12-2015

Experiences of Newly Licensed Registered Nurses Who Stay in Their First Jobs

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I am submitting herewith a dissertation written by Lisa D. Kirkland entitled "Experiences of Newly Licensed Registered Nurses Who Stay in Their First Jobs." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Sandra Thomas, Major Professor

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Experiences of Newly Licensed Registered Nurses Who Stay in Their First Jobs

A Dissertation Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Lisa D. Kirkland
December 2015

Dedication

This dissertation is dedicated to:

My husband,
Randy Kirkland

and

My children,
Marc and Ashley Webb

and

My mother,
Charolette Wilson,

for praying for me
and providing love,
support, and encouragement
throughout this academic journey

and

In loving memory of:

My father,
Allen Ray Jenkins

whose battle with cancer began the
year I started the doctoral program;
he made it to his finish line
before I made it to mine.

Acknowledgements

My deepest appreciation is extended to the nurses who so willingly shared stories of their clinical practice experiences. I am thankful for the time you took out of your busy schedules to help me draw attention to the collective experiences of new nurses who stay in hospital nursing. I am honored that you chose to participate in my research study and that you trusted me to tell your story. I appreciate your encouragement and support throughout this study.

I would like to extend a special thanks to Dr. Sandra Thomas, my committee chair and faculty advisor, for her leadership, guidance, and support. Dr. Thomas has been an exceptional teacher of phenomenological research and role model of academic integrity. I would also like to thank Dr. Mary Gunther for sparking my interest in phenomenology as part of a research practicum - I may be hooked for life. To Dr. Katherine Greenberg, thank you bringing an interdisciplinary perspective to my research study. I have also enjoyed learning from you in the phenomenology research group. And finally, Dr. Reba Umberger, thank you for so willingly stepping in to fill a committee seat vacated by Dr. Ken Phillips. To all, thank you for your time and dedication to serve on my committee; your expertise and knowledge are greatly appreciated.

I would like to thank members of the interdisciplinary phenomenology research group for helping me learn the art of phenomenology. Thank you for reading my transcripts and offering valuable insight throughout this study. I would also like to thank the UTK College of Nursing Research Scholarship committee and Sigma Theta Tau Gamma Chi Chapter for providing financial assistance with this research project.

I would like to thank my work family at Tennessee Wesleyan College-Fort Sanders Nursing Department for supporting and encouraging me throughout this journey. Thank you for

flexible schedules and allowing me to focus on my own academic milestones. I appreciate the opportunity to role-model lifelong learning to our students.

I would like to acknowledge all my family and friends who loved and supported me through this long endeavor. There are no words to express my gratitude. I want to extend a special word of thanks to my childhood friends (Sherrie, Randy, and David) who claim to have taught me everything I needed to know. Finally, I must give God all the glory, honor, and praise for allowing me to successfully complete my doctoral program.

It is over now...let's go fishing!

Abstract

Most newly licensed registered nurses go to work in acute care hospitals, which means they enter an increasingly complex healthcare environment where they experience staffing shortages, high nurse-patient ratios, and workplace violence. The purpose of this study is to attempt to understand the experiences of newly licensed registered nurses who have endured the early years of bedside hospital nursing and continue to work in their first nursing job. The existential phenomenological philosophy of Merleau-Ponty serves as the guiding framework for this qualitative research study. Following IRB approval, criterion and snowball sampling were used to recruit newly licensed registered nurses who graduated between May 2012 and May 2013. An open-ended unstructured interview format was used to collect data from nine nurses willing to be interviewed about their clinical experiences. Participants ranged in age from 24 to 43 years, represented day and night shifts, and included acute and critical care settings from five different health systems across the state of Tennessee. Data were analyzed by the researcher and the Interpretive Research Group at the University of Tennessee using the Thomas-Pollio existential phenomenological approach. All transcripts were read and analyzed for meaning units and global themes which were used to develop a thematic structure. The researcher, research group, and willing study participants agreed upon the final thematic structure. Five figural themes emerged from the data: 1) *I found the perfect fit*; 2) *we're a pretty cohesive group*; 3) *it's about caring for the patients*; 4) *I've learned a lot*; and 5) *I make a difference*. Study rigor was maintained by bracketing, data saturation, interdisciplinary review, member checking, and the use of direct quotes to support findings. This research has implications for nursing education and clinical practice. Findings are applicable to student nurses, newly licensed registered nurses, nurse educators, clinical preceptors, nurse managers, and hospital administrators.

