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New graduate nurses' understanding and attitudes about patient safety upon transition to practice

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New graduate nurses' understanding and attitudes about patient safety upon transition to practice

Abstract

Aims: to explore the transition experiences of newly graduated registered nurses with particular attention to patient safety.

Background: New graduate registered nurses' (NGRNs) transition is accompanied by a degree of shock which may be in tune with the described theory-practice gap. The limited exposure to clinical settings and experiences leaves these nurses at risk of making errors and not recognising deterioration, prioritizing time management and task completion over patient safety and care.

Design: Qualitative descriptive approach using semi-structured interviews.

Methods: Data were collected during 2017-18 from 11 participants consenting to face-to-face or telephone semi-structured interviews. Interviews were transcribed verbatim and data were analysed using thematic analysis techniques assisted by Nvivo coding software. The study follows the COREQ guidelines for qualitative studies (see Supplementary File 1).

Results: Key themes isolated from the interview transcripts were: patient safety and insights; time management; making a mistake; experiential learning; and transition. Medication administration was a significant cause of stress that adds to time management anguish. Although the NGRNs clinical acumen was improving, they still felt they were moving two steps forward, one step back with regards to their understanding of patient care and safety.

Conclusion: Transition shock leaves NGRNs focused on time management and task completion over patient safety and holistic care. Encouragement and support needed to foster a safety culture that foster safe practices in our new nurses.

Relevance to practice: Having an understanding of the NGRNs experiences and understanding of practice will assist Graduate Nurse Program coordinators, and senior nurses, to plan and provide the relevant information and education during these initial months of transition to help mitigate the risk of errors occurring during this time.

Keywords

Confidence; new graduate nurses; patient safety; qualitative; transition

INTRODUCTION

The Institute of Medicine (IOM) (Kohn, Corrigan & Donaldson, 2000) brought to light the significance of patient safety within healthcare, kick starting a worldwide movement toward providing quality care to all patients. However, incidents of poor patient care continue globally with major health service inquiries continuing to highlight major failings (Davies, 2005; Francis, 2013; Kirkup, 2015). It is not only major failings that we need to be wary of, but also the increased incidence of errors occurring during the transition of new staff, such newly graduated nurses and doctors into the workplace. These new staff members have to contend with stresses related to the complexity of practice, and their knowledge gaps which have been shown to contribute to an increased incidence of errors at this time (Duckett & Moran, 2018; Hayes, 2018; Hirani & McFarlane, 2016; Treiber & Jones, 2018). Knowledge gaps are not unique to healthcare, or nursing in particular, they are also evident in professions such as education and accounting, (Jansen, 2018; Roegman & Woulfin, 2018), however the outcomes of errors in these professions may not have the dire effect that they do in healthcare.

BACKGROUND

The fundamental ethical principle of healthcare is to do no harm, a principle that Florence Nightingale called attention to and which is now the focus of the World Health Organisation (WHO) (WHO, 2017). Since the IOM report, the WHO launched their patient safety program which has seen the introduction of the Hand Hygiene Initiative, Surgical Safety Checklist, Safe Childbirth Checklist, and most recently the launch of the third patient safety initiative: Medication without harm (Patient Safety: Making health care safer, 2017). Even with these initiatives, one in ten of the 421 million worldwide hospitalisations suffer an adverse event during their stay, making adverse events the 14th leading cause of death and injury (WHO, 2018). Approximately half of all adverse events are surgical related, with half of those being considered preventable (Patient safety: making health care safer, 2017). Given the WHO's latest patient safety initiative is Medication without harm, and as medication administration is an important aspect of patient safety, it is alarming to note that approximately 55% of nurses with under five years of experience have admitted to making a medication error (Treiber & Jones, 2018).

It has been asserted that new graduate registered nurses (NGRNs) have not yet developed the critical thinking skills or the situational awareness to provide a sufficient level of expected care and that NGRNs may simply not know what they do not know (Benner, 1984; Benner, Tanner, and Chesla, 2009; Missen, McKenna, Beauchamp & Larkins, 2016). It has also been established that a NGRNs transition from student to registered nurse (RN) is accompanied by a degree of shock (Chang & Daly, 2016; Duchscher, 2008; Kramer, 1974).

Transition, in the nursing context, has been defined by Phillips, Kenny, Esterman and Smith (2014, p. 106-107) as "a period where new graduates undergo a process of learning and adjustment, and socialisation to a new culture, the work place." Duchscher (2009)

developed the Transition Shock Model to describe the process of new graduate nurses beyond any knowledge-practice gaps. It serves to explain the physical and psychological experiences of new graduate nurse transition encompassing responsibilities, roles, knowledge, and relationships, with transition shock incorporating doubt, confusion, disorientation, and loss (Duchscher, 2009). The transition shock model sits alongside Duchscher's Stages of Transition Theory (2008) that describes three stages (doing, being, knowing) through which a new graduate nurse progresses during the twelve month transition from student nurse to competent registered nurse.

The transition shock period is associated with Duchscher's first stage of transition, doing. It is this stage where new graduate nurses are learning their profession; performing nursing tasks while concealing their anxieties; adjusting to the expectations of the nursing profession in the real world; and accommodating practices that may not be the same as those taught in undergraduate education, and to which confidence to speak up remains lacking (Duchscher, 2008; 2012). This stage culminates at three to four months from commencement of clinical practice. Cheng, Tsai, Chang and Liou (2014) also demonstrate that clinical stress is highest at three months post-graduation, mimicking Duchscher's transition shock model. What is not as established is how new graduate nurses' transition experience affects their patient safety practices.

