine NGNs who had paid pre-registration employment in acute care facilities as UNEs, LPNs, or NAs prior to graduation from a Canadian nursing program. One participant transitioned from a LPN to a RN, two participants transitioned from NAs to RNs, and the other six participants transitioned from UNEs to RNs (two of these also worked as NAs prior to transitioning to the UNE
role). The participants were all Caucasian females. The participants all worked between three months and one-year post completion of their nursing program and worked a minimum of three months in a 0.5 FTE (see Table 1 for participant characteristics).

Table 1

*Participant Characteristics, n=9*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>19-20 years</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>21-22 years</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>23-24 years</td>
<td>4 (45%)</td>
</tr>
<tr>
<td>25-30 years</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>30-39 years</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>&gt;40 years</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Months since graduation</td>
<td></td>
</tr>
<tr>
<td>3-5 months</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>6-9 months</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>10-12 months</td>
<td>4 (45%)</td>
</tr>
<tr>
<td>Nursing program</td>
<td></td>
</tr>
<tr>
<td>Athabasca University</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Mount Royal University</td>
<td>4 (45%)</td>
</tr>
<tr>
<td>University of Alberta</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>University of Calgary</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Pre-Registration Employment</td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>LPN</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>UNE</td>
<td>6 (67%)</td>
</tr>
</tbody>
</table>

Participants contacted me and an interview was set up at a time and place that each participant chose. I did offer to meet participants in a private place away from others but the majority of participants preferred to meet in a coffee shop, so this is where I met with most of them. Elwood and Martin (2000) mentioned that many qualitative researchers discussed that often the best places to meet participants were in a place that is convenient for the participant. I conducted one interview per participant that lasted
approximately one hour but I did not place a time limit on this. Interviews lasted from as short as 45 minutes to as long as 90 minutes. Prior to the interview, I obtained consent to tape record the interview. Interviews continued until data saturation was reached.

**Data Collection and Analysis**

Initially, I asked demographic questions (see Appendix E) for descriptive information of the participants. Sandelowski (2000) mentioned semi-structured interviews provided a guided approach to the interview process and ensured that the participants’ view of reality was preserved; questions needed to be asked that did not steer participants to a particular answer. As I used a semi-structured interview guide (see Appendix F), it helped to provide consistency for data collection and allowed opportunities for NGNs to describe their own personal experiences. The semi-structured interview guide also allowed me to gain rich description of NGNs’ perspective of their transition from student to GNs and RNs.

Sandelowski (2011) stated that data collection could be completed in various ways but the research method used by the researcher determined how to complete the data categorization. Creswell (1994) mentioned that data analysis required taking large amounts of data and reduced it, or took it apart and found the pertinent information to the topic of interest. Qualitative researchers use this reduction and look for patterns, themes, and meanings that participants place on the phenomena of interest (Creswell, 2007), or in this research, the transition experience of NGNs with direct paid pre-registration employment. Therefore, an important component of the descriptive qualitative design is a description of the participants’ experiences and the importance they place on the phenomena of interest (Sandelowski, 2000).
I obtained permission from each participant to audio-tape the interview prior to starting the conversation. Each interview was audiotaped, transcribed, and analysed to find themes and meanings from NGN’s viewpoint of the transition experience. I transcribed the majority of the interviews but I hired a professional transcriptionist for two of the nine interviews. This individual signed a confidentiality agreement (see Appendix G). The interviews were transcribed verbatim. I listened to all audiotaped recordings and compared them to the transcriptions for accuracy.

I followed Creswell’s (1994) method of data collection and analysis, listening to each individual audiotaped interview before I completed the next one, which assisted with understanding the experiences, key concepts, and themes, helped me with developing personal interview skills, evaluating questions, and assisted with guiding subsequent interviews. As I am an inexperienced interviewer, I recognized early in the interviews that a concerted effort was required to ask open-ended questions.

Loiselle and colleagues (2011) mentioned that immersion in the data was an important component of qualitative research. I obtained greater immersion in the data and understanding of the participants’ viewpoints as I listened to interviews and read transcripts. Streubert (2011) mentioned that saturation of data was an important aspect of qualitative research and referred to repetition and confirmation of the information. I continued the interviews until data saturation was obtained.

Sandelowski (2000) mentioned that understanding the participants’ view was an important component of descriptive qualitative research. I read each transcript line by line to understand the transition experience of each participant. I then analysed each interview individually and found key concepts of the participants. After I completed the
initial analysis of each interview individually, I identified the key concepts by participant one and itemized these key concepts on a separate sheet of paper. Next, I identified the key concepts from participant two. Then I compared and added these to the list from the first participant. I continued this process until all nine participants’ key concepts were added and compared to previous participants. Initially, I was unsure of categorizing one set of ideas as a theme but as I started to determine which key concepts might link to the theme, it became apparent that this was also a theme. I manually completed each of these steps.

**Rigour**

Rigour is the trustworthiness of a research study (Koch, 1994). One way that a researcher ensures there is rigor is to include an audit trail which documents the events, influences, actions, and steps of the research (Koch, 2006). Lincoln and Guba (1985) stated that rigour was the credibility, transferability, and dependability of a research study. According to Streubert (2011), a reflective journal assisted with observations, thoughts, and being open to the data collected. I kept a reflective journal, as Koch (1994) and Sandelowski (2000) suggested this type of documentation, increased subjectivity, rigour, reliability, trustworthiness, and allowed for an audit trail. I kept a journal to describe my thoughts, feelings, and preconceptions throughout the study. I also transcribed and discussed early interviews with my supervisor, which assisted with this process. Separating my thoughts and feelings from those of a CNE, student, and researcher was an important component of the reflective journal to help prevent bias. The journal was available at any time to my committee members and allowed for an audit trail and assisted with decreased bias.
Rigour is an important aspect of qualitative research and necessary to stay “true” to the data. Therefore, I used terminology that the participants described when completing the data analysis and presenting the results. To assist with rigour, I discussed how the data was collected and analysed as well as kept a journal to outline my thoughts and feelings as a student, nurse, and educator. All of these components were available for perusal by my supervisor and gave an audit trail for review and trustworthiness of the research conducted.

**Ethical Considerations**

I obtained ethics approval from CHREB and AHS prior to any recruitment for the study. I received permission from the research department of AHS to contact CNEs and managers and placed posters at each of the four acute care facilities in Calgary, Alberta.

Prior to each of the participant’s interviews, I obtained informed written consent (see Appendix H). Participants’ consent forms and demographic information are kept in a locked cupboard in my office. Digital recordings and transcriptions are kept on a password protected memory stick and external hard drive in a locked file cabinet at my home. Audiotaped recordings and transcripts will be kept for minimum of five years after the research is completed.

Ensuring there is respect for confidentiality, anonymity, and privacy are key components to any research study and building trust is an important aspect of the relationship between the researcher and participant (Carpenter, 2011; Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans [TCPS2], 2005). I met with participants in a location of their choice and away from the acute care facility, which assisted with building trust and confidentiality. Anonymity may not always be possible as
participants may talk to each other or their work colleagues as I stated in the consent form.

There should be no coercion to participate in a research study (TCPS2, 2005) and all my participants freely volunteered. I am currently a CNE on an acute care medical cardiology unit and conduct orientation to new staff for all cardiac units in the city. Therefore, participants from the units whom I instructed or interacted with in a supervisory or instructor capacity were excluded to decrease possible bias and feelings of coercion.

Carpenter (2011) mentioned that qualitative researchers needed to be cognizant of non-maleficence or beneficence to their participants. I informed participants that they did not need to answer any questions they felt uncomfortable with. If the interview brought up any distressing feelings or thoughts, I planned to refer the participant to the Employee and Family Assistance Program (EFAP), which was available to all AHS employees. If at any time during the interview any participant was to bring up unprofessional nursing or administrative practices, I planned to encourage the participant to report these practices to their manager or professional body. As a member of CARNA, it is my responsibility to ensure that all registered nurses are practicing in a professional and ethical manner. One participant mentioned a concern about a potential unprofessional practice but she had already dealt with the situation prior to our interview. If a participant was unable or unwilling to report any unprofessional or unethical practices that they had disclosed, I would have assisted the participant to report these practices or reported this myself.

Participants were also informed that they could withdraw from the study at any time and
they were each given a copy of the research consent form with information on how to contact myself or my faculty supervisor.

**Summary**

I used a descriptive qualitative design to gain rich descriptions of NGNs with paid pre-registration employment, in acute care facilities, prior to graduation from their nursing program, which assisted with understanding how they viewed their transition phase. I interviewed a purposive sample of nine participants. By using a semi-structured interview guide, audiotaping each interview, and listening to these recordings numerous times helped me to discover themes and meanings. I analysed recordings and transcripts line by line to obtain NGNs’ perspective of their experiences in the transition phase. Implementing ethical standards assisted me with confidentiality and ensured that participants were treated with respect.
Chapter Four: Findings

I conducted a study with a descriptive qualitative design with nine participants who had direct paid pre-registration employment in an acute care facility prior to graduation from their nursing programs. Six of these participants had worked as UNEs, one as a LPN, and two as NAs. The findings of my research are discussed in this chapter. Initially, I asked the participants what transition meant to them. The themes of the research emerged from my conversations with the participants about their transition experiences.

Transition

The participants began their interviews with a question from me about what transition meant to them. The participants described transition in many ways. It was noted to be “a very stressful period of life” (Heidi)1, moving “from one role to the next (Denise), “getting into the groove of what works best for you” (Fiona), and a “movement … to independent practice and to make decisions to be totally independent” (Carolyn). Evelyn noted, “I wouldn't have been able to answer that [question] 6 months ago.” She went on to describe transition as “just an upgrade, really. I find that the transition from an UNE to a GN was really smooth; there was very little difference for me in the responsibility that I had been given on the units.” Isabelle noted that transition was “going into something … different, possibly even better.” Heidi stated that another concept of transition was “mainly how you are processing the change between one unit to one situation or to a different one.” Gail mentioned that transition was “vague, because

1 Pseudonyms used
transition can be to the point where I am comfortable … I think, it’s just like a continuous learning, um, and moving to like, even the next stage in life.” Participants mentioned that it would be difficult to understand when they had fully transitioned as Gail stated, “it’s not like walking up the stairs and oh, I’m done!” Heidi echoed these comments and stated:

I initially want to say it is when you feel like you’ve, like, learned all you can but that is never going to happen in nursing… I don’t think there is going to be any one thing that lets me just know; I think it is going to be a comfort level.

Evelyn felt her transition will be complete when she was able “to look at my assignment and go, it is just another shift rather than go, Holy Crap! This is going to be a lot.” Denise also mentioned that she would recognize that her transition to a RN was complete when I am no longer looking at everybody as I am doing wrong, that will probably confirm that my transition is done. When I am on the other side of the fence, where I am not always feeling, ah, I fucked that up.

Angela, alternatively stated that “in reality, I don’t think there is a transition, I think it is stupid and then you are an RN, and you’re in charge a year later, I guess.” Transition, whether stressful, smooth, supportive, or unsupportive was something that all participants had to go through.

Themes

In the analysis, I identified five main themes from understandings gained from the transition experience of the nine participants. These five themes were support, vulnerability, de-stress, becoming comfortable, and gaining confidence.
Support

Support was noted to be people or resources that participants used to assist with decreased stress, anxiety, vulnerability, as well as increased comfort and confidence as they gained knowledge and experiences in their new role of RNs. The participants identified supports that assisted when they had feelings of vulnerability and needed to de-stress. The participants also used their supports to assist with increased comfort and confidence. Some of these supports were family, friends, and previous nursing classmates that the participants leaned on for assistance during the transition period. I further separated support into unit and non-unit supports. Unit supports were co-workers and resources that the participants found on the units, which assisted them in the transition phase. The participants also used non-unit supports, which were identified as external support systems that were not related to the unit, such as family and friends.

Unit supports. Unit supports were noted to be people or resources on the unit that the participants used, which assisted with decreased stress and anxiety. These supports also helped with increased knowledge, comfort, and confidence during the transition phase. Some unit supports that participants used were other nurses on the unit, policies and procedures, unit manuals, and the internal website for AHS (Insite). A couple of participants felt the supports they found and used were determined by “trial and error” (Fiona, Gail). Evelyn noted that unit supports were essential and gave her “lots of opportunity to build my skills, to seek that confidence that I need to make those decisions and a lot of the time, in this case, it is life and death.” To assist with understanding of the unit supports available on the unit, I have divided these unit supports into nursing and non-nursing supports.
**Nursing supports.** Nursing supports were identified by the participants as nurses on the unit they would go to when they required support or assistance with information, were overwhelmed, unsure of themselves, or felt a lack of knowledge. Nursing supports were identified by some participants as “the people there with experience” (Denise), as well as nurses who “checked in with me regularly, so, I didn't feel like I was left on my own devices” (Evelyn). Participants felt that finding mentors was also important because “you can’t do this alone. Find someone who is strong that you admire their practice and ask them to help you” (Denise). Nurses on the unit assisted when participants were overwhelmed or uncertain. Evelyn felt that in times of uncertainty she used the experienced nurses on her unit to help her.