Table of Contents

Chapter 1

Introduction

The experiences of newly licensed registered nurses (NLRNs) were chosen as the focus of this dissertation research, because attrition of these new nurses is a critical national problem. In this chapter, I provided an introduction to the phenomenon of interest, defined the problem, and stated the purpose for the research study. Next, I provided personal and philosophical perspectives, assumptions, conceptual definitions, delimitations, and limitations. The chapter concludes with a summary statement of the significance to nursing practice.

Newly licensed registered nurses (NLRN) bring new life and energy to an organization yet something steals their joy and excitement for nursing way too soon. According to Nursing Solutions, Inc. (NSI, 2014), a national high volume nurse recruitment and retention firm, hospitals in 2013 experienced the highest registered nurse (RN) turnover (14.2%) since 2009; more specifically, turnover rates for full and part-time nurses at the bedside were at an all time high (12.5%) with medical/surgical units experiencing the highest (24.0%) turnover among all specialty groups. First year turnover among RNs was 25.7%; nurses with two to five years of service had turnover rates of 21.0% (NSI, 2014). Hospital administrators acknowledge retention is a significant problem, yet less than half the reporting hospitals (n = 113; 43.5%) have formal retention strategies in place for experienced staff and only 54.5% have implemented strategies to retain newly hired RNs (NSI, 2014). The majority of nurses who leave nursing suggest it is easier to retain current nurses than to try to bring inactive nurses back into the workforce (Skillman, Palazzo, Hart, & Keepnews, 2010).

Nurses who leave bedside nursing often move to non-hospital environments or leave nursing altogether. Sixty-two percent of registered nurses in the state of Washington who

allowed their license to expire before retirement age indicated they would never return to clinical practice and 53% would not advise young people to enter nursing (Skillman, et al., 2010). Non-practicing, non-retired nurses who were moderately or extremely dissatisfied most often attributed their leaving nursing to job stress, fatigue, unsafe nursing practice, physical demands, and professional dissatisfaction.

Recognizing that 20.5% of hospitals currently have RN vacancy rates greater than 10%, NSI (2014) anticipates that as the economy improves more nurses will likely retire or take part-time positions. Hospitals reported on average 36 to 97 days to recruit an experienced RN (NSI, 2014). Vacant positions are typically covered with expensive strategies such as overtime and agency staff; however, with recent reimbursement changes, hospital administrators should focus on retention efforts to secure a full complement of nursing staff (NSI, 2014). In order to better understand the underlying problem, one must consider the context in which the NLRN enters the workforce.

As nursing graduates transition from student to registered nurse, they become the victims of the ever-widening education-practice gap and often leave their first job. In a recent study, 135 chief nursing officers reported only 10.4% of new nurses are prepared for hospital nursing, whereas 89.9% of nursing school leaders felt graduates were fully prepared to provide safe and effective care in hospital settings (Greene, 2010). Most newly licensed registered nurses go to work in acute care hospitals which means they enter an increasingly complex healthcare environment where they experience staffing shortages, high nurse patient ratios, and workplace violence. As a result, high turnover rates within the first one to two years of practice not only compromise the nursing workforce, but also negatively affect patient care outcomes (NCSBN,

2015). High turnover rates among newly licensed nurses warrant the need for nurse managers to first deal with the transition to practice experience then shift the focus toward retention efforts.

The problem of high turnover rates among NLRN is not a new one. In fact, the seminal work of Kramer's (1974) Anticipatory Socialization Program was designed to reduce job hopping and mass exodus from nursing practice, yet this continues to be a significant problem 40 years later. Physicians, pharmacists, and pastoral care ministers are not expected to perform competently as soon as they graduate (Greene, 2010), so why should nurses? New nurses require opportunities to work through the value conflicts created by the transition from an idealistic academic perspective to the realities of clinical practice. The experiences of NLRN have social, economic, ethical, and policy implications.

Social:

Newly licensed nurses' decision to stay in or leave their job affects the nursing profession on multiple levels. Occupational employment projections indicate nursing jobs will increase by 19% from 2012-2022 based on increased needs of an aging population, financial pressures on hospitals to discharge earlier, and the need to replace workers who retire (Bureau of Labor Statistics, [BLS], 2014), which is consistent with the 2014 twenty-one percent increase demand for RNs projected by the U.S. Department of Health and Human Services, (USDHHS) Health Resources and Services Administration (HRSA). The 2012-2025 HRSA Health Workforce Simulation Model projects a greater (33%) supply of RNs than what will be required or demanded (21%) by 2025; however, supply and demand projections were based on the assumption that the 2012 labor force was balanced, meaning the supply of RNs equaled the demand for RNs (U.S. Department of Health and Human Services [USDHSS], 2014). Although

the projections for retirement are included, the supply and demand model does not reflect the volume of nurses who enter the workforce but leave prematurely.