It is during the early months of transition where new graduate nurses have low levels of confidence in some of their abilities, with Myers et al. (2010) establishing that during transition NGRNs are concerned about the technical aspects of nursing practice and are lacking confidence and knowledge about all forms of medication administration. Halpin, Terry and Curzio (2017) found that NGRNs are terrified of making a mistake regarding medication, making them slow during medication administration, thus further adding to

their stress. As the role of the student nurse is quite different from the role of the registered nurse, NGRNs have been reported as being unable to prioritise care and multi task to include situations such as answering the phone, managing patient safety incidents and attending to other areas of the hospital when necessary all while maintaining a full patient load (Mellor & Greenhill, 2014). It is initial and ongoing support and clinical supervision during the early months as a registered nurse that goes a long way to alleviating the anxieties and stresses experienced by NGRNs during this time (Duchscher, 2008, 2009; Mellor & Greenhill, 2014).

Since Kramer's findings of 'reality shock', and subsequently Duchscher's 'transition shock', there have been programs established globally to mitigate some of the issues surrounding NGRN transition. These programs include Graduate Nurse Programs (GNP), Nurse Residency programs, mentorship and preceptorship programs (Chang & Daly, 2016; El Haddad, Moxham & Broadbent, 2013; Walsh, 2018). All of these were established with the aim of providing extensive orientation, ongoing support, advanced skills development, and professional development opportunities during that crucial initial 12 months of practice (Walsh, 2018). Having a structured transition to practice program aids the NGRN to work within their scope of practice, something many NGRNs find is difficult due to staff allocations and skill mix in their workplace (El Haddad et al., 2017; Lea & Cruickshank, 2015; Missen et al., 2016). These programs require supportive leadership to facilitate staff support for NGRNs. Fostering inter-professional networks is also an important feature of a transition program, however it is the preceptorship that is of greatest benefit to the NGRN (Herron, 2018; Mellor & Greenhill, 2014). The provision of an allocated preceptor from whom the NGRN can seek assistance, clinical support and feedback for anywhere between six months

and two years gives the NGRN the opportunity to safely build their skill and knowledge base while providing safe, quality care (Mellor & Greenhill, 2014).

As nurses have the highest interaction with patients, they are best placed to influence patient outcomes (Hendricks, Cope & Baum, 2015). As transitioning NGRNs have had limited exposure to clinical settings and experiences, classified as 'advanced beginner' under Benner's (1984) skill acquisition model, they experience anxiety related to the recognition of patient deterioration. The increasing patient acuity and decreasing length of stay in contemporary healthcare settings leaves little time for NGRNs to develop the clinical reasoning or critical thinking skills required to detect changes in their patients (Kavanagh & Szweda, 2017). While they are exposed to many simulated emergent situations as students, they may not have witnessed deterioration in the clinical setting, either as a student, or during their GNP orientation time (Herron, 2018). To assist NGRNs manage these situations, simulation, both low and high fidelity, has been increasingly used in undergraduate education for nursing students to learn to manage patients in specific situations, and in the workplace for qualified nurses to practice skills that may not be used regularly (Herron, 2018; Wall, Andrus & Morrison, 2014).

It is also reported by Missen et al.(2016) that while NGRNs perform adequately within their scope of practice in basic clinical skills, their advanced clinical skills remain an area of concern. Kavanagh and Szweda (2017, p.57) assert that "...knowledge development in clinical practice requires experiential teaching and learning through facilitated, situated cognition with reflection..." a statement supporting Benner's (1984) 'novice to expert' model. This paper discusses the findings from the qualitative arm of a mixed methods study which explored new graduate registered nurses transition experiences particularly related to patient safety.

Study aim

The aim of this study was to explore the transition experiences of newly graduated registered nurses with particular attention to patient safety. The following research questions were formed to direct the investigation of the NGRNs self-reported knowledge of patient safety and medical errors upon their transition from student to registered nurse.

1. What is a NGRNs understanding and attitudes about patient safety upon initial entry to clinical practice?
2. Is undergraduate patient safety theory being translated to clinical practice?
3. Has the NGRNs transition experience influenced their ability to integrate patient safety practices into their clinical practice?

METHOD

Design

This study was undertaken using a mixed methods convergent design. The quantitative and qualitative data were collected and analysed separately before results being merged and inferences drawn (Creswell, 2015). The qualitative arm of this study used a qualitative descriptive approach. The study follows the COREQ guidelines for qualitative studies (see Supplementary File 1) with the purpose of this paper being to report on the qualitative results of this mixed method study.

Setting

Participants were recruited from two large metropolitan tertiary hospitals in Western Australia (WA). One of these hospitals is a 600-bed general Magnet accredited public

hospital with the largest intake of NGRNs into its GNP in WA annually. The second hospital is a 722-bed combined private/public facility. This allowed description of participant experiences from Australia's two main healthcare streams, public and private.