Okay, I have no idea what I am doing when I walk into this situation. Can you give me some pointers or what has worked for you in the past? So, seeking out the supports when I need it or when I am feeling overwhelmed.

Denise also mentioned that she was able to go to experienced nurses on her unit for support.

It’s always nice to be able to grab another nurse and be like, this is what’s going on like, can you come and support me in this situation, um, or can you come help me support one of my patients. I use the staff, the people that have been there … for a while.

Angela felt that the best way to receive support from her co-workers was to “just milk it for as long as you can because eventually you aren’t new anymore.” Other nurses also helped participants with debriefing and learning opportunities. “We kind of [talked] about
it … that code we had at four in the morning a few weeks ago … with all the nurses that were on, um, what went well, what we could have done better for next time” (Betty).

Some participants felt that their clinical nurse educators (CNEs) were very helpful and easily accessible. “I felt the unit educator was a huge support – always available to answer any questions” (Evelyn). “I would say our nurse educator is a biggest mentor, she is so awesome” (Betty). Whereas other participants had difficulty accessing their CNEs because the educators were constantly off the unit. Denise stated “the educators aren’t on the floor much,” “I don’t see her [the educator] around much” (Heidi). Angela stated it was difficult to gain assistance from her CNE as “she is off orientating new staff all the time or is away at meetings or education days and those types of things, so very, very rarely [do] we see her.”

Other nursing supports the participants found helpful were staff nurses on the unit. “It’s more knowing what nurses are good to go to for help and stuff. … they know what is going on and they are up to date with new stuff” (Fiona). Charge nurses were seen as a good source of information and support as well; “I would ask charge a lot of questions” (Gail). One participant noted that the “resource nurse on the floor … helps with transition” (Heidi). Working previously on the unit assisted participants with knowing who they would approach for support, “it’s easier to approach those nurses, when, you know, you have that trusting relationship and you have worked with them before, you know they are going to support you” (Betty). Navigation of the unit included determining who participants approached for assistance as Carolyn mentioned, “the more senior nurses, I think are a huge resource but not all nurses support their colleagues.”

Nurses on the unit are a great resource for NGNs transitioning from students to RNs.
Experienced nurses can support by being available for questions, helping to find resources, debriefing in difficult situations, and being willing to go with NGNs to the bedside in uncomfortable situations.

**Non-nursing supports.** Non-nursing supports were resources that participants used other than nurses on the unit. Some of these supports were developed by other nurses but were available when nursing staff were busy or unavailable to assist NGNs. These resources were used by participants and assisted with “direction, clarification, … knowing where to find that stuff” (Carolyn). Examples of non-nursing supports participants used were unit drives, policies and procedures, unit manuals, and knowledge resource information. “We actually have on our unit … [a] drive folder which … our educators have created with certain policies or how this works … like any updated policies or procedures” (Gail). Often these unit drives also contained policies and procedures specific to the unit where NGNs were working. “We have a special shared drive for our unit for policies that are up to date or … unit specific that they don’t really have policies for which I find helpful and are good supports” (Fiona). Participants found that nursing unit manuals were also important for support, “it has a bunch of policies and procedures just folders, nursing skills, and anything you might kind of encounter on that unit” (Heidi). Another method of support was “the knowledge resource tab” which Denise found was helpful and helped to increase her knowledge.

**Non-unit support.** Non-unit supports were typically people, but not co-workers, the participants used to assist them in their transition experience especially when they had a particularly stressful or difficult day in their work environment. These non-unit supports were identified by the participants as family and friends. Nursing family were
noted to be family members that were also nurses. Friends were either from the non-nursing environment or friends they made in their nursing program who the participants stayed in contact with after graduation.

**Nursing family and friends.** Nursing family and friends were people who had a nursing background and were able to help the participants when they felt they needed support outside of the work environment. Most participants used both unit and non-unit supports. Often participants mentioned that nursing family and friends were good support systems. “My mom is in nursing, so she is a good resource, she is [in] critical care so her stories are always much worse than I have heard” (Isabelle). These stories allowed Isabelle to realize that her difficulties were normal. Gail mentioned she would “call my mom my first day [of my rotation] and walk through [my] patients,” which assisted with her learning. Participants also mentioned when they talked to other nursing friends, it was helpful. Carolyn stated that friends were helpful “because we were able to debrief and get together and talk with each other.” “You have all your friends who are in nursing and when you have a little freak out you can call them and it is kind of nice because everybody seems to have kind of the same kind of experience” (Isabelle). Sometimes talking to someone else was helpful as Betty mentioned, “I’m really a talker so I like being able to just off load that way.” Talking without judgement was important because “you don’t want someone to tell you how to fix your problem but just someone that, you [know], gets where you are right then” (Carolyn). Sometimes, participants looked for an opportunity to vent and re-structure their inner thoughts and feelings. Carolyn also talked about how she and her nursing friends texted each other after a bad day,
I guess bad days, those were the ones when I would text my friends and be like, my gosh, this was a nightmare and I hated every moment of it. We all have had those like, a group conversation and you could read back and just go, yeah, obviously it makes you feel better because it doesn’t happen as often.

Participants were able to look back at situations that had happened and realized they did not happen as often as earlier in their transition. This assisted participants to feel better about their work life and recognized that things were getting better.

**Non-nursing family and friends.** Family and friends from non-nursing backgrounds were seen by the participants as both supportive and unsupportive during the transition experience. Sometimes participants talked to someone without any nursing experience as “they were neutral in the situation so, it would help … it was nice sometimes to have someone who knew nothing about the situation, who knew nothing about nursing” (Fiona). Three of the participants stated that non-nursing family and friends were not helpful. “When I call my mom, crying about things, she is like ‘you are amazing, it’s okay.’ It is great but it’s not always what you need to hear and it doesn’t provide any advice and support” (Angela). Carolyn noted that her non-nursing friends did not understand how NGNs functioned on a unit and actually made her feel worse.

‘It’s just a new job Carolyn, it will get fine, like, you know, it will start out slow, they will give you more responsibility,’ yeah, it doesn’t work that way…it was de-validating like, you are telling me my job isn’t hard, you don’t understand.

Isabelle summed it up by stating:

I think people who are not in nursing, don’t quite get it, so it is kind of hard. I will tell some of my friends who are in like, geology about something, and they just,
they are like, how do you do it? I don’t really know, it is a lot easier to relate to other nurses because, we’ve all had the same experience.

Participants used one or all of their support systems for different reasons. Some of these reasons were ways to decrease feelings of vulnerability, to de-stress, to gain confidence and comfort in skills, and acceptance on the unit.

**Vulnerability**

Participants identified vulnerability as fear of not being accepted as a member of the unit, not being recognized for their previous knowledge, and when they felt like they were not “true” nurses. Vulnerability was often noted by participants as when they doubted themselves due to their lack of knowledge, experience, and were unsure of how to complete their daily tasks without assistance. “You are so sensitive that anything anybody says like ‘good morning,’ and oh, they are judging me. What did I do wrong” (Denise)? Participants described vulnerability as when they felt de-validated in their new roles as RNs. Vulnerability was a consequence of being “wet behind the ears …you are second guessing yourself all the time” (Evelyn), and being “walked all over” (Carolyn). Gail noted that vulnerability was “intimidating” because you were “not going to know all the answers and I am going to look dumb at some point.” Betty noted that vulnerability was related to the steep learning curve.

Any time you go from point A to point B um, it’s a huge, it’s a huge learning curve and you are vulnerable, right, because um, there might be a lot of things that you don’t know until you are an experienced nurse.

Vulnerability was also related to NGNs expectations to function as an experienced nurse as Carolyn talked about these feelings in her interview.
I’d have an awful, awful assignment some day and there was not a lot you could do about it. … I am expected to do what a nurse who worked for years is expected to do, right? It’s like, you go in and hopefully your assignment is manageable.

Vulnerability was noted by some participants to occur when they felt they could be eaten alive by their nursing colleagues on the unit. Angela noted “it’s still a lot of that eat your young mentality.” Conversely, Denise stated that it was not the other nurses but due to her own expectations she felt vulnerable. “I am my biggest enemy. I want to know it all and I will never know it all, and I will never be the best and I want to be the best and it is just not going to happen.”

Participants frequently used their support systems with these periods of vulnerability and they hung out with friends, exercised, or had “panic blabs” (Isabelle). One strategy Denise mentioned was “you go turtle in a new environment.” Another participant stated that “when a lot of people struggle, they just kind of lay low and you don’t want to ruffle any feathers” (Angela). Gail stated that one way she dealt with the vulnerability was to embrace it.

I am not going to know all the answers and I am going to look dumb at some point, okay, I am going to make a mistake. … so like, knowing that is going to happen, 100% because that is literally the only way that you are going to learn. Vulnerability was further broken down into key concepts, including: feeling overwhelmed, self-doubt, being de-validated, stress, and imposter syndrome.

**Overwhelmed.** Being overwhelmed was identified by the participants as when
they felt they could not do all the tasks required of them in their day. Often feelings of being overwhelmed happened when the participants felt that they could not or should not ask others to help them. Part of this was noted because the participants were still gaining time management skills and a large amount of time was spent looking up information on tests, procedures, and medications due to their decreased knowledge. When Evelyn was “a little overwhelmed” and needed “to find more information” she realized that she could “go to other nurses on the unit for support” and help finding the required information.

When NGNs were now primarily responsible for a full patient load, they found they did not have time to complete all their tasks and this also led to feelings of being overwhelmed. Heidi stated that “I would be halfway through the shift before I had a chance to read the orders.” Carolyn mentioned “I feel like often, once your shift starts, there’s like, you don’t … have time to sit down and look for something unless of course I need to, then I need to put everything else on hold.” Carolyn also talked about “crying on the way to work, crying on the way home, and a lot of the time hating [her job] and dreading it…just not knowing what to do but knowing that you just had to keep on.”

Part of being overwhelmed came from worry of what would happen to them and the patient if a mistake was made, Isabelle found she “got a little panicky, It’s not like you can make a mistake at, in a business job and it’s just some numbers. This is like an actual human.” Denise’s fear was “I know what could go wrong and hope to hell it doesn’t happen on your shift with this patient.” Sometimes, Gail stated when she felt overwhelmed the best strategy was just to continue on “I can’t even think about this day or it’s going to be, I’ll start crying.”

**Self-doubt.** Self-doubt was identified by the participants to be very common early
in the transition phase and was related to their lack of knowledge and experience. Due
to their new environment and competing tasks, the participants talked about doubting
whether they remembered to do all their required tasks and often used checking and re-
checking to confirm that they did not forget anything. Nurses are often hardest on
themselves as Fiona stated that “…you doubt yourself and you are like, I am such a
terrible nurse, I can’t do this or whatever and then you don’t enjoy work because you
think you are terrible.” Denise felt that the common phrase “nurses eat their young” was
not correct but knew she was “eating myself up … I was so sensitive that if they gave me
constructive criticism … you are so insecure in your knowledge and your practice that
you take it so personally that they are eating you, they are killing you.” Isabelle
mentioned that she doubted herself all the time “if I feel like I forgot to do something, the
next day I would like, double check to make sure so I would know that I did it and not
have to go home with those feelings of self-doubt” and stated that she used this self-doubt
to help her “gain confidence” that she was actually doing things correctly.

**De-validated.** The participants in this study felt de-validated when other people
did not understand how difficult their life was during the transition phase as Carolyn
mentioned “it was just de-validating.” Participants wanted to be accepted and recognized
for when they asked for support, which assisted with decreased stress and anxiety but
when support was not given they felt de-validated. Participants also stated they felt de-
validated when others did not accept them for who they were or ignored their previous
experience, and told “me my job isn’t hard” (Carolyn). Being de-validated caused the
participants to have periods of vulnerability. “Some people would laugh, like my mom
would say, ‘you are being so dramatic’” (Carolyn). Denise talked about a situation when an experienced nurse took over and de-validated her previous experiences.

I had a long strip and I was just like, give me a minute to analyze it … she grabs the strip from me and she’s like, oh, this is VT and I am like, really? … but I didn’t have time to analyze it so I just took her word for it.

When NGNs felt de-validated, it was difficult for them to gain confidence or comfort in their roles as RNs. The participants felt this was a transient period as Carolyn stated “it’s a lot better” now and one of the ways they moved forward in their transition was they learned to “find their voice” (Denise).

**Stress.** Stress was often perceived by the participants as being “shocked” (Gail), “a little panicky” (Fiona & Isabelle), or “trapped in a corner” (Carolyn). “I overanalyze everything I do like, you go home and you are like, omg, did I do this, did I do this” (Isabelle)? The participants also noted stress was because “there is no more, 'I am a student' or 'I am still learning' or 'I haven't achieved that goal yet', … there is no more cop out” (Evelyn). Lack of sleep was also noted by the participants to be related to stress.