Prior to the recent economic downturn, new nurse turnover rates have been reported at 30.0% during the first year of practice and as high as 57.0% in the second year (Bowles & Candela, 2005). More recent data show first year turnover among NLRNs was 25.7%, and 21.0% for those with two to five years experience (NSI, 2014). Researchers monitoring the effectiveness of nurse residency programs reported turnover rates as high as 36.1% during the first year before the programs were implemented (Trepanier & Carman, 2012). Decreased turnover rates have been attributed to the economic downturn and older nurses delaying retirement. The RN workforce is sensitive to retirement age; approximately 850,000 RNs (1/3 of the workforce) are between the ages 50-64 (Buerhaus, Auerbach, Staiger, & Muench, 2013). In recent years, nurses have delayed retirement; during the period 1991-2012, of the nurses working at age fifty, 74% were still working at age 62 and 24% at age 69 (Auerbach, Buerhaus, & Douglas, 2014). However, there has been an unexpected influx of younger RNs entering the workforce, but that alone will not be enough to offset the volume of nurses expected to retire by 2020. There will also be an increase demand for nurses as the healthcare system engages with an additional 32 million Americans insured under the Affordable Care Act (Buerhaus et al., 2013).

Patient care is also affected by the NLRN workplace experiences. The new nurses' attitude is easily perceived by their patients. Perry (2008) suggests when nurses and patients feel satisfied with care, a positive cycle is created in which the patient expresses gratitude, and the nurse is encouraged to continue caring for the patient. However, fear, guilt, and embarrassment interfere with the new graduate nurses' ability to learn new skills. When nurses are unhappy,

disillusioned, or experiencing moral conflicts they provide less effective patient care, and often experience burnout which negatively influences patient care (Bowles & Candela, 2005).

Healthcare administrators have executive responsibilities for both employees and patients. Organizational outcomes are reflected in employee satisfaction and nursing sensitive patient outcomes. Organizations emphasizing patient care contribute to new nurses' satisfaction which is often reflected in employment statistics and the number of job vacancies on a particular work unit or within a particular organization. On the other hand, when nurses perceive the work environment hinders their ability to provide quality patient care they experience greater dissatisfaction and are more likely to leave the job (Buerhaus et al., 2005). Patient satisfaction scores become major social and economic concerns since reimbursement under the Affordable Care Act is based on patients perception of performance outcomes (Werner & Dudley, 2012).

Economic

Changes in healthcare reimbursement calls for a new plan to control labor expenses. In July 2007, the average replacement cost for one RN was estimated at $82,000 - $88,000 (Jones, 2008, table 4); therefore, high turnover rates create substantial costs for hospitals. With high RN vacancy rates, escalating turnover among NLRN, and decreased hospital reimbursement, investing in retention programs for new nurses is a key component that can address both patient outcomes and hospital reimbursement. McHugh, Berez, and Small (2013) found hospitals with higher nurse staff levels had 25% lower odds of being penalized for Medicare readmissions. It is reasonable to expect the hospital administrators who are able to retain an adequate workforce will decrease their risk for being penalized for avoidable readmissions under the Affordable Care Act.

During times of economic downturn, it is not atypical for employment rates to remain steady; therefore, job turnover rates are not always indicative of job satisfaction or quality patient care. When new nurses maintain employment primarily to meet personal financial obligations rather than embracing opportunities to improve patient care, ethical issues may arise.

Ethical

According to the American Nurses Association (ANA), "the employer is responsible and accountable to provide an environment conducive to competent practice" (2014, para 1.). The public has a right to expect *and* hospitalized patients deserve an adequate number of competent nurses on duty to provide safe quality care. According to Benner et al. (2010) NLRN are not prepared to deal with complex patient care, especially in an unstable or unsupportive environment. Whenever new nurses are not properly transitioned into the workplace, more medication errors occur and patient safety is compromised. When new nurses feel increased stress levels, there is an increased risk for patient safety and practice errors (NCSBN, 2013). Cimiotti, Aiken, Sloane, and Wu (2012) found higher rates of urinary tract and post-surgical infections in hospitals with higher nurse-patient ratios; increasing the nurses workload by only one patient, coupled with nurse burnout, was a factor across all 161 hospitals. Blegen, Goode, Spetz, Vaughn, and Park (2013) found higher staffing protects patients from poor outcomes such as infections, prolonged length of stay, failure to rescue, and mortality. It is imperative that hospital administrators not only pay attention to factors affecting patient outcomes and nurse attrition but also establish policies and procedures to retain competent staff nurses at the bedside.