Participants

Between the participating hospitals, the GNPs admit approximately 80 new graduate nurses per intake. Recruitment of participants occurred across three GNP intakes between August 2016 and August 2017, giving a prospective pool of 210 nurses. All NGRNs from the prospective pool were invited to participate following a short presentation at their graduate nurse program orientation day. Graduate enrolled nurses were excluded from this study. Ninety-five NGRNs in total across the three intakes consented to participate in the overall study. Eleven of these NGRNs accepted the invitation to participate in a semi structured interview. All interview participants were female aged 18-55, working in Graduate Nurse Programs (GNPs) at either of the participating sites. These participants represented four of the five universities in Western Australia who, at the time, offered undergraduate nursing degrees.

Data collection

Data were collected through one-on-one, semi-structured interviews conducted either face-to-face or via telephone with the chief researcher. Interviews were held in an informal setting at a time and location convenient to the participant. Participants were asked questions including "what has it been like to be a new graduate RN?", "what do you understand patient safety to be?", "how do you incorporate this into your practice?", and

“what have been your biggest challenges?” Participant responses were audio recorded and transcribed verbatim.

Data analysis

The resulting qualitative data were analysed using Braun and Clarke’s (2006) six steps of thematic analysis. Following these steps, the researcher was able to define key concepts and subsequently identify themes relevant to NGRN patient safety practices during transition. Using Nvivo coding assistance software and manual coding, key concepts were isolated, themes developed, and quotes were identified within the interview transcripts that facilitates illustration of data analysis. Data saturation was achieved through the eleven interviews.

Ethical considerations

The University Human Research Ethics Committee (HREC), as well as the HRECs of the participating sites, approved the study (#12959, #2016-068, & #1607). Written informed consent was obtained from all participants and at all times the research adhered to the National Health and Medical Research Council research ethics guidelines (2018).

Trustworthiness

The four aspects of trustworthiness in qualitative research, credibility, transferability, dependability and confirmability (Guba, 1981; Schneider et al., 2013), have been recognised and utilised in this study.

The interviews were conducted by the chief researcher who is a registered nurse and PhD candidate working in the university sector. The participants were guided through the

interview with semi-structured open-ended questions that allowed them the freedom to speak as much or as little as they like regarding their experiences. The interviews were digitally recorded, transcribed verbatim and returned to the participant for verification. This process aids to enhance the authenticity, integrity and credibility of the research for the reader (Liamputtong, 2013; Neergaard, Olesen, Andersen & Sondergaard, 2009; Schneider et al, 2013). The transcripts were reviewed by the chief researcher, and her PhD supervisors using an iterative process to establish themes. Upon completion of data analysis, member checking occurred with themes and main findings sent to the interview participants for comment.

RESULTS

Eleven NGRNs were interviewed. All participants were female aged 18 to 55 who were employed in a GNP at the participating hospital sites. One participant was on a twelve-month perioperative graduate program, and another was in a mental health program which has the graduates rotate through acute medical and surgical before commencing in a mental health facility. All remaining interviewees were in their second of two six-month rotations. Of these nurses, one had rotated from a day procedure unit, all others had worked on a surgical or medical ward in their first rotation. The analysis of interview data resulted in five main themes: “patient safety and insights”; “time management”; “making a mistake”; “experiential learning”; and “transition”. These five themes will each be illuminated to follow.

In support of these themes, the word trees presented in figures 1 to 3, developed from the verbatim quotes of transcripts from the participants, illustrate the context of 'patient safety', 'time management', and 'confidence' to provide perspective of the NGRNs thinking.

Theme 1: Patient safety and insights

On the whole, NGRNs identified that patient safety is, as per the World Health Organisation's (WHO) definition, to do no harm (WHO, 2018). All participants spoke of the prevention of harm by being aware of the patient's situation and of their surroundings. When probed further, responses included working to hospital policy and ensuring others are also following hospital policy; prioritisation; working within their scope; and knowing medications. Some responses included insight into risk and mitigation of risk. There was recognition that risks can change during a patient's stay, and where there are more co-morbidities, there is more risk as illuminated in the following quotes and figure 1.

"Patient safety is like preventing harm...minimizing the risks that they may come across whilst treating them that will expose them to further harm...recognizing that risks can change" (Participant 2)

"Not to cause unnecessary harm, discomfort or distress to a patient...making sure that I follow policies and keeping an eye out for other people following policies." (Participant 6)

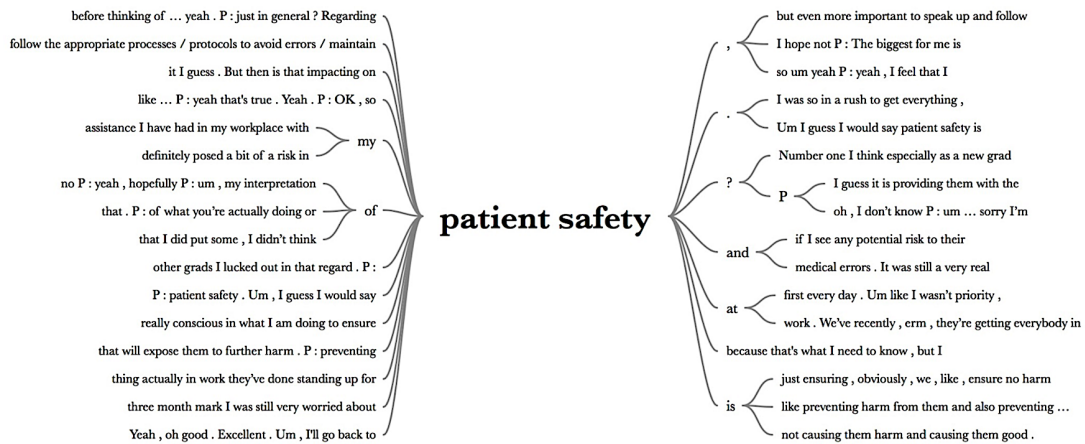


Figure 1 “Patient safety” word tree

There was some internal conflict for some NGRNs when witnessing the practice of more senior registered nurses (RN), particularly around medication administration practices. These NGRNs struggled to speak up for themselves to request RNs to follow the patient safety practices that NGRNs have been taught are essential.