The general theme is it will get better but when you like, you are so stressed you can’t sleep, you’re so stressed you just dread going to work. I keep hearing that it will eventually get better is no consolation at all. (Carolyn)

Participants mentioned that some of the reasons for stress came from “relearning teams” (Denise) and navigation of the unit and the system; “you have all the resources on Insite but again it is a matter of finding it … It has a huge wealth of information but finding anything in there is just a nightmare” (Gail). One part of navigation of the unit was noted by participants as finding where medications and supplies were. Heidi
mentioned, “you have to choose every single medication … it is in three different spots and then if it isn’t there then you have to call pharmacy.” Gail stated she felt stressed with the amount of time it took to find supplies:

There is like [carts] in four different areas and some have some stuff and others have the other stuff … there [were] two med rooms, so like one will have this dose of zoplicone the other one has this dose, so it is like, there is so much [on] the unit that can make it confusing.

Acceptance on the unit can also lead to stress as Angela stated, “at the end of the day, you still want to be accepted and don’t want to pressure people and be the popstar. No one wants to associate with and you don’t want the ‘b’ title either.”

Imposter syndrome. Participants mentioned that imposter syndrome was noted to be “fake it ‘til you become it” (Isabelle). As NGNs left their past student persona behind, they often mentioned they did not feel like “real” nurses yet. “When you first come out, you kind of feel like an imposter. Like, you want me to do that? I don’t think that I can do that. I’m not responsible to do that” (Angela). Isabelle mentioned that she felt she was an imposter and stated: “Why am I on my own? I shouldn’t be on my own.”

De-stress

De-stress was identified by the participants of this research study as ways they decreased stress during the transition phase. Some ways that participants mentioned they de-stressed were organization of workload, normalizing feelings, self-reflection, de-briefing with other staff in difficult situations, exercising after work, time management, and prioritization of patients and workload. Denise felt the ways she used to de-stress were to “use humor,” asked for permission to “just let me do it,” and would “talk myself
through it.” Heidi mentioned “just try to stay organized for the most part” helped her with decreased stress and vulnerability. Gail stated that another nurse told her to “slow down your walking, slow down your pace” and then she could say “okay, breathe, it is going to be okay.”

Feedback either from others or by self-reflection helped participants to de-stress “but then [I] also found because [of] those people’s feedback, it made me give myself feedback too in situations” (Fiona). “Talking about it helps … yeah, learning and advancement, right a sort of debrief, that you use as a stop gap” (Betty). Denise found she would “talk [herself] through it.” Sometimes not just talking but being able to “have a panic blab, to, especially other nurses that you are friends with and then they are like, oh, it’s not that bad, like something similar happened to me” (Isabelle). Carolyn also mentioned, “I think sometimes you got to … pull your pants up and get on with it. Like, there is nothing that is going to make it go away, there is nothing that is going to make it easier.” If NGNs are able to survive the vulnerable periods and find ways to assist with decreasing their stress, they are able to start to feel comfortable and confident in the new reality of being RNs.

**Becoming comfortable**

Before NGNs start to feel comfortable, they need to go through uncomfortable periods. Becoming comfortable was identified as when participants felt they could come to work without stress and anxiety. Often in the initial phase of the transition experience participants mentioned they felt very uncomfortable due to decreased confidence and when they lacked knowledge.
The one LPN in this study mentioned she felt she should have been comfortable when she moved from the LPN to RN role as there were not many differences but she recognized early on that this was not the case.

I think it is an illusion as an LPN but I didn’t have … the responsibility that an RN does when a patient is declining, in a rapid way. You are there as the primary to give the background information but you couldn’t do any of the competencies that are required for an ACLS rescue so you are only there as the background information and chest compressions, which is still very important but there isn’t that independence. As an RN you are very much responsible for that, you know, uh, making the appropriate connections and calling in who you need to and getting the patient stable. Whereas I think, I was so used to handing that off … I didn’t think I was but looking back at it, I was. [I wondered] why am I so panicked all the time, like I used to do this [but] … not so much.

Angela stated “sometimes, the struggle is knowing where your place [is] … how do I fit into the hierarchy, and is there a hierarchy?” Participants noted that one uncomfortable part of being NGNs was delegation.

I come out as a brand new grad and then I have to delegate to LPNs who have been working for 30 years and there is something that feels uncomfortable about it and I don’t want to step on anyone’s toes but there are times when there are things that I have to do that you can’t … and I need to do this and it’s just the way that it rolls. (Angela)

As NGNs move through their transition phase, they start to gain comfort. Consistency was seen by participants as a way to help with gaining comfort, “going into a temp line
actually really helped cause my shifts were consistent. So, I’d have the same
assignment for four days” (Gail). Betty stated that “the more shifts you get the better,
more familiar you are.”

Participants stated that experience assisted with gaining comfort, “once you get
more experience then you just become more comfortable with the job” (Heidi).
Participants also noted they felt they might never know everything but that they could
still be comfortable, “I am comfortable with the unknown now” (Gail). “I am a lot more
comfortable and I know where to go if I have questions or I am not confident or unsure of
what I am not sure of” (Carolyn).

A huge part of my comfort has been the support I have got on the new job. Um,
yea, I asked a million questions, um, and I am not afraid to ask questions. Um, so
that I am a lot more comfortable and I feel more supported. I definitely know that
when I feel like if something goes wrong, I feel like I am not alone. (Gail)
Carolyn noted that part of being comfortable was the recognition that “I can adapt and I
have the skills and knowing that it’s okay to be uncomfortable.”

Building trust also helped participants as they gained comfort in the workplace
both with self-trust as well as trust from others.

I think I just kind of learned to, you know, trust myself a little more. Yes, I am
able to do this. I got through the 4 years, you learn every day at work, so, it is
kind of like a continuation of school. (Isabelle)

Building relationships with other nurses on the unit assisted participants with gaining that
trust. As one participant stated, “I think that … [by] building those relationships I was
able … [to] form some trust, trust in a lot of the nurses as well” (Betty). One participant
stated that some of this trust was gained from being on the unit previously, “we trust you, we know you, like, they had three months of watching me, so, I knew that, that independence was a little bit more, a little less dependent” (Evelyn). Part of comfort includes gaining confidence and I believe it is virtually impossible to gain comfort without confidence in nursing. Additionally, as NGNs start to develop confidence they become more comfortable in their new roles.

**Gaining Confidence**

Participants identified they felt confident when they gained the knowledge and experience required to fulfill their day to day jobs. The participants often described confidence as when they started to feel comfortable and competent as RNs. Experience and self-reflection assisted participants with increased confidence. Carolyn stated that “you like to think that you only make the same mistake twice but each time you do something, obviously you like, gain confidence through self-reflection.” Carolyn also mentioned that “in nursing you are not expected to know everything perfectly but you are expected to, to be competent enough right away to, and that’s a huge, like, at least that’s how I felt.” Angela echoed that gaining confidence was important as “after doing it for a certain amount of time, it becomes more, more familiar to you.”

Fiona felt that confidence was linked to both personal and professional life “it’s not just confidence in yourself as a nurse but like confidence in yourself as a person… your personal and work life are so interconnected.” Confidence was something that participants gained by experience.

You have to be confident in yourself, know what your limits are at. I think that … also part of that big life experience is that you don’t know who you are as a
person, you can’t take a stand on certain things because how, you don’t know how you feel. (Angela)

The participants explained that part of confidence was being willing to ask for help “it’s okay to ask questions, … it’s better to clarify than to be unsure” (Carolyn). You have to “ask a lot of questions, and find people you trust and then you can develop your voice because you can’t have a voice if you are not knowing what you are saying” (Denise).

Continuing to ask questions when I am unsure and not just go, well, they assume that I know so I am not going to ask. Just being aware of my own shortfalls and where I need to bridge gaps so that I am an effective nurse really. (Evelyn)

Many participants felt that confidence was a way to know that they had transitioned in their roles as RNs. Evelyn felt that she had “more, uh, confidence in my ability to move forward and make a decision on behalf of my patients.”

I think the confidence increase, just the calmness going in, going in without your heart beating a million miles a minute will be, getting not even transitioned, I guess that … transition [is] just calmer. You just know what is going on, you are able to react easily to most situations. It’s almost like second nature, you don’t even need to think it through so hard. (Denise)

Therefore, how individuals view themselves is a large part of both their personal and professional lives and as Fiona mentioned it is hard to separate these two lives.

Summary

As I was interested in understanding paid pre-registration employment and the transition experience of the NGN, it was necessary to understand what transition meant to the participants. Transitional theories assisted me with NGNs understanding of their
transition from student nursing roles to RNs. Different theorists’ transitional theories were used to guide through the analysis phase of this descriptive qualitative design. The main themes of the transition experience, from the participants’ voices, were *supports*, *vulnerability*, *de-stress*, *becoming comfortable*, and *gaining confidence*. Using supports to de-stress assisted participants with moving from periods of vulnerability to comfort and confidence and these supports were noted to be very helpful in the transition period. Most participants felt that comfort and confidence were ways that they would know they had transitioned into competent RNs.
Chapter Five: Discussion of Findings

In this chapter, I discuss the findings as they are situated in the literature about the transition experience, in the context of nursing. Each theme warrants further discussion to provide enhanced understanding of the transition experience of NGNs with direct paid pre-registration employment. Based on the data from this research, I answer the sub questions of the research which are: What does the word transition mean to the NGN? Does employment in direct patient care roles influence the transition experience? What supports does the NGN use to assist with the transition experience?

**Transition Experiences**

The first question I asked of each participant was what transition meant to them. Participants noted that this was something they had not thought of prior to the interview and an indication of transition was when they felt they would be comfortable or moving into different roles such as charge nurse or to the code team. Participants also mentioned that transition was moving into a different stage or place. Similarly, a dictionary definition of transition was a “passage from one state, stage, subject, or place to another” (Merriam-Webster, n.d). Participants of this research study felt their transition was easier because of the knowledge and experience they gained in their direct paid pre-registration employment roles. Cantrell and Browne (2005) mentioned that transition was not just gaining skills but also communication, navigation and integration of the system and unit, and understanding of the RN role. Participants who stayed in the same area they were previously employed in felt they had already started to navigate the unit (i.e. where to find supplies, medications, what types of patients were common) and gained some knowledge of the culture of nursing. In my study, NGNs went through a series of stages
and steps in their transition. The participants of this study had periods of vulnerability, used coping strategies to assist with this vulnerability, and then moved onto an acceptance of their new reality as a registered nurse.

**Vulnerability**

When NGNs complete their nursing programs they exhibit excitement and readiness for the next stage in their lives and think they can change the world. This is similar to M. Kramer’s (1974) honeymoon phase. Unfortunately, this excitement can lead to feelings of fear, stress, and anxiety that can relate to NGNs’ vulnerability. This vulnerable phase is similar to Bridges’ (2009) first stage of letting go which requires a period of breaking away from the past before being able to recognize a new identity. Participants also had feelings of fear as they were no longer students and were now the most responsible person. M. Kramer’s (1974) shock or rejection phase is similar to these feelings as NGNs realize that the world they are entering is not exactly what they expect. These feelings of fear can also relate to when they have to let go of their past and leave some of their friends behind. Bridges (2009) likened this to walking across a bridge where you cannot see where you came from or where you were going. Therefore, for a RN to fully transition it is essential they leave their past student persona or previous employment roles behind before they can continue in their transition.

Participants felt the hardest part of letting go from being a student was the feelings of vulnerability and recognition that they were the person most responsible for direct patient care and now had to make decisions on their own as they no longer had a preceptor or instructor supporting them. Rush and colleagues (2013) mentioned that NGNs found the most difficult part of the transition phase was when they needed a
support person to ask questions or clarify information. It is essential that NGNs recognize even though they no longer have an instructor, they should never feel they are alone. Most participants in this study identified experienced nurses on their unit who were available for assistance and participants felt comfortable approaching them when they were in the transition phase. Bridges (2009) discussed how change was external but transition was internal. Participants echoed this as even though they had moved from student roles to GNs and then RNs (external) they still did not feel like they were real nurses (internal). Letting go of their past and no longer identifying as students caused feelings of anxiety and vulnerability in the participants and feelings of ambivalence.

**Coping**

To deal with these feelings the vulnerable phase evoked, participants used coping strategies that assisted them as they continued their transition. One of the coping strategies participants mentioned was they became very focused on tasks and time management. This is similar to Duchscher’s (2008; 2009; 2012) first stage of doing and where NGNs focus on tasks and skill acquisition. Being focused on tasks allowed NGNs to feel a sense of accomplishment but they still needed supports in this period. During this coping, participants felt they could not find their balance. Newly graduated nurses cannot return to being students or to their previous roles of UNEs, LPNs, or NAs and are often living in an uncomfortable world. Using coping strategies assisted with these periods of vulnerability. Participants all mentioned they had periods of vulnerability especially when they lacked knowledge, had periods where they were not comfortable, and did not feel like “real” RNs yet. Georges (2004) stated that transition is going from a comfortable to an uncomfortable place. Even though participants had all started to feel
comfortable in their previous direct paid pre-registration employment roles, these roles had now changed which still caused feelings of being uncomfortable.