Policy

Most hospitals have policies in place to ensure new nurses participate in some form of general nursing orientation; however all programs are not equivalent. New graduate nurses

experience from a few weeks to a full year in orientation or transition to practice programs (Krugman et al., 2006). Longer orientation programs produce nurses with a greater sense of belonging and job satisfaction (Winter-Collins & McDaniel, 2000).

In the past ten years, numerous organizations have recommended programs in which new nurses could acquire knowledge and skills to deliver safe, quality care (Benner et al., 2010; Institute of Medicine [IOM], 2011). Job satisfaction and turnover rates improve with various new-hire programs such as looping or rotating through various clinical settings (Beecroft, Kunzman, & Krozek, 2001), simulation (Beyea, Slattery, & Von Reyn, 2010), interactive modules (Anderson, Allen, Linden, & Gibbs, 2009), mentoring (Bratt, 2009; Messmer, Bragg, & Williams, 2011), and individualized orientation programs (Herdrich & Lindsay, 2006). Nursing literature is replete with evidence that residency programs increase new nurses' confidence, competence, and job satisfaction while simultaneously improving retention rates, which result in employer cost avoidance (Beecroft et al., 2001; Pine & Tart, 2007; Rush, Adamack, Gordon, Lilly, & Janke, 2013; Williams, Goode, Krsek, Bednash, & Lynn, 2007). The future of nurse residency programs will depend upon support from academic, government, and philanthropic organizations.

The American Association of Colleges of Nursing (AACN) has adopted the accreditation standards for post-baccalaureate nurse residency programs established by the Commission on Collegiate Nursing Education (AACN, 2008, CCNE, 2008). The National Council of State Boards of Nursing has *recommended* state boards of nursing enforce transition to practice programs as part of licensure (NCSBN, 2013); however, no mandates for transition to practice programs exist at this time. The IOM (2011) recommended the Secretary of Health and Human Services, health care organizations, Health Resources and Services Administration, and Centers

for Medicare and Medicaid Services, along with philanthropic organizations redirect funds to develop and implement nurse residency programs. Until that time, hospital administrators and nurse leaders must consider the value of individual and collective experiences of the NLRN who choose to stay in bedside nursing.

Statement of Problem

High turnover among NLRN poses a significant problem within healthcare. As healthcare reform offers lower reimbursement structures for hospital care, there is a greater need for an adequate number of competent nurses at the bedside. In addition to attrition and high turnover rates, the HRSA projections indicate nursing jobs will increase by 21% from 2012-2025 based on increased needs of an aging population, financial pressures on hospitals to discharge earlier, and the need to replace workers who retire. In spite of a 33% projected increase in the supply of NLRNs and an unexpected influx of new nurses entering the workforce, that alone will not be enough to fill future RN vacancies if the NLRNs continue to leave at such high rates.

Prior to the recent economic downturn, NLRN turnover rates were as high as 30.0% during the first year and 57.0% in the second year (Bowles & Candela, 2005). In 2013, 20.5% of hospitals reported overall RN vacancy rates greater than 10%; first year turnover among NLRNs was 25.7%, and 21.0% for those with two to five years experience (NSI, 2014). There is even more evidence in nursing literature of nurses who frequently consider leaving or intend to leave their current job within one to three years. There is also evidence that nurses who leave nursing are not likely to return to clinical practice. In one study, 62% of RNs who allowed license to expire before retirement age indicated they would never return to clinical practice, and 53% would not advise young people to enter nursing (Skillman et al., 2010). As mentioned in the introduction, the estimated cost to replace one nurse is over $82,000 (Jones, 2008, table 4).

Hospital administrators acknowledge high turnover rates, but less than half have implemented formal retention programs or strategies to keep nurses at the bedside.

Previous research with NLRNs focused primarily on predicting turnover and investigating why nurses leave the bedside within the first one to two years; little is known regarding the experience of nurses who stayed in their first bedside nursing job. Literature indicated the workplace environment and patient care issues plays a significant role in determining whether a nurse stays in or leaves the job. While I found the previous research helpful in making recommendations to improve retention, I wondered if unreflected descriptions and the meaning of the NLRNs experiences would confirm or add to the recommendations made by other researchers. The problem explored in this study was the lack of empirical evidence available in nursing literature related to the perceptions of NLRN who have stayed in their first RN job beyond the transition to practice period.