“I was going to do an I.V. AB and my nurse wasn’t going to come to the bedside and I said hey, this is an APINCH drug, shouldn’t we go to the bedside? And I got her to come. But I felt a little bit awkward afterwards.” (Participant 4)

These experiences were also dependant on the ‘culture’ of the ward/unit they were working on at the time. As the NGRNs moved between wards at the end of their rotations, they recognised the differences in ward/unit practices. This was put down to the different leadership within each ward, with some seemingly more safety focused than others.

“I know other wards do go to bedside to check. But in this particular ward they don't go to the bedside and check.” (Participant 5)

“Different wards have different methods depending on how busy they are and how they actually work together as a team.” (Participant 6)

After initially describing their perceptions of patient safety, the NGRNs dialogue heavily focused on medication administration and safety. There was great stress initially described by the NGRNs who felt they were too slow conducting medication rounds due to having to research/review each drug they were administering.

“It was hard with time management and having to sit on the MIMs to know what I’m giving, but it’s important to know what I’m giving.” (Participant 6)

There was expression of a deficiency in knowledge related to types of medications and their interactions. Alarming, some comments exposed a lack of insight regarding the NGRN’s own role in education on medications: *“I can’t believe we have three years of uni and I come out probably only knowing, you know, what paracetamol is” (participant 5)*; and evidence of shifting accountability to others: *“I sort of leave it up to the pharmacist to know the interactions, to look at that med chart and think hang on a second these are not supposed to be given together.” (Participant 4)*

Generally speaking, while there was great concern about medication administration and safety, most recognised that the whole of their practice was to keep the patient safe and that all of their interactions with the patient had an undercurrent of safety. Initial concerns about time management and knowledge deficits had them battling internally with the best way to approach their practice to maintain the expected level of safety.

“I am actively thinking like every time I’m doing a task ‘am I doing it safely?’” (Participant 9)

"I was desperate to get everything done that I did put some, I didn't think of patient safety at first every day." (Participant 8)

Theme 2: Time management

Much of the NGRNs apprehension related to time management and the ability to complete all of their 'tasks' during their shift. Seven of the participants expressed feeling time pressured and felt they struggled with time management in the early months of transition. There was overarching focus on completing tasks and it was the completion of these tasks that determined how they felt about their shift.

Participants expressed concern about managing a balance between time management and patient safety, with their initial focus shifting to time management over safety. Discussion of this can be seen in the following quotes, while figure 2 adds context to other participants comments.

"It was a big toss between being able to do your time management and maintain safety. Like that equilibrium between the two, at the start that was really hard to meet ... But yeah it's definitely that Safety vs Time Management sort of thing that happens I think. So you always maintain your safety but your time management sort of goes out the door and I think as you sort of go through the processes of when you learn and you remember what all those medications are for, that's when your time management comes back into play." (Participant 7)

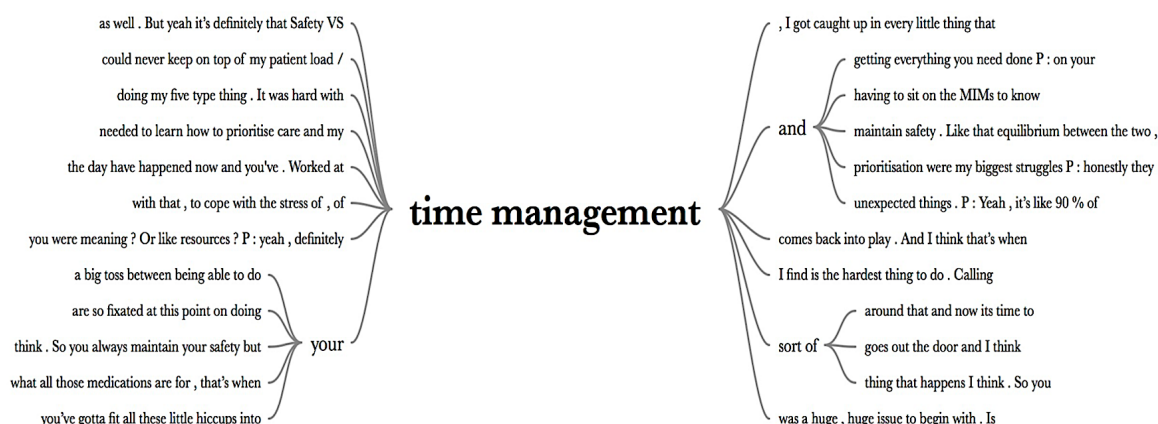


Figure 2 “Time management” word tree

Theme 3: Making a mistake

Combined with apprehension about time management was the underlying fear of making a mistake or missing something that would result in the deterioration of a patient. This was central to much of the participants’ discussion. At the time of the interviews, most NGRNs were transitioning to their second graduate rotation, were again in a new environment and as such this fear of making a mistake was heightened at this time as depicted in the following verbatim quotes