During this coping phase, participants often felt like imposters as they felt they were not qualified to be RNs and care for their patient load. Participants also felt they did not have the knowledge or experience and so were in a place where they were no longer students but had not fully transitioned into the RN role. The coping stage is similar to Bridges’ (2009) neutral phase and M. Kramer’s (1974) shock or rejection phase. Bridges (2009) discussed that the neutral phase was essential for a successful transition. Similarly, the coping strategies that NGNs use will assist them as they move forward in their careers. This neutral phase can also be comparable to Duchscher’s (2009) phase of being; in this phase participants begin to gain knowledge, skills, experience, and start to become more comfortable in their role of RNs. Participants in this study echoed feelings being uncomfortable, feeling like imposters, as well as feelings of vulnerability. The participants who had moved through these stages and recognized coping mechanisms already had stopped feeling like imposters.

Acceptance

As NGNs gain knowledge, comfort, and confidence they move towards acceptance of their new role of being RNs. Bridges’ (2009) final phase discussed recognition of a new reality and M. Kramer’s (1974) final stage was the resolution phase. This acceptance is when NGNs are able to meld all the information they obtain in their nursing programs with the knowledge and experience they gain and are able to become functioning members of the unit and nursing culture. Duchscher (2009) called this final phase knowing; where NGNs knew they were RNs and no longer felt like imposters.
If NGNs have support, they are able to successfully go through the first and second stages to reach the final stage which is an acceptance of their new roles of RNs. Some of the participants of this study had reached this final stage, others were not there yet but could describe what being a RN might feel like. Some ways the participants mentioned their transition would be complete was when they felt comfortable coming to work, they could take any assignment on the unit and not be stressed, they knew how to care for their patients, and they would be comfortable with the unknown.

Most of the participants felt it would be very difficult to actually tell when they finished their transition phase as there were always new things to learn. Health care and nursing are constantly changing (Kennedy, 2013) as policies change due to many different factors. For example, the reporting and learning system (RLS) in AHS is a voluntary reporting system where staff report incidents or near miss situations such as medication errors, patient identification, or falls (AHS, n.d. a). Some of the changes from this reporting system affect how to identify or dispense medications to prevent errors from occurring such as the high alert medication policy (AHS, 2014). These changes from the RLS reporting system as well as new products and research make it necessary to change policies and procedures. This constant changing environment makes it difficult to identify when a transition has fully finished. Many participants mentioned their transition would end when they had more responsibility or entered another transition. Some of the new transitions or responsibilities were noted to be charge nurse trained, being trained for the code team, and when they mentored or preceptored students.

Each of the participants moved through the stages in their transition process at different rates. Initially participants had a vulnerable period where they experienced fear,
anxiety, and stress. As the participants worked through this vulnerability, they used coping strategies. It is necessary for NGNs to go through each of the transitional stages prior to accepting and entering into the new reality of RNs. This process may appear to be linear but there are many skills and abilities that need to be acquired. Each NGN will move at a different pace dependent on the experiences both as a student and on the unit so it is often a circular process. The participants in this study noted that they moved through these stages faster than their counterparts who did not have direct paid pre-registration employment in acute care but they still needed to go through them. Newly graduated nurses must be given time to assimilate into the unit and profession prior to moving on to different roles and responsibilities on the unit. Managers should be aware that NGNs need time to go through the transition phase prior to adding extra responsibilities. Sometimes, due to staffing, managers may try to push NGNs to new areas of practice before they are ready. If NGNs are not yet comfortable in their current role as RNs this can be detrimental to their development and I believe it can relate to higher rates of attrition on the unit.

**Themes**

The themes I discovered from the analysis of this research were *support, vulnerability, de-stress, becoming comfortable,* and *gaining confidence*. Participants mentioned that supports were required when they felt vulnerable; these supports helped with feelings of fear, stress, anxiety, uncertainty, and being overwhelmed. Most supports were seen as positive in the transition phase but it was also noted that de-validation caused vulnerability in the participants. Supports also assisted with de-stress as NGNs had people they talked or vented to, developed organization, as well as normalized their
thoughts and feelings. It is difficult to have confidence without feeling comfortable and the more comfort a person has in their job, both with acceptance and skills, the more confident a person feels. Newly graduated nurses have to be comfortable and confident in who they are before they can be comfortable and confident in their work life.

Support

There were many different supports participants used that assisted with their transition from nursing students to RNs both on and off the unit. A dictionary identified support as being able to help, assist, give a foundation to (Merriam-Webster, n.d.) or “one who provides assistance, protection, backing” (Etymology dictionary, n.d.). The participants in this study felt their support systems assisted them when they lacked knowledge, had fear, anxiety, stress, and vulnerability. Researchers mentioned that supportive environments were correlated to a positive transition experience (Gamroth et al., 2006) and assisted with a successful transition (Kilpatrick & Frunchak, 2006). Support systems are also necessary as NGNs require someone to listen to their concerns, fears, as well as give encouragement especially when they are having a bad day (Beecroft, Santer, Lacy, Kunzman, & Dorey, 2006). Alternatively, if NGNs do not receive support, they have more stress and dissatisfaction with their job. Participants felt that supportive nurses on the unit were important to help them when they were having a bad shift or stressful times on the unit and this support was associated with a positive transition experience.

Support is an integral component of a NGNs daily work environment as it is impossible to initially be competent in all skills and knowledge for their work environment. Ellerton and Gregor (2000) discussed that some of the challenges NGNs
had were learning new procedures, tasks, diagnoses, and medications they were unfamiliar with. Many NGNs must acquire these new learning activities as they transition in their roles as RNs. The NGN gradually accomplishes all these tasks which is a coping strategy and consistent with Duchscher’s (2008; 2009; 2012) first stage of doing but NGNs still need to understand why they do them. Each of the participants identified supports such as people, both on and off the unit, as well as resources that assisted them in their transition phase. Both researchers and participants mentioned that supports were necessary for knowledge acquisition (Anderson et al., 2012; Morrow, 2009), helped with decreased vulnerability (Cantrell & Browne, 2005; Morrow, 2009; Rush et al., 2013), assisted with de-stress (Anderson et al., 2012; Casey et al., 2004; Spiva et al., 2013), and helped with comfort and confidence (Anderson et al., 2012; Blanzola et al., 2004; Rush et al., 2013).

Managers, CNEs, and experienced nurses need to recognize NGNs require supportive environments and support people on the unit to assist them in their transition phase as Gamroth and colleagues (2006) mentioned that support from experienced nurses and management was essential as NGNs transitioned to RNs. Therefore, managers must support NGNs by being available for questions, assistance with navigation of the unit, and evaluating if additional supports are necessary. Clinical nurse educators need to be available to assist NGNs both in the orientation period and after they start working on the unit. The initial orientation is a small part of the transition process for NGNs and additional knowledge and experience is necessary as they transition into RN roles. An orientation program should include clinical nurse educators assisting NGNs with identification of their learning goals and how to find mentors on the unit. These strategies
should assist with increasing comfort and confidence. Experienced nurses are essential in the transition phase (Phillips et al., 2014b) and need to be available for support as NGNs gain knowledge and experience. Supportive environments as well as integrating supports from family and friends assists NGNs with decreasing stress, anxiety, and fear, as well as increasing comfort and confidence. I believe that supportive environments also assist with retention on the units as NGNs need to feel they are a part of the unit and not an outsider.

**Vulnerability**

The participants of this study had feelings of fear, stress, and anxiety as they moved through the transition period, especially when they felt on their own. These feelings could be related to vulnerability which was defined as the ability to “wound, hurt, injure, maim” (etymological dictionary, n.d.). Varner and Leeds (2012) stated that NGNs should be considered a vulnerable population and should receive supports during their transition phase, which helped with decreased fear, stress, and anxiety. Vulnerability was noted to be one of the stages of transition for NGNs in Cantrell and Browne’s (2005) study and was often a transient period (Rush et al., 2013; Williams et al., 2007). Bridges’ (2009) first and second phases of transitional theory could lead to vulnerability in NGNs. Participants mentioned that often innocuous things caused them to feel like others judged them and caused vulnerability. M. Kramer and colleagues (2012) mentioned that another reason for vulnerability was that NGNs were so scared they might make mistakes that they still required validity in tasks where they should have been confident.

When NGNs leave their past student persona behind and move into the neutral phase of transition they often have difficulty as they identify where they fit in the
hierarchy; they are no longer students but also have not moved into full recognition of being RNs. Participants, in this study, felt that supports helped with decreased vulnerability caused by fear, stress, and anxiety.

Participants in this study realized as they moved from paid pre-registration employment roles of UNEs, LPNs, and NAs, they had benefits other NGNs (without paid pre-registration employment) did not have but still had periods of vulnerability as they were not competent in all skills. Some of these benefits were greater acceptance from their colleagues and previous comfort of caring for a full patient care load independently. Similarly, Phillips et al. (2014b) noted that NGNs with paid pre-registration employment in direct patient care roles felt vulnerable when they realized they still had a difficult transition. One reason for this vulnerability was that in their previous roles they could not do everything for their patients as they were not able to complete certifiable skills but now as NGNs this was a requirement. When UNEs and LPNs were unable to accomplish certain skills and deferred these skills to experienced RNs it caused an unrealistic view of the NGNs’ time management abilities as they were now expected to do everything for their patients. This is consistent with Roziers and colleagues’ (2014) research which showed that some components of vulnerability were related to NGNs performing tasks they were uncomfortable or not competent with as well as the lack of role clarity with the nursing profession. Some participants mentioned that due to the lack of role clarity in their previous jobs they needed to be careful and they needed to ensure they only completed tasks within their scope of practice.

As noted, many participants felt like imposters as they realized they were no longer students but did not feel like RNs yet. Imposter syndrome is very common when
starting a new job (Robinson-Walker, 2011) and often causes fear (Kumar & Jagacinski, 2006). Imposter syndrome increased feelings of vulnerability as Draycup and Bryan-Brown (2004) mentioned that NGNs did not want to be exposed as frauds.

Stress can be described as “an imbalance between a person's resources and appraised demands” (Olssen, Kandolin, & Kauppinen-Toropainen, 1990, p. 176). Some participants mentioned they had many physical symptoms of feeling unwell as well as sleeplessness during their vulnerable periods. Likewise, Duchscher (2009) and Morales (2013) discussed that stress was a common component of transition for NGNs and often led to sleeplessness. Some participants mentioned they had many physical symptoms of feeling unwell as well as sleeplessness during their vulnerable periods. Similarly, Rheaume and colleagues (2011) stated that stress caused many physical symptoms such as headaches, stomach pains, and sleepless nights. One of the participants echoed this when she talked about being so stressed she could not sleep. Stress causes exhaustion (Morrow, 2009) as NGNs are often unable to leave their problems in the work environment (Rheaume et al., 2011) and continue to focus on their perceived or actual inabilitys in the workplace. Therefore, this stress is carried into their personal lives as well. Decreased stress assists with an increase of self-confidence and retention of NGNs (Beecroft et al., 2006). Therefore, ways to decrease this stress are necessary to assist NGNs in the transition phase and help with emotional and physical health as well as increasing comfort, confidence, and retention. The findings of this research study show that supports are important and that NGNs use them as coping strategies during periods of vulnerability to de-stress.
Managers need to be able to recognize signs and symptoms of stress in all staff, particularly NGNs. Staff who experience stress may not recognize it as such but often have an increase in sick time. Managers need to be aware these symptoms, such as an increase in sick time, may indicate stress and put supports in place to assist NGNs during the transition phase. Newly graduated nurses should gain insight of the signs and symptoms of stress as individuals may exhibit different manifestations of stress and recognize when they need to de-stress.

De-Stress

When the participants in this research study encountered stress, they used coping strategies to de-stress. Stress relates to hardship or adversity (Merriam-Webster, n.d.) whereas de-stress is moving away from stress. De-stress can be identified as ways that participants use to decrease the amount of stress they have and move forward in their transition such as using humour, personal insights, and self-reflection. De-stress is a way “to release bodily or mental tension” or to “unwind” (Merriam-Webster, n.d.). Participants mentioned that consistency of shifts also helped with decreasing stress. Phillips and colleagues (2014a) also mentioned that supportive environments, consistent shifts, staff that were willing and helped NGNs, as well as organized orientation were all ways that decreased stress.

The participants of this research study mentioned organization skills assisted with decreased stress. Even NGNs who were previously employed in direct patient care roles had difficulties with organization as they were now responsible for everything for their patients and no longer had things that they could “pass off.” Gamroth and colleagues (2006) noted that organization was an important factor in decreasing stress. Additionally,
NGNs incur more stress as they feel they should do it all on their own and not always accept assistance from other nurses on the unit. There are many ways to de-stress and help NGNs move through the transition phase and everyone will find what works best for them.

Ways to decrease stress are necessary to assist NGNs with emotional and physical health as well as increase comfort, confidence, and retention. Experienced nurses on the unit may recognize NGNs who are having difficulties on the unit and assist with decreasing stress by being available for assistance, debriefing, and being a “sounding board.” Managers need to keep lines of communication open with their staff so that experienced staff can feel comfortable identifying if new staff require additional supports. Also, CNEs need to be in constant communication with NGNs and can assist with their learning needs as this is part of their job description (Calgary Health Region, 2004) (see Appendix I).