Purpose of the Study

The purpose of this qualitative phenomenological study is to attempt to understand the experiences of newly licensed registered nurses who have stayed in their first nursing job in an acute care hospital for 18 to 36 months in order to help nurse managers and hospital administrators develop effective organizational retention plans. The specific time frame was an attempt to move beyond the first two years of clinical practice but not beyond the stage wherein the NLRN was no longer considered a "new" nurse. Benner's (1984) novice to expert categories guided the timeframe, i.e.: stage 3 or competent nurse is usually two to three years and stage 4 or proficient nurse is approximately three to five years.

Researcher Perspective

The impetus for this study originated from my desire to reveal the positive aspects of the new nurses' chosen career. While teaching a leadership and management course that is designed to prepare senior baccalaureate students for the transition to practice, I became very interested in the ever-widening education-practice gap as described by Benner et al. (2010). I was admittedly defensive when nurse administrators expressed concern that schools of nursing were not keeping up with the rapid pace of changes in the practice arena. *Was I perceived as not doing my job effectively?*

For the past ten years, I have watched the joy, excitement, and apprehension build within the senior nursing students as they begin their initial job search, pass the NCLEX-RN, and accept their first professional nursing job. I do not perceive my role as a faculty mentor to be over on graduation day. I continue to celebrate the graduates' successes and counsel those who question their readiness for independent practice. I see first-hand evidence of Kramer's (1974) honeymoon phase when students communicate with me after graduation. For example, one recent graduate sent me a text message to say she placed her first nasogastric tube on a premature infant; another came by my office to tell me he obtained his ideal job working in critical care unit. Yet another former student called in tears saying her manager and preceptor want to take her off orientation but she does not think she is ready for this transition.

It was the latter nurse's experience that prompted me to consider this research area. I knew the quality of her work, the compassion she possessed, and her desire to use her nursing skills as an opportunity to help other people. Yet as this neophyte nurse sat in front of me, she focused only on the things she had *not* been able to do as a new nurse. She was overcome with

fear and trepidation of moving forward in her career. I found myself reminding her of previous success stories and asking her to remember why she wanted to be a nurse.

After my encounter with this distraught newly licensed nurse, I realized how quickly some lose the joy and excitement for their chosen career path. I find nursing literature spanning 75 years to be replete with evidence of difficult transitions from student to practicing nurse and dissatisfaction with the workplace. However, this body of research offers little in regards to the experiences of newly licensed nurses who chose to stay in direct patient care at the hospital bedside.

Philosophical Framework

The methodology for this study, existential phenomenology, is one of the approaches within the worldview of social constructivism. The paradigm of social constructivism suggests individuals seek understanding of their world and develop subjective meanings of their experiences. Creswell (2013) discussed the tenets of social constructivism as follows:

- *Ontological beliefs* relate to the nature of reality and its characteristics. In social constructivism, qualitative researchers embrace the idea of multiple realities constructed through lived experiences and interactions with others.
- *Epistemological beliefs* arise from the researcher's attempt to get as close as possible to the participants being studied. Knowledge is discovered by the constructivist scholar through the subjective experiences of people, as revealed in dialogue. Reality is co-constructed between the researcher and the researched.
- *Axiological beliefs* account for the role of values. In social constructivism, individual values are honored, and are negotiated among individuals. Subjective meanings arise from interactions with others and through cultural and historical norms.

- *Methodological beliefs* of the social constructivist are characterized as inductive - from the ground up, emerging, and shaped by the researcher's experience in collecting and analyzing qualitative data. In social constructivism, a more literary style of writing is used and data are obtained through interviews, observation, and texts. (Creswell, 2013, p. 19-22, 36)

Existential Phenomenological Philosophy

The basic purpose of existential phenomenology is to describe the universal essence of a given phenomenon. An essence, by definition, is "the basic nature of a thing; the quality or qualities that make a thing what it is" (Merriam-Webster, 2015). A phenomenological study seeks to describe the common meaning and lived experiences of a particular phenomenon from the perspective of several individuals while reducing individual experiences to a description of the universal essence (Creswell, 2013). This research study is based on the philosophical perspective of Maurice Merleau-Ponty who states, "it [phenomenology] tries to give a direct description of our experience as it is, without taking account of its psychological origin and the causal explanations which the scientist, the historian, or the sociologist may be able to provide" (Merleau-Ponty, 1945/1962, p. vii).