“...doing something really wrong, you know patient dying because of you”

(Participant 1)

“...making a really big mistake and causing someone to deteriorate or not

notice someone deteriorating” (Participant 8)

Theme 4: Experiential learning

On the whole, a majority of the NGRNs recognised their graduate placements as supported learning environments. Whilst they are a registered nurse and have all the

responsibilities of being a registered nurse, the graduate program provided these nurses' with the ability to transition to professional practice in the supported environment that the twelve-month graduate program provides. There was also realisation that ongoing learning was ultimately their own responsibility and that along with theoretical learning, skills application was mostly experiential. Some of these NGRNs could recognise when they needed to learn more before they felt comfortable or confident in certain situations as illustrated in the following verbatim quotes

"A lot of it is on the job learning. Um, yeah and so I'm like studying every night and just trying to gain more learning and things like that" (Participant 9)

"...I am still learning and still more to learn." (Participant 2)

However, there were also some NGRNs who appeared not to recognise learning opportunities or acknowledge their own role in learning. At times they shifted the responsibility for their own knowledge deficits and errors to their universities or their workplace.

"I didn't know about the sepsis pathway because they [ward staff] had their training on it the week before I arrived." (Participant 5)

"...it didn't sink in for me because it was just theory, it had no meaning for me." (Participant 5)

Theme 5: Transition

Throughout the interviews, NGRNs talked of their experiences to date, expressing their impressions of being a NGRN; of the different experiences and responsibilities they

suddenly had that they did not have as a student nurse. The safety net had gone and they were wholly responsible for their patients and their actions. Three sub-themes from these impressions developed from the analysis and they are apprehension, confidence and doubt, and two steps forward one step back.

Sub-theme: Apprehension

NGRNs describe their initial transition as 'nerve wracking', 'scary', 'stressful', and 'overwhelming'. There was apprehension about taking on a role for which some feel they were not fully prepared; that they were suddenly wholly responsible for the patients in their care. It was a fear of the unknown and doubt over their knowledge and ability to recognise deterioration.

"The whole not knowing, like, not recognising what you do really know from uni, like, what you have really learned" (Participant 4)

"The sense of responsibility to patients that I found so overwhelming... all of a sudden, you've got people lives in your hands" (Participant 10)

They were not confident in their own skills and certainly not confident enough to question others. They described hesitation to question for fear of embarrassment with one participant saying, *"...well either I get embarrassed and this patient gets good treatment, or I save my face, and something goes wrong" (Participant 2)*. They spend a lot of time worrying about whether they are doing things right.

"As a grad you're like oh I should, this seems so simple I should know how to do it. So, then you spend a lot of time like. Yeah, just like second guessing that in your mind and then being like but do I know it? Have I learned it, like where can I

look it up? Well, like you go through all these steps like who should I ask? Like is going to be the right person to ask is going to be silly. And then you, um, end up wasting all of mental energy I think because you are worrying” (Participant 2)

Apprehension eased as confidence increased and the initial shock of being the Registered Nurse (RN) wore off. The NGRNs were able to shift focus from their tasks and progress more toward the view of holistic care of the patient. Their time management improved, their confidence grew, and they questioned themselves less and were less afraid to speak up, not only for their patient but also for themselves. They reached a stage of realisation where questions asked had changed from ‘how’ to ‘why’ as they started recognising patterns in routine and patient trends.

“Sometimes as a grad you're not confident enough to, I don't know, like stand up and question things” (Participant 2)

In addition to initial apprehension, there was an element of role confusion. These new nurses were the RNs, senior to enrolled nurses (ENs), and felt inadequate working alongside sometimes vastly more experienced ENs to whom they had often looked to for guidance as a student.

*“I found it especially hard being an RN working with EN's that've got so much more experience than me yet I'm the one holding the keys, like it just felt silly.”
(Participant 10)*

“I think knowing the responsibility you have as an RN over an EN, I only just pulled out the scope of practice for an EN, I don't think I had ever viewed that

before. So obviously you're working alongside them and often I'm working along with experienced EN's." (Participant 11)

Sub-theme: Confidence and doubt

Another progression for the NGRNs was confidence in communication. There was initial fear of communicating with the multidisciplinary team, especially medical staff. The initial challenge was 'how to know when to contact them', to 'how to contact them', which morphed into overcoming confidence fears of actually calling allied health professionals, interns, consultants, and specialists.

NGRNs had so much initial doubt in their own skills and abilities; questioning almost every step of their practice, further adding to their time management struggle. When seeking help there was a sense of awe from the NGRNs of the experienced RNs, as these RNs ostensibly knew, instinctively, what to look/check for, who to contact and why (figure 3). This added to the NGRNs frustrations as they question why they 'didn't think of that?'

"...this seems so simple I should know how to do it. So, then you spend a lot of time like. Yeah, just like second guessing that in your mind and then being like but do I know it? Have I learned it, like where can I look it up? Well, like you go through all these steps like who should I ask? Like is going to be the right person to ask is going to be silly. And then you, um, end up wasting all of mental energy."