**Becoming Comfortable**

Participants often felt uncomfortable at the beginning of their transition when they had stress, anxiety, and feelings of vulnerability but as they started to gain knowledge, skills, and experience they had increased comfort levels. Being uncomfortable was identified as embarrassed, uneasy, or when participants felt physical discomfort whereas comfort was defined as helping others “to feel less worried, upset, (or) frightened” (Merriam-Webster, n.d.). Before becoming comfortable NGNs will have uncomfortable periods. Bridges (2009) mentioned that the neutral phase brought feelings of discomfort and it was important to find ways to alleviate this discomfort in the process of becoming comfortable (Morrow, 2009). Newly graduated nurses must successfully move from
being students to RNs in the work environment (Casey et al., 2004). Ellerton and
Gregor (2000) noted that often NGNs without paid pre-registration employment took
longer to complete tasks than experienced nurses, had difficulty with time management,
and did not always understand the findings from their assessments which all related to the
difficulty to gain comfort in their new roles. Romyn and colleagues (2009) noted that it
took at least six months for NGNs to gain comfort and confidence and become
independent in their new role of an RN. Each of the participants discussed how
uncomfortable they felt either at the beginning of their direct paid pre-registration
employment or when they finished their nursing program and were no longer students.
This uncomfortable feeling was related to when they were unsure of themselves, lacked
knowledge, were frightened, or worried about their work lives. Each participant discussed
coping strategies that assisted with gaining comfort. Phillips and colleagues (2014b)
noted that when NGNs lacked support it increased anxiety, fatigue, and decreased job
satisfaction and so supports were necessary to assist with becoming comfortable.
Participants used their supports, which assisted with increased knowledge and experience
and helped with becoming comfortable.

Lantham and colleagues (2011) mentioned that advocacy by experienced nurses
assisted in increased retention of NGNs; this retention was usually related to comfort.
Some of the participants in this study talked about self-advocacy and being willing to
admit when they needed assistance. Self-advocacy is a way to help NGNs become more
comfortable. Interestingly, participants did not discuss other nurses advocating for them
but they did discuss the support they were given so it was possible this advocacy was just
not identified as such. Research studies about advocacy discussed nurses advocating for
patients and NGNs but the only information on self-advocacy was in the patient context. I was unable to find any literature about nurses self-advocating which was definitely discussed by participants of this research study. Participants felt there were times they needed to advocate for themselves or they could be “walked over.”

Participants of this research study stated that comfort came when they gained more experience. Researchers also mentioned that experience helped with gaining comfort (Casey et al., 2004; Morrow, 2009; Wagensteen & Johansson, 2008). Another aspect of comfort was when participants accepted responsibility and acknowledged they knew what they were doing. Another component of becoming comfortable for the participants was being accepted on the unit. Cantrell and Browne (2005) also mentioned that acceptance and socialization on the unit were important factors in NGNs becoming comfortable; support from other nurses on the unit was an integral factor in this acceptance and socialization. Participants’ comments echoed that acceptance and support from other nurses on the unit assisted with gaining comfort on the unit and as RNs.

Newly graduated nurses need to recognize uncomfortable periods are normal even if they have previously been in direct paid patient care roles. As NGNs gain experience and consistency, these uncomfortable periods should decrease. Ways NGNs gain comfort are to actively look for ways to gain knowledge, skills, and experiences. Experienced nurses on the unit should assist with acquisition of knowledge and skills by asking NGNs if there are skills or tasks they need experience with. Also, NGNs need to be willing to self-advocate when they are feeling pressured into situations where they lack experience or are uncomfortable with. Assisting NGNs with becoming comfortable will increase
retention and stability on acute care units (Anderson et al., 2012; Casey et al., 2004; Rush et al., 2013).

**Gaining Confidence**

A lack of confidence is often noted with NGNs and will decrease as they become more comfortable in their job, skill level, and acceptance on the unit. Confidence is a “feeling or belief that you [can] do something well or succeed at something” (Merriam-Webster, n.d.). Even though NGNs have academic preparation to become RNs they often lack confidence and feel insecure (M. Kramer, 1974). Duchscher (2008) stated that many NGNs do not feel confident as their practical experience had not exposed them to the high acuity and full workload of the nursing unit. Part of the reason for this lack of confidence is because students have minimal exposure to critically ill patients and therefore, they have an unrealistic idea of the RN’s role (Aleco, 2009). Some of the participants of this study felt that they were not fully prepared for the transition from nursing students to RNs but they felt it was virtually impossible to prepare for a role when there were so many different areas of practice. Another reason participants felt they were not fully prepared for the transition to RN was that they realized they always had a support person in their direct paid pre-registration employment roles and now they felt they should be able to do everything by themselves. Blanzola and colleagues (2004) also mentioned that confidence assisted with competence and gaining confidence is often related to increased comfort on a unit, knowledge, experience, and feedback. Participants felt that even though they were not fully prepared for practice, they were more prepared than NGNs who did not have the benefit of direct paid pre-registration employment.
As NGNs become confident, feel a sense of control, and start to re-construct their view of themselves as a RN, their ability to navigate and integrate into the language and culture of the unit and nursing profession improves (Romyn et al., 2009). Participants in this research study felt they had started the integration into the nursing profession in their previous roles of UNEs, LPNs, and NAs but still had periods where they were not confident. Participants felt increased knowledge, experiences, and feedback assisted with increased confidence. Part of confidence is also recognition that NGNs are responsible for their own actions.

Phillips and colleagues (2013) mentioned that confidence was gained when NGNs acknowledged their practice, were accepted by the team, and attained competency in their desired workplace. Participants recognized that knowledge, education, and research that increased their knowledge of patients increased their confidence. The participants in this study felt confidence was necessary as they moved ahead in their transition and started to form the new reality of being RNs. Support from colleagues, acceptance on the unit, and gaining knowledge and experience are all noted to be related to increased confidence in NGNs (Nuttall, 2009).

For NGNs to become confident they require support, gain comfort and acceptance on the unit, as well as increase knowledge of their practice area. Managers must assist NGNs with identifying expectations early on in the employment phase and preferably even in the interview phase. Experienced nurses on the unit should offer support and assist with opportunities for NGNs to gain experience with skills. Clinical nurse educators must ensure that orientation programs allow opportunities for NGNs to gain knowledge of the area that they have chosen to practice in. These CNEs can also assist
with pairing NGNs with supportive staff during the orientation period. When staff assist NGNs with an increase in confidence and satisfaction it helps with a decrease in attrition (Anon, 2008; Beecroft et al., 2006; Casey, 2004; Kamboj, 2013; Phillips et al., 2014; Rush et al., 2013). If the NGN is not confident, it is difficult to be comfortable, and even more difficult to feel that one is a competent nurse. Confidence was not something participants felt came immediately but was gradually gained as knowledge and skills were developed and participants started to feel more comfortable on the job and this had already stared in their direct paid pre-registration employment roles.

**Resiliency**

Resiliency was not a theme in this research but was definitely mentioned by some participants. I believe that resiliency related partially to comfort and confidence. I had a few participants who I felt were very resilient as they seemed to have a successful transition but did not receive good supports. Someone who is able to transition even without support is often seen as resilient (Adam et al., 2014; Murphy, Blustein, Bohlig, & Platt, 2010; Pellico, Brewer, & Kovner, 2008; Richez, 2014). I do not believe that this study would be complete without a mention of resiliency because if NGNs do not have confidence in themselves, it is more difficult to become comfortable and move through their transition period. Resiliency is often related to previous experiences in personal or work lives.

**Paid Pre-Registration Employment**

For the purposes of this study, pre-registration employment was being employed in the direct paid patient care roles of UNEs, LPNs, and NAs. Paid pre-registration employment allows nursing students opportunities to experience the nursing culture in a
different way than being students on the unit (Cantrell & Brown, 2005). This opportunity allows a “privileged” or insightful perspective as the participant is often a member of the team rather than students who are not usually part of the unit. Gamroth and colleagues (2006) also noted that increased confidence and competence were benefits of pre-registration employment.

Participants who were hired as NGNs on the units where they had either direct paid pre-registration employment prior to completion of their nursing program or completed their final preceptorship on the same unit felt they were more comfortable than other NGNs on their units. Returning to a familiar environment helped NGNs become comfortable in their jobs (Harkins et al., 1983). Part of this comfort comes from having knowledge of the patients and expectations of the unit as well as being familiar with the unit layout, knowing where supplies are, and what is normal for the patient population. All of the participants felt that direct paid pre-registration employment assisted with increased knowledge, navigation of the system and unit, as well as understanding what it was to be RNs. Participants in this study were involved in active learning as they took the skills and knowledge they attained in their nursing programs and put these into practice, in the work environment, prior to graduation.

Working as UNEs gives opportunities as nursing students develop organizational skills, work in a team environment, refine clinical skills, and increase learning (Gamroth et al., 2006). The participants in this study also felt that working as UNEs assisted with increased knowledge, gaining skills and acceptance on the unit, and a smoother transition. Phillips and colleagues (2012) noted that some of the benefits of working as UNEs or externs were increased socialization, knowledge, and skill acquisition, as well
as decreased orientation and stress. Working as UNEs helps with a smoother transition experience often because they have acceptance, require less assistance from their colleagues, and have already been essentially responsible for their patients (Gamroth et al., 2006). Participants also mentioned that working as UNEs “solidified” the information they were given in school as well as the opportunity to practice their skills. Similarly, Aleco (2009) mentioned that learning in the environment assisted with retained information whereas classroom learning was difficult to retain. Even though it was noted earlier that UNEs cannot perform all nursing skills for their patients, they are still responsible for ensuring that all care is completed. A finding of Gamroth and colleagues’ (2006) research study was that there was increased satisfaction of experienced nurses when UNEs were hired on the unit. These authors felt that reasons for this might be the opportunity for experienced nurses to share their knowledge, experiences, and what “being a nurse” meant to them. So, the UNE experience benefits the unit as a whole and not just the nursing student who is working in a direct paid employment role. The participants in this research study mentioned that working as UNEs not only assisted them in their final practicums but also in their transition phase. It would be interesting to note if the increased knowledge and skills as well comfort and confidence were due to their UNE experiences, increased comfort in their final practicums, or a combination of both. As this was not a component of the research, I have not expanded beyond this comment but this could be a further research project.

Melrose and Gordon stated (2011) that many LPNs who transition to RN roles do so to gain credibility and to support their practice. The participant who was previously a LPN felt that she did everything an RN did but once she started her transition, she
realized that the RN role was more complex than she had originally thought as also mentioned by Melrose and Gordon (2011). Often, it is not until LPNs became RNs that they recognized the differences as the participant of this study mentioned possibly due to the lack of clarity between RN and LPN roles. Additionally, LPNs have increased their scope of practice so much in the last few years that sometimes there appears to be very little differences between the two roles (White et al., 2008). Therefore, LPNs who are transitioning to RNs often have difficulties understanding the role changes in their practice. The former LPN in this research study had difficulties in the transition phase as she had not recognized that RNs and LPNs functioned differently in the work environment until after she graduated and was working as a RN.

Comfort with personal care is a benefit of working as NAs prior to becoming NGNs as it assists with comfort and confidence with personal care, skills, and communication. Romyn et al. (2009) noted that NGNs who had previously worked as NAs seemed to do better in their nursing programs than nursing students who did not have this experience because of the hands on experiences which increased their comfort and confidence and decreased their anxiety. Delegation was difficult, especially for the one former NA who stayed on the same unit as a RN and was friends with other NAs on the unit. Nuttall (2010) also noted that delegation was often seen as a skill that took time to acquire; this delegation was more difficult for NGNs who worked as NAs previously, especially if they stayed on the same unit. Additionally, the past experiences of giving personal care to patients increased the participants’ confidence and decreased their anxiety when they moved to their new roles as NGNs; they were comfortable with
providing personal care which allowed them to focus on some of the other aspects of RN roles.

Paid pre-registration employment in direct patient care roles gave participants knowledge and experiences that their other classmates did not have. Even with these added benefits, NGNs still had some difficulties in the transition phase but seemed to require decreased transition time than their counterparts without this experience. Some of the difficulties the participants had were when they had exposure to skills and situations that they were not able to do in their previous direct patient pre-registration employment roles such as caring for central venous catheters. A number of participants also had difficulties with the realization that they were now a RN; the license itself seemed to cause them some stress as now they perceived that they were now more culpable. If NGNs are aware they will still have some difficulties in the transition phase, it can help prepare them for times when they feel fear, stress, anxiety, and vulnerability. Managers and CNEs need to recognize that all NGNs will require assistance, even those with direct paid pre-registration employment.