Merleau-Ponty rejects the reductionistic theory of Descartes' dualism which separates the mind and body by relying exclusively on the rational mind. Instead, Merleau-Ponty's phenomenological perspective draws on the more holistic Gestalt psychology which places more emphasis on personal meaning and value. Much of Merleau-Ponty's philosophy is based on the work of the German philosopher, Edmund Husserl who first introduced phenomenology in 1900 as a rigorous, scientific approach to research. Merleau-Ponty, like Husserl, believed this method of knowing and talking about human experiences affords a vastly different perspective for viewing the world as compared to rationalism and behavioralism. Key concepts of Merleau-

Ponty's philosophy include: perception, intentionality, situational context, freedom, and figure-ground.

Perception, for Merleau-Ponty, is the primary task for describing the human experience and is concerned with the ongoing exploration and discovery from which a world of things gradually emerge. Simply stated, perception is the way you think about or understand something. Perception is your view or opinion which is construed by past experiences and awareness of a given situation. Merleau-Ponty (1945/1962) also argues, perception "is the background from which all acts stand out, and is presupposed by them" (p. x). Therefore, if perception is the means for understanding the world around us then perception requires constant interaction between person and world.

The concept of *intentionality* includes various types of experiences which are filtered through our consciousness of or about something. Reflection or analysis of an experience then involves a complex account of temporal and spatial awareness, attention, self-consciousness, self-awareness, thinking, acting, embodiment, awareness of others, linguistic activity, social interaction, and our own culture. For Merleau-Ponty, intentionality captures the dialect between person and world as they co-construct one another (Thomas & Pollio, 2002; Van Manen, 2014). The intentionality arc projects the past, present, and future and situates us within the world. It is the intentionality arc that threads or connects the moments of our lives into a unified experience.

The concept of *freedom* suggests there must be room to move and there must be special possibilities or realities; there is no absolute truth (Van Manen, 2014). Merleau-Ponty (1945/1962) suggests that we are born of the world and into the world; therefore we are open to infinite possibilities. People are free to choose their attitude and how to respond to situations which are constantly changing and dynamically shifting human reality (Van Manen, 2014).

The concept of *figure-ground* is most often demonstrated with Edgar Rubin's perceptual drawing of *The Rubin goblet* (Dewey, 2007), also known as "vases and faces" (see Figure 1). If you focus on the white area, the goblet stands out and becomes figural; whereas if you focus on the black areas, two faces stand out and the white becomes the ground. Neither the vase nor the faces can be seen without the presence of the other because they co-create one another as a single event, not a cause and effect. The figure-ground structure of perception is necessary because it allows the person to focus on a perceived image or phenomenon in order to identify it; yet to identify it, you have to be able to distinguish from the whole (Merleau-Ponty, 1945/1962).

Figure 1. The Rubin goblet

Within phenomenology, experience involves passive experiences such as vision and hearing, and active experiences such as walking and talking. Experience can be experienced retrospectively as we focus on what stands out as figural; for example, the smell of cookies may conjure up memories from grandma's house or hearing a song may remind you of someone special. Merleau-Ponty addressed various existential grounds or conditions that help contextualize personal existence. The four grounds of human experience in Merleau-Ponty's philosophy are body, others, time, and world.

Merleau-Ponty did not accept the Cartesian perspective in which the **body** and mind are separate. Instead, he focused on the experience of one's own body being both *in the world* and *of the world.* The body is one's point of view upon the world and one of the objects of that world (Merleau-Ponty, 1945/1962). Three major themes commonly describe the experience and meaning of the body: engagement, corporeality, and interpersonal meaning (Pollio, Henley, & Thompson, 1997; Thomas & Pollio, 2002).

First, *engagement* is concerned with situations in which one experiences his body in terms of full participation. Terms such as vitality (feeling totally alive and absorbed in the world) and activity (concrete movements) are used to describe engagement (Pollio et al., 1997; Thomas & Pollio, 2002). While engaged in the world, at what point does one become aware of our body? *Corporeality* considers the experience of the physical body as an object or subject (Pollio et al., 1997; Thomas & Pollio, 2002; Van Manen, 2014). Corporeality involves awareness, desire, fears, anxieties, body image, touch, sexuality, and secrecy (Van Manen, 2014). *Interpersonal meaning* considers experiences in which the body is described in regards to social or symbolic meaning. Terms such as appearance (open and public) and expression (closed and private) are commonly used to describe the body and body image. (Thomas & Pollio, 2002).