(Participant 2)

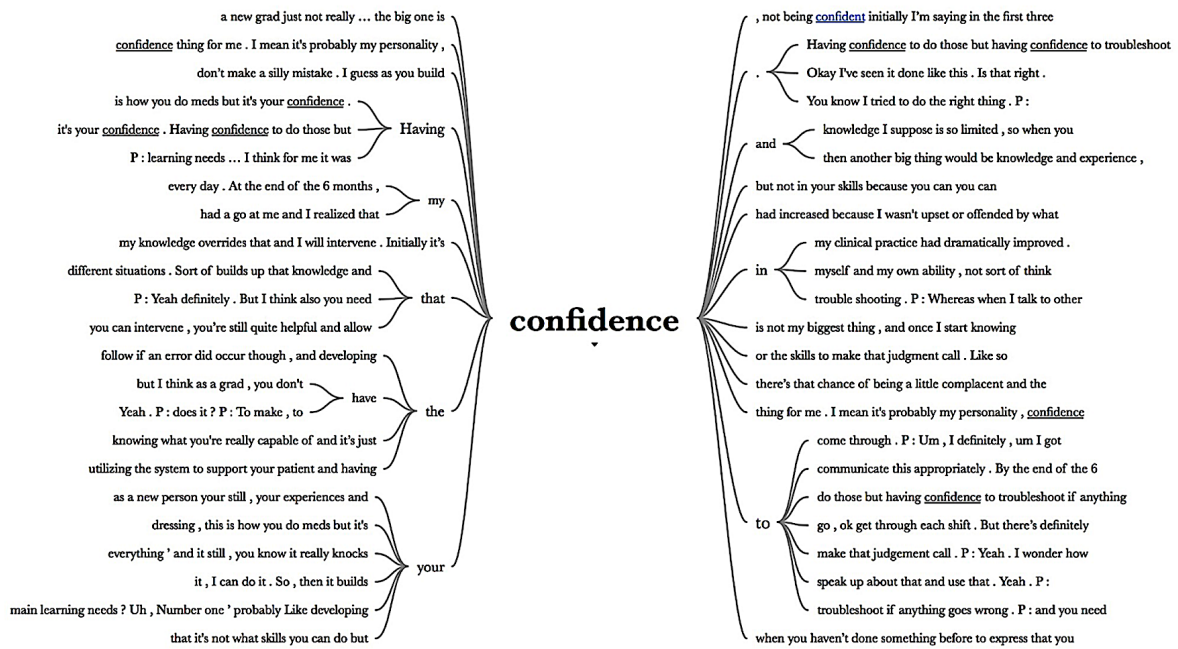


Figure 3 “Confidence” word tree

Sub-theme: Two steps forward, one step back

As the NGRNs progressed through their GNP, they started feeling that things were falling into place. They were beginning to manage their time more efficiently; beginning to look beyond the tasks to the bigger patient picture. They had settled into the ward/unit routine, were becoming socialised to the environment, and gaining confidence in their nursing ability. As there is a rotation at six months into the graduate nurse program, many of the participants expressed that rotating/changing wards was akin to going ‘two steps forward and one step back’. While transition to the second ward was easier than initial transition from student to NGRN, there was a setback in confidence as skills were challenged in new specialties and new relationships needed to be formed.

“I found doing the grad program I think it’s great that we get to experience different areas but at the same time you’ve just found your feet, you’re just getting

really confident and feeling like, you know, you're contributing positively to a ward, you know and you've made friends and then you're in a new ward and you're sort of starting from scratch again it's almost like you have to earn everybody's trust and respect again" (Participant 10)

"...surgical was new to me, there was all these procedures I hadn't dealt with before, I found the attitude of staff wasn't as welcoming." (Participant 11)

DISCUSSION

The narratives of the NGRNs' initial weeks into clinical practice reflect Duchscher's (2009) Transition Shock Model. These nurses described situations that reflect doubt and confusion and a questioning of their skills and knowledge base. They felt overwhelmed, scared, and stressed. There was role confusion between themselves and the ENs. They were now the RN, 'higher-ranked' than the ENs, however regularly seeking the ENs advice as they find their feet in their new environment. There was mention of struggling to find work/life balance, especially for those for whom this was their first full time job.

As the NGRNs were interviewed early in their second rotation, approximately six months into their GNP, some were feeling they were beginning to look beyond their task list or time planner and were now able to begin to consider the patient as a whole as described by Benner, Tanner and Chesla (2009). They were challenged once again though by the new or different procedures and routines requiring different skills than they had developed through their first rotation: the 'two steps forward and one step back' that caused a repetition of stress. The research of both Herron (2018) and Ortiz (2016) reflected similar

findings with new nurses struggling with confidence and the ability to provide holistic care to their patients.

Similarly to Myers et al. (2010), many of the NGRNs' safety concerns in this study focussed on medications. Whether it be administration of drugs, deciphering charts, or knowing the interactions of the prescribed medications, NGRNs felt their initial time management was hampered by their ability to complete the medication round in an acceptable amount of time, as also described in the findings of Halpin et al. (2017), as they looked up unfamiliar medications prior to administering. Concerns were voiced about administration of medications that as student nurses they were not allowed to administer (controlled drugs), but which with they were now expected to be proficient.