Summary

The transition from nursing student to RN is a difficult process and requires support from friends, family, and other nurses both on and off the unit especially when the NGN feels vulnerable. The NGN will need to leave their past student persona behind before they can move forward through the different stages until they finally have reached the comfort and confidence of being a RN. Participants felt that direct paid pre-registration employment seemed to not only assist with clinical placements but ultimately with the transition to RNs. Recognition that working in acute care environments assists
with the transition from nursing student to RN should allow both nursing programs and hospitals to collaborate and find ways to allow more of these opportunities for nursing students.
Chapter Six: Conclusion

The transition experience is different with all NGNs but the first year appears to be the most difficult as NGNs move from being student nurses into accepting the new reality of RNs. The main research focus was understanding paid pre-registration employment and the transition experience of the NGN. Therefore, nine NGNs who were employed in direct patient care roles of UNEs, LPNs, and NAs were interviewed to gain rich descriptions of their transition experience. These rich descriptions help to understand the findings of the study and assist with finding information to improve the transition experience of NGNs.

In this chapter, I discuss the significance of the study and strengths and limitations. There are recommendations for managers of human resources, the information technology department, and acute care units of AHS as possible ways to enhance the transition experience of NGNs. There are also recommendations for undergraduate nursing educators and participants of this study. In the last section, I discuss future areas of research and plans for dissemination.

Significance of the Study

There are a number reasons why this study is significant. The first reason is that NGNs believe they are not fully ready for practice and require support that is not always given. This is significant because NGNs might not perform to the standards that their employers require. The findings of this study noted that all NGNs required support to assist them as they transitioned from nursing students to RNs even when they were employed in direct paid patient care roles prior to graduation from their nursing programs. They still required knowledge of the unit, organization, policies, and
procedures. Sometimes, NGNs felt they should not ask for help but they recognized that they still required assistance possibly because NGNs goals do not necessarily meet their expectations. A second reason for not performing to employer standards is that nursing programs may not provide enough experiences for students. Additionally, there is a role for experienced nurses to be available for questions and assistance when NGNs are in their transition phase. Experienced nurses, managers and CNEs also must assist by helping NGNs realize that asking for help does not mean they are failing but instead recognize there are times they cannot accomplish everything alone.

A second significance of this study is that participants felt paid employment in direct patient care roles facilitated their transition to being RNs. We need to explore ways to provide these learning opportunities for all nursing students during their nursing program. Each of the participants were employed in one of three roles in an acute care environment such as UNE, LPN, and NA. This was significant because identifying direct patient care roles as part of the inclusion criteria allows for consistency in determining if these specific roles assist with the transition phase of NGNs.

A third significance of this study is any direct paid pre-registration employment was beneficial to the transition experience but the specific type of direct patient care role (i.e. UNE, LPN, NA) did not seem to impact the transition experience. This is significant as there is an opportunity for nursing programs and acute care facilities to collaborate and find opportunities for nursing students to have direct paid pre-registration employment during their nursing programs as a way to decrease stress and anxiety in the transition phase.
Strengths of the Research Study

Many researchers noted the most difficult time for NGNs was the first year of employment (Anderson et al., 2012; Chen & Lou, 2013; Ellerton & Gregor, 2000; Morrow, 2009; M. Kramer, 1974; Spiva et al., 2013). A strength of this study was that all the participants were NGNs in their first year of nursing post completion of their program. As mentioned previously, there were minimal studies that captured participants in their first year of practice post-graduation. Some researchers’ participants were up to three years post completion of the nursing program (Cantrell & Brown, 2005, 2006; Cantrell et al., 2005; Collins, 1991; Nutall, 2010).

Phillips and colleagues (2012, 2013, 2014a, 2014b) discussed transition experiences of nursing students who had unknown health care related employment. This specific study had participants who were employed in direct patient care roles in acute care prior to completion of their nursing program. Setting criteria for participants who were in direct paid pre-employment patient care roles allowed for consistency in determining if these specific roles assisted with the transition phase of NGNs.

A second strength of this study was the participants came from four different academic programs. Each of these academic programs were based in different areas and had different expectations as students moved throughout their programs. A third strength was that the participant’s voice was preserved. By using a descriptive qualitative design, the focus was on the rich descriptions of the participants and not changing their reflections into complex, highly abstracted thoughts and ideas as Sandelowski (2000) mentioned.
Limitations of the Study

One of the limitations of this study was that it was conducted in a large urban centre in Canada and so may not be transferable to other towns or cities. Other areas and centres may offer different orientation programs which might influence the experiences of NGNs. A second limitation was that all the participants interviewed were Caucasian females. A male perspective or culturally diverse participants could have given different information than was obtained. It would have been interesting to have perspectives from males or culturally diverse populations for this research but unfortunately, this was not a reality.

A third limitation was that with a sample of nine participants, even though data saturation was achieved, this might not be reflective of the larger body of NGNs. The findings of this study may not be generalizable to other areas as nursing programs and orientation at various hospitals could be different than in the Calgary region. There were participants from four different nursing programs and not all participants completed their programs and practicums in the Calgary region but all the participants started their first work experience as GNs or RNs in Calgary.

A fourth limitation is that I work in the acute care system as a CNE and am often involved in orientation of NGNs. It was important to ensure that I monitored myself for bias during both the collection and interpretation of data and took substantive measures to ensure that the voice of the participants was dominant in this research. To address this concern, I included information about reflexivity and methods I used to ensure that it was the participants’ voices and not mine.
Reflexivity

I have included this section on reflexivity that I used to separate my CNE voice in this research study. Berger (2013) mentioned that an important component of reflexivity is for the researcher to continually evaluating biases, opinions, and use self-reflection to separate thoughts and feelings (Berger, 2013). Sandelowski and Barrosso (2007) wrote that validity and credibility of a research study included accounting for reflexivity, which compromised of documenting the strategies, rationale, and procedures used to ensure that there was an explanation of the researcher’s own biases.

To ensure that the findings of this research are credible, it was necessary to account as Cutcliffe (2003) wrote “for researcher values, beliefs, knowledge, and biases” (137). I made a conscious effort to delineate myself and my role as educator. This delineation was accomplished by identifying my thoughts and feelings as a student researcher and CNE. I kept an audit trail by journaling throughout the research process as well as meeting with my supervisor. Creswell (1994) stated that the information obtained from data analysis could be completed in a pictorial way to help inform the reader how the researcher obtained the data. I have included a pictogram of themes and key concepts as an audit trail (see Appendix J).

Recommendations

I have made five recommendations based upon the study’s findings and are derived from the participants themselves. The first three recommendations are given to different departments in the AHS organization with rationale and strategies to assist with possible changes to the current system. The first of these is to the manager of human resources, the second is to the manager of the informational technology (IT) department,
the third is to unit managers of AHS in the acute care system. The last two recommendations are to undergraduate nursing educators and the participants of this study.

**Recommendation #1a:** The manager of the human resources department at AHS will ensure consistency in orientation programs for new nursing staff across the province.

**Rationale:** Participants expressed that consistency with orientation and appropriate support should be in place for new staff as Heidi mentioned with her first job she “did not even get orientation shifts” and was “just an extra nurse on the floor” but in a later position she “actually had real orientation shifts which was amazing.” I believe this would increase retention of nursing staff, provide a smooth transition for NGNs, and offer a smooth transition for NGNs between units and hospitals. The ultimate outcome will be nursing staff who are able to practice to full scope and so patient care is potentially better from the start of employment on a unit.

**Recommendation #1b:** The manager of the human resources department at AHS will include an additional two orientation days for all new nursing staff in addition to the current orientation period.

**Rationale:** I believe that one or two orientation shifts three to six months after the initial orientation period would benefit NGNs. Often, NGNs are inundated with information when they are orientated and could not retain all this information. Ways to increase retention of information are to include teaching materials and repetition of information (Kessels, 2003). Having an orientation day or two a few months post initial orientation would allow NGNs an opportunity to go over skills and information pertinent to their area of practice. These additional orientation days may assist NGNs with time to
develop skills, with on unit nursing support, that they are not comfortable with or have not had opportunities to complete yet.

When we started there, we were given what was it a week in classroom … you went through everything. You couldn’t understand what you were doing … and then you are on the floor and you can start putting two and two together. I would think that after being on the floor for three or six months, you should take everybody back … [for] more learning. (Denise)

**Strategies:**

- A checklist of orientation requirements should be made available to CNEs to assist with consistency of NGNs
- NGNs need to identify learning goals and orientation needs; a written or online module might be useful for this task.
- CNEs and NGNs should have a formal meeting at approximately three months to determine if learning goals are being achieved
- Set up a collaborative study group with representatives from human resources, management from acute care units, CNEs, and NGNs to discuss the orientation process for new staff.

**Recommendation #2:** The manager of the IT department at AHS will implement ways to make Insite more accessible for new staff.

**Rationale:** Insite is a web site that has excellent resources but participants of this study state it is not very user friendly. The spelling has to be exactly what is on the document and a short version will not bring up any documents (e.g. if you type in a partial word it will not bring up anything for that topic). Additionally, the policy and
Procedure page was noted to be difficult for the participants when they navigated the site. Staff must know if the policy they are looking for is either provincial or regional. If the staff member goes to the regional policy page, they will not find the provincial policies and vice-versa. “Insite is actually useless … It has a huge wealth of information but finding anything in there is just a nightmare, so, it takes me hours to find something so it is not user friendly” (Heidi).

**Strategies:**

- Hold focus groups to determine ways for better search functionality of Insite.
- Develop an algorithm to determine what nurses use Insite for; which should assist with making it more user friendly.

**Recommendation #3:** Acute care managers of AHS will determine ways to provide consistency of shifts for new nursing staff members.

**Rationale:** Not working for a few days in a row and always having a new assignment when coming in increased the amount of stress and anxiety in NGNs. Working in a temporary line position or even having a number of shifts in a row helped with decreased stress and anxiety in new staff members and provided opportunities for increased knowledge and skills. Participants who were given an opportunity to work a few days in a row, noted this consistency helped with their learning needs, allowed them to keep the same patients, and time management was better on each subsequent day. An example of this was when Gail mentioned that having “a new assignment for an evening and then 2 days later, a new assignment for nights” was difficult but once she had consistent shifts “being there every day … also contributed a lot to the comfort.”
**Strategies:**

- Provide a line for NGNs
- Provide consistency of shifts for casual NGNs; identify a minimum of 3 consecutive shifts

**Recommendation #4:** Undergraduate nursing program educators will ensure they include information to nursing students about identifying support systems for the difficult transition experience as part of the nursing curriculum.

**Rationale:** Many participants in this study stated that they been informed about the difficulties of transition. Carolyn mentioned they” talk[ed] in nursing school about how stressful it [was] going to be … but no one talk[ed] about crying all the time.” Carolyn found friends and they “supported each other a lot.” Each participant found the support systems that worked for them but each did identify that supports were crucial.

**Strategies:**

- Assist nursing students with how to identify support systems
- Assist nursing students with information about self-identifying mentors

**Recommendation 5:** Participants of this study will support other NGNs as they continue in their nursing career.

**Rationale:** Participants in this research study recognized the difficulty with the transition experience and can assist other NGNs as they enter this difficult time with support, encouragement, and mentorship. Angela mentioned that she wanted to “give back to people who want[ed] to learn from me, people that are junior to you” and to be “aware and supportive of those people who are willing to learn”
**Strategies:**

- Mentor NGNs that are on the unit
- Look for opportunities to help NGNs on the unit.

**Future Areas of Research**

Based upon the findings of this study, there are numerous areas rich for further investigation. Qualitative studies could be undertaken with undergraduate students who had direct paid pre-registration employment in acute care in other urban or rural areas. These qualitative studies could assist with transferability of this study’s findings to other health care settings. A quantitative study may garner information on transition of NGNs. This quantitative study could give statistical information about the value of specific orientation programs. Information about retention rates could be found with a longitudinal study. A mixed methods study could be conducted with NGNs who had direct paid pre-registration employment. Many participants mentioned that paid employment in direct patient care roles assisted them in their final practicums and allowed them more opportunities for learning. Some participants felt that their final practicum was easier as they were more comfortable with basic care of patients and looked for different learning opportunities than their counterparts without this experience. As noted, there were not any culturally diverse or male participants in this study. A study with a more culturally diverse population could be conducted to see if results are similar or different as perhaps orientation programs might need to acknowledge cultural strategies for learning new roles, such as the RN role.
Knowledge Translation

The Canadian Institutes of Health Research (CIHR) defined knowledge translation “as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system” (CIHR, 2016, p. 1). Dissemination of research results is important to inform nursing practice, policy, and quality assurance. One way of doing this is to present the results to those who will benefit from it. Straus, Tetroe, and Graham (2009) stated that key stakeholders needed to be included in any practice changes which may arise from research. Key stakeholders from this study include NGNs, human resources, educators (both in nursing programs and acute care), and managers. To assist with dissemination, findings of this study will be presented at a conference within the next year. I will also submit an article or two from this research for publication within the next year. An executive summary will be presented to AHS to assist with information gathering or programs, which will allow all undergraduate students in their final year to have the opportunity for employment in a direct care capacity.