Three major themes commonly used to describe experiences of **other people** are: relationship, comparison, and benefit (Pollio et al., 1997; Thomas & Pollio, 2002). First, *relationships* which may bring about either positive or negative feelings may be categorized as: 1) significant others - close relationships; 2) generalized others - social groups (norms); or 3) other others - people who are simply present in the world. Second, *comparison* involves the tendency to categorize people as similar or different from oneself. Third, *benefit* refers to the

other person's ability to meet our needs and our judgment of whether they are good or bad for us and/or other people (Pollio et al., 1997; Thomas & Pollio, 2002). Van Manen (2014) calls this existential theme *relationality* but ascribes to similar premises.

Merleau-Ponty viewed **time** as a mobile setting moving either toward or away from us. He postulates that it is only in the present that time and consciousness coincide; otherwise, events are experienced in relationship to what went before and what is to come (Merleau-Ponty, 1945/1962; Thomas & Pollio, 2002). Time represents internal and external changes and is commonly expressed as four interrelated meanings: 1) *change and continuity* - captures the essence of things changing yet remaining the same; 2) *limits and choices* - doing things in time, making choices and accepting limits; 3) *now or never* - the most basic experience of time, expressed as a sense of urgency; or 4) *fast and slow* - the rate at which events take place (Pollio et al., 1997).

The fourth existential ground is **world** which encompasses space and place. *Spatial* orientation refers to a point of reference such as: left or right, front or back, above or below as projected from the body. *Place* includes the geographical landmarks that may be used as a guide and human experiences of special places. For example, some people garner a sense of identity from a place that might evoke special memories; others describe a connection with another human or a universal being. For some individuals, a special place offers a sense of security and familiarity, while other places may afford opportunities or possibilities for change and growth. Finally, people express concerned feelings of appreciation, beauty and awe, of their special place in the universe (Thomas & Pollio, 2002; Van Manen, 2014).

In order to increase scientific rigor, Husserl introduced a process of phenomenological reduction, or bracketing, in which the researcher suspends their natural attitude and judgment in

order to scrutinize the data without *a priori* decisions of what will be found. However, Merleau-Ponty (1945/1962) suggested a complete reduction or separation from the phenomenon is not possible because the researcher cannot fully remove himself or herself from the experience. Bracketing sensitizes the researcher to his or her own presuppositions in order not to impose them onto participants during the interview and subsequent interpretation (Thomas & Pollio, 2002; Van Manen, 2014). Other aspects of the phenomenological methodology derived from Merleau-Ponty's philosophy will be discussed in Chapter 3.

Research Assumptions

The assumptions brought to this study are grounded in the literature and my years of experience as a registered nurse and an undergraduate faculty member. The assumptions are:

- New nurses enter a fast-paced, complex, and sometimes hostile healthcare environment.
- New nurses periodically experience lack of self-confidence during the first year of practice.
- New nurses expect to be respected and accepted as part of the team.
- Nurses want to make a difference in the lives of their patients.
- Nurses' provision of quality patient care depends on knowledge, technical skills, interest and satisfaction derived from the work.
- Some nurses enter nursing with a short-term plan to stay at the bedside; staying only long enough to meet criteria for particular graduate programs or specialty jobs.

Conceptual Definitions

Graduate Nurse

According to Merriam-Webster (2015), a *graduate nurse* is "a person who has completed the regular course of study and practical hospital training in nursing school". Taber's Medical

Dictionary (2013) says a graduate nurse is one "who is a graduate of a state-approved school of nursing but has not yet passed the National Council Licensure Examination-Registered Nurse (NCLEX-RN)". Colleges and universities offering masters degrees in nursing refer to the upper-division nursing courses as "graduate nurse programs". Therefore, because of this inconsistent use and meaning, there has been a recent turn away from the use of new graduate nurse in the literature.

Newly Licensed Registered Nurse

The term *newly licensed registered nurse* is appearing in more recent literature and better describes the transition to practice experience which begins as a new graduate but extends beyond the first year of clinical practice. For the purpose of this study, *newly licensed registered nurse* refers to registered nurses with an associates or baccalaureate degree who have practiced less than three years.

Retention /Attrition

According to Merriam-Webster (2015), *retention* is the act of keeping someone or something. In this study, retention refers to hospital administrators keeping employees, primarily newly licensed registered nurses. Retention is not to be confused with the term *attrition* which is a reduction in the number of employees that occurs because people resign or retire and are not replaced (Merriam-Webster, 2015). Retention and attrition are opposites.