There was self-reported apprehension about failure to recognise deterioration or missing a vital aspect of care. Herron (2018) asserts that while nursing students are exposed to emergent events in simulated environments, their critical thinking and clinical reasoning is guided by the preceptor or tutor. Many NGRNs have not had exposure to an emergent event or deterioration requiring urgent attention during their undergraduate placements, thus compounding their stress and apprehension upon assuming the RN role (Herron, 2018). Many of the NGRNs recognised that continued self-directed learning would aid to ease this apprehension, along with the Early Warning Score format of observation charts, a proven method to assist in the early recognition and subsequent reporting of deterioration (Pain et al., 2017). NGRNs recognised this as a tool to assist them to keep their patient safe from deterioration as they could recognise trends and were confident in most instances to act on these.

The flip side to this was the confidence in communicating with the multidisciplinary team. Some NGRNs were confident in doing this, whilst for others, it was a source of anxiety. Most expressed that knowing how to initiate the communication was an issue. Their initial communication hurdle concerned 'who was the right person to contact about their issue', and then how to go about contacting the right person. This apprehension supports that described by Herron (2018) and Ortiz (2016) whose participants expressed anxiety in contacting doctors and also in the process of contacting members of the multidisciplinary team.

Having the confidence to ask for help was a concern of many. Their internal struggle about asking for help over fumbling along and possibly making an error was often at the forefront. They felt that asking too many questions would be 'annoying' or give the image that they 'didn't know anything'. Over time, their concern for the safety of their patients won whereby they throw caution to the wind and if unsure, asked straight away. To assist in NGRN transition, guidance related to learning/knowing the system is an important aspect for the patient safety practices of these nurses; knowing who to call on, when to question, and who is available to access when help is required.

Limitations

This study was conducted at only two metropolitan hospitals in Western Australia. These facilities had graduate nurse program intakes twice a year, limiting the pool of NGRNs available to recruit from. As such, this may limit generalisation of results to all NGRNs.

CONCLUSION

This study reports that NGRNs have an understanding of patient safety and what it means for their patient and their practice. Medication safety is at the forefront of a NGRNs mind during initial clinical practice, especially in relation to patient safety, often causing anxiety and distress that at times leads to error. This study also confirms that NGRNs enter clinical practice experiencing transition shock and it is this initial shock that limits their ability to look beyond their tasks to the bigger picture. It is this shock that at times left the NGRNs choosing between patient safety and time management and to not consider the patient as foremost focus, thus influencing their ability to integrate patient safety practices into clinical practice.

Relevance to practice

Having an understanding of the NGRNs experiences and understanding of practice will assist Graduate Nurse Program coordinators, and senior nurses, to plan and provide the relevant information and education during these initial months of transition to help mitigate the risk of errors occurring during this time.

References

- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park: Addison-Wesley.
- Benner, P., Tanner, C., & Chesla, C. (2009). *Expertise in nursing practice*. New York: Springer Pub. Co.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa
- Chang, E., & Daly, J. (2016). *Transitions in nursing* (4th ed.). Chatswood: Elsevier.
- Cheng, C., Tsai, H., Chang, C., & Liou, S. (2014). New Graduate Nurses' Clinical Competence, Clinical Stress, and Intention to Leave: A Longitudinal Study in Taiwan. *The Scientific World Journal, 2014*, 1-9. doi: 10.1155/2014/748389
- Creswell, J. (2015). *A Concise Introduction to Mixed Methods Research*. Thousand Oaks: SAGE Publishing Inc.
- Creswell, J., & Creswell, J. (2018). *Research design: qualitative, quantitative & mixed methods approaches* (5th ed.). Thousand Oaks: SAGE Publishing Inc.
- Davies, G. (2005). *Queensland Public Hospitals Commission of Inquiry*. Queensland Department of Health. Retrieved from <http://www.qphci.qld.gov.au>
- Duchscher, J. (2008). A Process of Becoming: The Stages of New Nursing Graduate Professional Role Transition. *The Journal Of Continuing Education In Nursing, 39*(10), 441-450. doi: 10.3928/00220124-20081001-03

- Duchscher, J. (2009). Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal Of Advanced Nursing*, 65(5), 1103-1113. doi: 10.1111/j.1365-2648.2008.04898.x
- Duchscher, J. (2012). *From surviving to thriving*. Saskatoon: Nursing the Future.
- Duckett, S., & Moran, G. (2018). Why you should avoid hospitals in January. Retrieved from <http://theconversation.com/why-you-should-avoid-hospitals-in-january-89857>
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: Crown. Retrieved from <http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffpublicinquiry.com/report>
- Guba, E. (1981). Criteria for Assessing the Trustworthiness of Naturalistic Inquiry. *Educational Technology Research And Development*, 29(2). doi: 10.1007/BF02766777
- Halpin, Y., Terry, L., & Curzio, J. (2017). A longitudinal, mixed methods investigation of newly qualified nurses' workplace stressors and stress experiences during transition. *Journal Of Advanced Nursing*, 73(11), 2577-2586. doi: 10.1111/jan.13344
- Hayes, C. (2018). Simulation: Smoothing the transition from undergraduate to new graduate. *Journal Of Nursing Management*, 26(5), 495-497. doi: 10.1111/jonm.12676
- Hendricks, J., Cope, V., & Baum, G. (2015). Postgraduate nurses' insights into the nursing leadership role. Do they intuitively link the role to patient safety?. *Journal Of Nursing Education And Practice*, 5(9). doi: 10.5430/jnep.v5n9p72