Summary

If NGNs are not given support in the transition phase, they may have more difficulties, leave their current positions, or the profession. It is beneficial to find ways to assist them as they move from nursing students to RNs. One way to minimize the vulnerability of NGNs is to allow nursing students opportunities to work in paid pre-registration employment in direct patient care roles such as UNEs and NAs. This descriptive qualitative study included interviews of nine participants who worked as
UNEs, LPNs, or NAs prior to graduation from their nursing program. I have included information about the background, literature review, methods, how the study was conducted, the findings, and a discussion of pertinent information obtained. The main themes identified were support, vulnerability, de-stress, gaining comfort, and becoming confident. Additionally, I included information about the strengths and limitations, recommendations, and future areas of research.

Throughout my life, I have noted that some people seem to do better with transition than others. Prior to entering nursing, I worked in a variety of jobs requiring differing levels of skills. I entered my nursing career later in life and continued to notice this was a common theme in nursing as well. Now that I have worked in a number of different positions on my unit, such as staff nurse, nurse clinician, and CNE, I noted that nurses who have some experience in the acute care environment seem to have an easier transition period. This led to my research on understanding how direct paid pre-registration employment in acute care facilities influenced the transition experience of the NGN.
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http://journals.lww.com/advancesinnursingscience/Abstract/2004/10000/The_Politics_of_Suffering__Implications_for.2.aspx


http://www.ingentaconnect.com/content/mcgill/cjnr/2013/000000


Retrieved from

http://www.jstor.org/stable/40657413


Reimche, R. (2013). Preceptorship programs and incidence of adverse events with graduate nurses: A literature review. Unpublished manuscript, Department of Nursing, University of Calgary, Alberta, Canada.


Appendices

Appendix A: Medline Literature Search

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Appendix B: Literature Review Flowchart

Databases searched
- CINAHL (n = 229)
- MEDLINE (n = 49)
- EmBase (n = 8)
- ERIC (n = 4)
- Cochrane Review (n = 1)
- Proquest Thesis & Dissertations (n = 20)

Total (n = 311)
- Duplicates (n = 36)
- Excluded (n = 258)

Titles and abstracts (n = 275)
- Excluded (n = 3)
  - Nursing program from LPN-RN (n = 1)
  - Differences between ADN & LPN (n = 1)
  - Hospital orientation of LPNs (n = 1)

Full-texts (n = 17)
- Full-texts included in synthesis (n = 14)
## Appendix C: Literature Table

<table>
<thead>
<tr>
<th>Author, Year &amp; Location</th>
<th>Method</th>
<th>Sample Size</th>
<th>Type of Program</th>
<th>Length of Program</th>
<th>Benefits</th>
<th>Data Collection</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>Cantrell &amp; Browne, &amp; Lupinacci (Part I Quant findings), 2005, US</td>
<td>Cohort study</td>
<td>n= 52</td>
<td>Externship program (10 week summer program between 3rd and 4th year)</td>
<td>10 weeks. Contacted people up to 3 years post working as an extern. Average time was 1.5 years practicing as an RN</td>
<td>increased professionalism and role socialization</td>
<td>Nursing Activity Scales (Professionalism) Nurses Self-Description Form (Role Socialization) Sense of Belonging, McCloskey/Mueller Satisfaction Scale</td>
<td>to show that an externship program promotes professionalism, job satisfaction, sense of belonging, and role socialization</td>
</tr>
<tr>
<td>Cantrell, Browne, (Part II qual findings), 2005, US</td>
<td>grounded theory</td>
<td>n= 6 nurses who had worked as externs</td>
<td>10 week summer program between 3 &amp; 4 year of schooling</td>
<td>interviewed nurses 4-9 months after hiring</td>
<td>increased confidence, competence, socialization, skills,</td>
<td>focus groups</td>
<td>understanding of experience of being an extern and how it affects the transition phase</td>
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<tr>
<td>Cantrell &amp; Browne, (Part III, Recruitment and Retention), 2006, USA</td>
<td>quantitativ e</td>
<td>n=193</td>
<td>Externship program</td>
<td>10 weeks of employment in summer between 3 &amp; 4 year of nursing school</td>
<td>79% obtained RN positions 77% stayed for at least 12 months Retention 80-85% for externs</td>
<td>data collection: employment records</td>
<td>recruitment and retention</td>
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2 The method is how the authors described it in the literature
<table>
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<tr>
<th>Author, Year &amp; Location</th>
<th>Method</th>
<th>Sample Size</th>
<th>Type of Program</th>
<th>Length of Program</th>
<th>Benefits</th>
<th>Data Collection</th>
<th>Purpose</th>
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<tr>
<td>Collins, 1991, US</td>
<td>Descriptive qualitative</td>
<td>n= 131 nurses convenience sample</td>
<td>Internship and Externship programs</td>
<td>graduated within the last 3 years</td>
<td>Interns and externs were more satisfied with working conditions. Externs did not feel more able to cope with the adjustment from school to work</td>
<td>ANOVA</td>
<td>To study the effects of externship and internship on newly graduated nurses.</td>
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<tr>
<td>Gamroth, Budgen, &amp; Lougheed, Canada, 2006</td>
<td>quasi-experimental, used both qualitative and quantitative data</td>
<td>462 nurses, 123 students, 6 nursing leaders, and 42 faculty (implementation) 40 nurses, 173 new grads, &amp; 7 faculty for outcome evaluation</td>
<td>Undergraduate Nursing Program</td>
<td>final year of schooling</td>
<td>Increased confidence, organizational abilities, skills, competencies, teamwork, retention</td>
<td>2 cohorts: at nine months (1st cohort was also at 21 months). Focus groups</td>
<td>explore ways the undergraduate nursing deployment program was implemented, determine outcomes and ascertain future plans arising from the project</td>
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<tr>
<td>Author, Year &amp; Location</td>
<td>Method</td>
<td>Sample Size</td>
<td>Type of Program</td>
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<tr>
<td>Harkins, Schambach, &amp; Brodie, 1983, USA</td>
<td>Program development</td>
<td>n=11 nursing students</td>
<td>1.0 FTE, working as nursing assistants</td>
<td>12 weeks - 4 weeks each on a medical, psychiatry, and urology unit included weekly conferences where they would take turns presenting, clinical learning one afternoon a week on each of the areas, as well as leadership and professionalism</td>
<td>Allowed opportunities for the extern to discuss with others the reality shock that they were having and alternatives in how to deal with this. It allowed them an opportunity gain experiences and become socialized onto the units. Increased competence. Over the three years the program was run an increase from 15% - 36% of the nursing class being hired was realized.</td>
<td>Does not really discuss.</td>
<td>To ease the transition of newly graduated nurses and help to decrease the &quot;reality shock&quot;</td>
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<tr>
<td>Hutchison, 2013, USA</td>
<td>qualitative - evaluative case study</td>
<td>48 participants (29 nursing students, 13 faculty, &amp; new graduates)</td>
<td>ATNP (Accelerated transitional nursing program)</td>
<td>ATNP programs are typically 9-12 months and are to assist LVNs in transitioning to RNs</td>
<td>Themes identified were critical thinking vs problem solving, effective Nsg education assisted with critical thinking, and educators who have ownership of programs assist with student learning</td>
<td>qualitative and quantitative data - interviews and surveys</td>
<td>To determine how critical thinking skill acquisition for nursing students and new grads is integrated in an accelerated transitional nursing program</td>
</tr>
<tr>
<td>Kilpatrick &amp; Frunchak, 2006, Canada</td>
<td>Program evaluation</td>
<td>124 nursing students</td>
<td>Nursing Extern Program</td>
<td>15 weeks over the summer after the second year of nursing school (most participants worked for 12 weeks)</td>
<td>Cost effective, increased retention, externs were member of the unit, and assisted with consolidated student learning. Increased knowledge, confidence, support</td>
<td>Focus groups and questionnaires given to externs, preceptors, head nurse/CNS for feedback</td>
<td>Decrease effects of the nursing shortage and assist with transition of transition.</td>
</tr>
<tr>
<td>Author, Year &amp; Location</td>
<td>Method</td>
<td>Sample Size</td>
<td>Type of Program</td>
<td>Length of Program</td>
<td>Benefits</td>
<td>Data Collection</td>
<td>Purpose</td>
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<td>Melrose &amp; Gordon, 2008, Canada</td>
<td>Qualitative descriptive study</td>
<td>10 participants, 9 women and 1 man</td>
<td>description of the transition from LPN to RN</td>
<td>not a program, descriptive study of the transition from LPN to RN</td>
<td>There were difficulties with schooling and the transition process. Often previous experience was not accepted and they were not treated differently than other new grads</td>
<td>interviews</td>
<td>Investigate LPN to BN students' views of the role differences and the process of transitioning between these roles</td>
</tr>
<tr>
<td>Nuttall, 2010, Veteran's hospitals in US</td>
<td>quasi-experimental</td>
<td>n=300 (150 +150) convenience sample</td>
<td>comparison of VALOR extern program to non-VALOR externs</td>
<td>less than 3 years since graduation</td>
<td>The study did not show greater professionalism, job satisfaction, and socialization in the extern group. The participants in the VALOR program &gt;age 35 had higher sense of belonging and higher retention rates</td>
<td>electronic surveys</td>
<td>Examine effects of VALOR program on job satisfaction, sense of belonging, professionalism, and socialization</td>
</tr>
<tr>
<td>Author, Year &amp; Location</td>
<td>Method</td>
<td>Sample Size</td>
<td>Type of Program</td>
<td>Length of Program</td>
<td>Benefits</td>
<td>Data Collection</td>
<td>Purpose</td>
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<tr>
<td>Phillips, Kenny, Smith, &amp; Esterman 2012, Australia</td>
<td>qualitative (interpretive descriptive)</td>
<td>67 new graduates</td>
<td>not a program, discussed employment during last year of undergraduate education</td>
<td>not a program, retrospective study</td>
<td>Working in health care helped build confidence, experience, and an easier transition. It also helped with realization that this was the career they wanted. Greater chance of a job on graduation.</td>
<td>Focus groups</td>
<td>determine if NGN chose pre-registration employment in their final year of schooling, the type of employment, skills acquired, and if there was a link with where they worked and the transition phase as a NGN</td>
</tr>
<tr>
<td>Phillips, Esterman, Smith, &amp; Kenny, 2013, Australia</td>
<td>Descriptive questionnaire survey</td>
<td>392 new nurses participated</td>
<td>no program - retrospective</td>
<td>no program retrospective</td>
<td>UGN working in health care had higher transition scores. Successful transition predictors were: able to deal with complex patients, orientation to the new environment, and respect from colleagues</td>
<td>Used online format (Survey Monkey). Used SPSS 19 (computer program). Used numerous methods of data analysis depending on the type of question: chi squared, ANOVA, t-test, multiple linear regression</td>
<td>Identify predictors of successful transition from undergraduate student to RN and determine if pre-registration employment influences the transition process</td>
</tr>
<tr>
<td>Author, Year &amp; Location</td>
<td>Method</td>
<td>Sample Size</td>
<td>Type of Program</td>
<td>Length of Program</td>
<td>Benefits</td>
<td>Data Collection</td>
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<tr>
<td>Phillips, Kenny, Esterman, &amp; Smith, 2014a, Australia</td>
<td>Mixed methods</td>
<td>392 electronic surveys and 8 focus groups</td>
<td>no program - retrospective</td>
<td>no program retrospective</td>
<td>n/a</td>
<td>2 data collection sets 1) focus interviews 2) electronic survey</td>
<td>Does previous undergraduate work choice influence how graduate nurses are viewed by senior colleagues during their transition to registered nurse</td>
</tr>
<tr>
<td>Phillips, Kenny, Esterman, &amp; Smith, 2014b, Australia</td>
<td>Mixed methods utilizing Thorne's interpretive description</td>
<td>1) n= 67 2) n= 392</td>
<td>no program - retrospective</td>
<td>no program retrospective</td>
<td>n/a</td>
<td>2 data collection sets 1) focus interviews 2) electronic survey</td>
<td>to determine the factors that grad nurses feel will assist them in a successful transition to practice</td>
</tr>
</tbody>
</table>
Appendix D: Recruitment Poster

Research Opportunity for Newly Graduated Nurses
Pre-registration employment and transition to practice for the newly graduated nurse

- All newly graduated nurse who were employed as a nursing attendant (NA), Licensed Practical Nurse (LPN), or Undergraduate Nurse Employee (UNE) in acute care prior to completion of a Canadian nursing program are welcome to participate
- Time commitment: approximately 1 hour interview at a time and location of your choosing
- If interested, please contact Ruthanne at reimche@ucalgary.ca

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board

Ethics ID: REB15-2044
Appendix E: Demographic Questions

1. Are you:
   a. 19-20 years
   b. 21-22 years
   c. 23-24 years
   d. 25-30 years
   e. 31-40 years
   f. >40 years

2) Male or female?

3) What nursing program did you graduate from?

4) When did you finish your coursework from your nursing program?

5) What type of employment did you do in the final year of your nursing program?
   a. NA
   b. UNE
   c. LPN

6) Approximately how many months did you work in acute care as an UNE, NA, or LPN prior to becoming a GN/RN?

7) How long have you worked as a GN/RN?

8) Do you work casual or do you have a line position?

9) Approximately, how many hours do you work a week?