- Herron, E. (2017). New graduate nurses' preparation for recognition and prevention of failure to rescue: A qualitative study. *Journal Of Clinical Nursing*, 27(1-2), e390-e401. doi: 10.1111/jocn.14016
- Hirani, S., & McFarlane, J. (2016). Medication Errors by Novice Nurses in a Pediatric and Neonatal Care Setting of Pakistan: Analysis of Problems and Proposed Solutions. *Pediatrics And Neonatal Nursing: Open Access (ISSN 2470-0983)*, 2(1). doi: 10.16966/2470-0983.110
- Jansen, E. P. (2018) "Bridging the gap between theory and practice in management accounting: Reviewing the literature to shape interventions", *Accounting, Auditing & Accountability Journal*, 31(5), pp.1486-1509, doi: [10.1108/AAAJ-10-2015-2261](https://doi.org/10.1108/AAAJ-10-2015-2261)
- Kavanagh, J., & Szweda, C. (2017). A Crisis in Competency. *Nursing Education Perspectives*, 38(2), 57-62. doi: 10.1097/01.nep.0000000000000112
- Kirkup, B. (2015). *The report of the Morecambe Bay investigation*. Morecambe Bay Investigation. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
- Koehn, A., Ebright, P., & Draucker, C. (2016). Nurses' experiences with errors in nursing. *Nursing Outlook*, 64(6), 566-574. doi: 10.1016/j.outlook.2016.05.012
- Kohn, L., Corrigan, J., & Donaldson, M. (2000). *To Err is Human: Building a safer health system*. Washington: National Academy Press.
- Kramer, M. (1974). *Reality shock*. St Louis: C.V.Mosby.

- Lea, J., & Cruickshank, M. (2015). Supporting new graduate nurses making the transition to rural nursing practice: views from experienced rural nurses. *Journal Of Clinical Nursing, 24*(19-20), 2826-2834. doi: 10.1111/jocn.12890
- Liamputtong, P. (2013). *Qualitative Research Methods* (4th ed.). South Melbourne: Oxford university Press.
- Mellor, P., & Greenhill, J. (2014). A patient safety focused registered nurse transition to practice program. *Contemporary Nurse, 47*(1-2), 51-60. doi: 10.1080/10376178.2014.11081906
- Missen, K., McKenna, L., Beauchamp, A., & Larkins, J. (2016). Qualified nurses' rate new nursing graduates as lacking skills in key clinical areas. *Journal Of Clinical Nursing, 25*(15-16), 2134-2143. doi: 10.1111/jocn.13316
- Myers, S., Reidy, P., French, B., McHale, J., Chisholm, M., & Griffin, M. (2010). Safety Concerns of Hospital-Based New-to-Practice Registered Nurses and Their Preceptors. *The Journal Of Continuing Education In Nursing, 41*(4), 163-171. doi: 10.3928/00220124-20100326-02
- National Health and Medical Research Council. (2018). *National Statement on Ethical Conduct in Human Research 2007 (updated 2018)*. Canberra: Commonwealth of Australia.
- Neergaard, M., Olesen, F., Andersen, R., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research?. *BMC Medical Research Methodology, 9*(1). doi: 10.1186/1471-2288-9-52

Pain, C., Green, M., Duff, C., Hyland, D., Pantle, A., Fitzpatrick, K., & Hughes, C. (2016).

Between the flags: implementing a safety-net system at scale to recognise and manage deteriorating patients in the New South Wales Public Health System. *International Journal For Quality In Health Care*, 29(1). doi: 10.1093/intqhc/mzw132

Patient Safety: Making health care safer. (2017). Retrieved from

<https://www.who.int/patientsafety/publications/patient-safety-making-health-care-safer/en/>

Phillips, C., Kenny, A., Esterman, A., & Smith, C. (2014). A secondary data analysis examining the needs of graduate nurses in their transition to a new role. *Nurse Education In Practice*, 14(2), 106-111. doi: 10.1016/j.nepr.2013.07.007

Roegman, R. & Woulfin, S. (2018) "Got theory?: Reconceptualizing the nature of the theory-practice gap in K-12 educational leadership", *Journal of Educational Administration*, [doi:10.1108/JEA-01-2018-0002](https://doi.org/10.1108/JEA-01-2018-0002)

Schneider, Z., Whitehead, D., LoBiondo-Wood, G., & Haber, J. (2013). *Nursing & Midwifery Research: methods and appraisal for evidence-based practice* (4th ed.). Chatswood: Elsevier.

Treiber, L., & Jones, J. (2018). After the Medication Error: Recent Nursing Graduates' Reflections on Adequacy of Education. *Journal Of Nursing Education*, 57(5), 275-280. doi: 10.3928/01484834-20180420-04

Wall, P., Andrus, P., & Morrison, P. (2014). Bridging the Theory Practice Gap through Clinical Simulations in a Nursing Under - Graduate Degree Program in Australia. *International Journal Of Learning, Teaching And Educational Research*, 8(1), 127-135.

World Health Organisation. (2018). Retrieved from <http://www.who.int/patientsafety/en/>