10) Could you please describe your orientation?
Appendix F: Semi-structured Questions

1) Do you work on the same or a different unit than where you worked prior to course completion as an UNE, NA, or LPN?

2) If not, what was the reason for the change to a different unit?

3) When you hear the word transition, what does it mean to you?

4) Looking back, since finishing your nursing program, how would you describe your transition from being a GN/ RN to now?

5) How long do you think the transition phase will be?

6) Describe any difficulties you had with the transition from student to GN/RN?
   
   a. What strategies did you employ to address these difficulties?

7) What were the supports you had to assist in the transition from student to registered nurse?

8) What are some things that you think will help with this transition phase?

9) What supports are available to you? Describe your use of these supports?

10) I wonder how will you know that your transition is finished?

11) What additional comments would you like to add about your experiences as a newly graduated nurse that I have not covered in the above questions?
Appendix G: Confidentiality Agreement

Confidentiality Agreement for Research Assistants / Transcribers/Translators

Name of Researcher:  Ruthanne Reimche

Title of Project:  Understanding Pre-Registration Employment and Transition to Practice for the Newly Graduated Nurse

Before we can hire you to transcribe research interviews, we must obtain your explicit consent not to reveal any of the contents of the tapes, nor to reveal the identities of the participants (i.e. the students and supervisors interviewed and their place of employment). If you agree to these conditions, please sign below.

_________________________________________        _______________________
Print Name              Signature
Appendix H: Consent Form

TITLE: Pre-registration Employment and Transition to Practice for the Newly Graduated Nurse

SPONSOR: University of Calgary

INVESTIGATORS:  Dr. Sandra P. Hirst (PI)
Faculty of Nursing
University of Calgary

Ruthanne Reimche BN
University of Calgary

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND
This is a descriptive qualitative study to understand how pre-registration employment in acute care facilities in direct patient care roles influences the transition from student to registered nurse. This study will use a purposive sampling method. This sampling method is related to interviewing participants that have been exposed to the area of interest, namely working in acute care prior to completion of a Canadian nursing program. This study is part of a graduate student thesis project. If the student continues on to a doctorate degree pertinent information may be kept for a further study, if the participant agrees to this. A total of approximately 20 participants will be interviewed for this study.

WHAT IS THE PURPOSE OF THE STUDY?
The purpose of this study is to understand how pre-registration employment in acute care in direct patient care roles such as nursing assistants, undergraduate nurse employees, and licensed practical nurses influence the transition from student to registered nurse.

WHAT WOULD I HAVE TO DO?
You will be asked to participate in an interview that will last around 60 min. You will be asked some questions about your particular experiences as a newly graduated nurse. You do not have to answer any questions you do not wish to answer. The interviews will be audiotaped and transcribed for analysis.
WHAT ARE THE RISKS?
There are no foreseeable risks to you as a result of your participation in this. If discussion of your experiences triggers a difficult memory for you, the interviewer will stop the interview and refer you to employee and family assistance program (EFAP) available from Alberta Health Services.

WILL I BENEFIT IF I TAKE PART?
There are no direct benefits either, although it is hoped you will find the interview to be an enjoyable experience. If you agree to participate in this study, there may or may not be a direct benefit to you. However, the information we get from this study may help us determine if there is a benefit to being employed in acute care prior to graduation.

DO I HAVE TO PARTICIPATE?
Participation in this study is voluntary and you may withdraw from the study at any time without jeopardizing your employment. If you choose to withdraw, contact the Primary Investigator (Dr. Hirst) requesting withdrawal. If you do decide to withdraw, any quotes or statements made by you during the interview will be removed from the report of the study.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?
Other than participating in a one hour interview, there are no other requirements.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?
You will not be paid for your involvement, but neither will you have to pay anything.

WILL MY RECORDS BE KEPT PRIVATE?
The recording from the audiotape will be downloaded onto the password protected computer. The recordings will be transcribed and the transcripts from the interviews will be kept private. They will be held in a locked cabinet in an office. Only the Primary Investigator and members of the research team will have access to the digital recordings and transcripts. Further, we will ensure that names will be removed from the transcripts.

SIGNATURES
Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:
Dr. Sandra P. Hirst

Or

Ruthanne Reimche BN

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

__________________________________  ______________________________________
Participant’s Name                    Signature and Date

__________________________________  ______________________________________
Investigator/Delegate’s Name          Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.
Appendix I: CNE Job Description

Job Description Calgary Health Region

Job Number: UNA - 053  
Working Title: Clinical Nurse Educator  
Classification Title: Instructor  
Site: Calgary Health Region  
Supervisor:  
Bargaining Unit: United Nurses Association  
(UNA) Date: May 2004 Final Draft

This job description is intended to describe the general nature and level of work being performed. It is not intended to be an exhaustive list of all duties, responsibilities, and requirements for this position.

A. Position Summary:

The Instructor, Staff Development (ISD) (Clinical Nurse Educator - CNE) provides leadership in planning, co-ordination, implementation and evaluation of educational activities for nursing staff, including orientation, compulsory educational programs, clinical development and continuing education. The specific focus of the role is dependent on the vision of the program and the educational needs and practice requirements of the area(s).

The ISD (CNE) is responsible for delivery of programs based on identified needs which includes legislation, continued competencies, quality improvement, strategic plans and objectives and organizational needs. The ISD (CNE) participates in the development and ongoing maintenance of Regional educational programs and clinical policies and procedures.
B. Qualifications:

Education:
- Basic nursing education leading to registration as Registered Nurse required
- Baccalaureate in Nursing or equivalent health-related degree required
- Masters Degree in Nursing or equivalent health-related degree an asset
- Professional Certifications related to area of specialty preferred e.g. Canadian Nurses Association (CNA) certification

Professional Affiliation Nurses:
- Current registration in the Alberta Association of Registered Nurses (College and Association of Registered Nurses of Alberta) required
- Member of Association of the specialty relating to area of practice preferred, such as Canadian Association of Neuroscience Nurses, Canadian Association of Critical Care Nurses, as applicable

Applied Experience:
- Recent intensive experience in the clinical specialty, or extensive experience in several clinical specialties
- Experience in educational program design, delivery and measurement of learning outcomes preferred

Enhanced Abilities:
- Demonstrated expertise in:
  - Application of adult teaching – learning principles
  - Use of nursing process – assessment, planning, intervention, evaluation
  - Communication and collaboration skills with other health professionals
    - Leadership skills
  - Ability to promote the change process
  - Application and promotion of problem solving and creative thinking
  - Ability to critique development of staff and provide meaningful feedback
  - Prioritizing and meeting competing demands/requirements of setting
  - Computer skills in word processing, email, internet access
C. Key Responsibilities:

COMPETENT PRACTICE

1. Assessment
   1.1 Based on scientific knowledge and current evidence, assesses individual learning needs of nursing staff including:
      - Language skills
      - Cultural background, values and beliefs
      - Learner readiness/willingness
      - Education and experiential background
      - Professional background
      - Previous learning experiences
      - Prior learning assessment
      - Nursing practice skills, including assessment, planning, implementation and evaluation of nursing care.
   1.2 Assesses learner’s ability to analyze and synthesize evidence-based practice.
   1.3 Monitors and promotes changes in health care delivery including technology, service delivery and health care practice.
   1.4 Collaborates with members of the healthcare team to collect, validate and expand assessment data related to learning needs of nurses and staff.
   1.5 Identifies the foci of education in collaboration with the learner(s) and manager.
   1.6 Recognizes potentially critical knowledge gaps in nurses’ ability to provide health care and provides appropriate learning resources.
   1.7 Assesses the supports required for professional practice such as policy and protocols based on current evidence.
   1.8 Assesses the regional priorities and their impact on learning needs of clinical area and staff.

2. Planning
   2.1 Analyses assessment data to identify learner/practice setting needs and strengths.
   2.2 In partnership with the learner(s) and manager develops educational plans based on learning needs assessment and work cycle of the area and individual.
   2.3 Applies knowledge of pertinent education and healthcare research to development, delivery and evaluation of educational plans and programs.
   2.4 Adjusts learning plans as required to provide for unexpected, spontaneous learning
2.5 Collaborates with multidisciplinary program development teams to develop programs that meet the needs of the target population.

2.6 Identifies objectives and measurable outcomes of learning.

3. **Implementation**
   3.1 Incorporates a variety of teaching methods and appropriate technology to deliver learning program.

   3.2 Ensures educational program is in alignment with appropriate legislation, regional policies and professional standards.

   3.3 Communicates and markets educational programs.

   3.4 Performs specific instructor competencies in delivery of educational programs, e.g. presenting, facilitating, case-based learning, module development.

   3.5 Promotes positive learning environments.

   3.6 Provides individual support for nursing staff to facilitate learning and skill development.

   3.7 Assists with the implementation of new and updated policies and procedures.

   3.8 Represents role/practice specialty by participating in regional, department and clinical area committees and programs.

4. **Evaluation**
   4.1 Collaborates with manager and other multidisciplinary team members to evaluate outcomes of educational programs.

   4.2 Uses a variety of relevant evaluation methods to measure outcomes of learning e.g. survey, skills checklist, data tracking.

   4.3 Encourages and promotes reflection by the learner on clinical experiences and their impact on practice.

   4.4 Incorporates formative and summative evaluation methods.

   4.5 Adjusts learning plan/programs related to evaluation data and feedback.

**THE ART OF PRACTICE**

1. Maintains awareness of own values and ethical priorities and how they may impact on their own practice.

2. Develops therapeutic relationships with individuals/families/communities, nurses and colleagues, displaying appropriate use of communication skills, respect, empathy and an understanding of the unique values of each individual.
3. Displays respect for professional boundaries in interactions with individuals/families/communities and members of the healthcare team.

4. Advocates on behalf of learners including:
   - Providing access to information and resources in consultation and collaboration with other team members
   - Facilitating learners’ participation in decisions affecting learning
   - Intervening effectively in situations where actions of the learner may compromise the safety or well-being of individuals/families/communities; while respecting individual rights and diversity

5. Recognizes and examines processes to correct unsafe practice issues or inappropriate professional conduct

**ATTRIBUTES OF PRACTICE**

1. Understands and complies with:
   - Legal requirements of licensure
   - The Health Professionals Act
   - Calgary Health Region Policies and Procedures
   - Freedom of Information and Protection of Privacy Act (FOIPP)
   - Health Information Act
   - Protection of Persons in Care Act
   - Mental Health Act as appropriate
   - Public Health Act as appropriate
   - Other relevant legislation

2. Demonstrates insightful practice by reflecting on practice to achieve and maintain competence.

3. Identifies own professional development needs and competencies, seeks appropriate learning opportunities and evaluates own learning.

4. While providing learning opportunities, appropriately consults to and supervises care of unregulated healthcare providers, and assigns care to regulated members of the healthcare team according to their scope of practice and Calgary Health Region policies and procedures.

5. Demonstrates flexibility in meeting the unexpected spontaneous learning needs of learners and clinical area.
COMMITMENT TO PRACTICE

1. Shares knowledge gained through attendance at conferences, inservices, etc. with peers.
2. Participates in and supports the development and implementation of the plans, goals and objectives of the workplace.
3. Provides guidance and support to preceptors, learning guides, colleagues, and other personnel as appropriate.
4. Mentors colleagues in areas of expertise and seeks mentorship to achieve full potential in professional development.
5. Promotes evidence-based nursing practice by participating in the interpretation, dissemination and application of current information and research data.
6. Supports and participates in nursing research projects to advance clinical practice.
7. Promotes a positive work environment by:
   8. Fostering wellness and a healthy work/life balance
   9. Respecting others’ opinions, judgements and abilities
10. Using proper channels of communication
11. Managing conflict effectively
12. Demonstrating flexibility and reliability
13. Recognizes when to seek assistance.
14. Identifies system (environmental/unit) limitations and offers recommendations for change.
15. Participates in the development and implementation of Calgary Health Region nursing policies/procedures, practices and programs.
16. Maintains active participation in meetings and committees, and carries out related committee responsibilities.
17. Participates in quality improvement activities.
19. Models evidence based practice and professional demeanor in everyday practice and interactions.
20. Encourages and fosters an environment of inquiry and valuing of evidence based practice.
Nature of Contacts:

- Nursing staff and other health care professionals for the purpose of teaching nursing care
- Other (Clinical Nurse Educators) Instructors to identify resources for education; facilitates educational opportunities for nursing staff
- Regional committees to develop and review policy and practice standards, and program development
- Other educators and health professionals in participating and developing standards of clinical, educational and evidence-based practice

Working Conditions:

- Varies depending on the clinical program requirements

Physical Effort:

- Varies depending on the clinical program requirements

Note: The following factors are inherent at all levels within the profession.
- Confidentiality of patient information and medical records
- Adherence to nursing policy and practice standards
- Freedom of Action, within the constraints of nursing practice
- Legislative compliance
- Adherence to the Canadian Nurses Association Code of Ethics
- Personal accountability
- Professional development – continuing competence
- Professional responsibility
Appendix J: Audit Trail for Reflexivity and Rigour