Acute care hospital

An acute care hospital is described as an institution offering surgical and medical care for individuals with unexpected serious medical problems that need immediate assessment and treatment; average length of stay is usually less than 30 days ("Medical Dictionary for the Health Professions and Nursing(c) Farlex," 2012).

Limitations

There are several limitations associated with this study. Participants knew the researcher as a faculty member from their undergraduate nursing program; therefore the researchers presence may have biased participant responses. Nonprobability sampling may not reflect the perception of a more heterogeneous sample. Data were collected from Baccalaureate graduates; therefore limiting transferability to graduates from diploma, Associate, RN-to-BSN, or Masters programs. Workplace environment is a significant contributor to turnover and is expected to influence participant responses; however, the researcher had no control over the work-place environment or conditions in which participants were employed.

Delimitations

This study was conducted in one region in southeastern United States. Five hospital systems were represented. The number of months on the job may have affected participant responses; although this was not obvious in the data. Based on the high turnover during the first two years of clinical practice, as discussed in Chapter 2, I chose to interview nurses who had been practicing in their first RN job at least eighteen months but no more than three years after successfully completing the NCLEX-RN.

Significance of the Study

Nurse researchers have been trying to comprehend the issue of high turnover rates and job satisfaction for nearly 75 years (Kramer, 1974; Nahm, 1940). Numerous research studies focus on why nurses leave nursing but the repeated focus on job dis-satisfaction and high turnover rates have not led to significant improvements. In fact, turnover rates among new nurses remain high within the first two years of practice even with the advent of residencies and various orientation programs.

When nurse leaders merely pay attention to problems created by nurse turnover, the remaining new nurses are likely to become discouraged and less optimistic that the problems will ever go away. Shendell-Falik, Feinson, and Mohr (2007) propose, when organizations focus on "what's wrong", new nurses are likely to become more self-conscious and think about what *not* to do to prevent problems from reoccurring rather than focusing on what *they should do* to enhance their performance (p. 69). Cooperrider (2015) posits, "change is more powerful, energizing, and effective when we inquire into the true, the good, the better, and the possible..." (para 2). This study takes a new approach to a long-standing problem and contributes to nursing science by describing newly licensed registered nurses' experiences that keep them in hospital nursing beyond their first years of practice. The nurses' lived experiences take into account the ordinary and the extraordinary, the routine and the surprising, the dull and the ecstatic moments to provide concrete insights into the qualitative meanings of the early years of clinical practice (Van Manen, 2014). As healthcare organizations attend to a national nursing shortage and decreased government funding, maintaining and retaining a satisfied workforce is imperative for safe and quality patient care. Findings from this study may have implications for newly licensed registered nurses, nursing faculty, staff development educators, clinical preceptors, nurse managers, and hospital administrators.

Chapter 2

Review of Literature

The purpose of this research study was to attempt to understand the perceptions and experiences of newly licensed registered nurses who have stayed in their first nursing job in an acute care hospital for at least 18 months. In this chapter, I have presented a review of literature relevant to retention and turnover of newly licensed registered nurses (NLRN) and their reasons for staying in or leaving nursing practice. First, I described the method, databases, and key words used to search the literature. Then I identified themes that emerged from the literature related to NLRN reasons for staying in or leaving nursing practice. Selected literature was examined and critiqued. Finally, I identified gaps in the literature and described how this study contributes to nursing science.

Method of Literature Search

Key terms used in the initial literature search included: newly licensed registered nurse, new graduate nurse, retention, job turnover, intent to leave, and intent to stay. Electronic databases included CINAHL Complete, Academic Search Premier, Humanities International Complete, and PsycINFO. Publication dates range from 1974 to 2014. I performed a cursory review of 191 articles and one dissertation that included the additional term "registered nurse". A total of 24 research articles were evaluated and utilized in this literature review. Inclusion criteria included research using the key terms and peer reviewed publications written in the English language. Intervention studies such as but not limited to nurse residency programs; program evaluations; non-hospital sites such as home health, schools, prisons, skilled nursing facilities; advanced practice nurses, licensed practical nurses, unlicensed assistive personnel, students, and patient reported experiences were excluded. Studies designed explicitly to measure

job or career satisfaction were excluded. Nurses may be unsatisfied and stay in their jobs or be satisfied with nursing but leave for other reasons.

The literature pertaining to retention of newly licensed registered nurses was categorized into the following areas for discussion and critique: foundational theory, transition experiences, predicting turnover intention, workplace environment, reasons for leaving, and why stay in nursing.

Foundational Theory

Kramer (1974) was the first researcher to suggest reality shock as a significant factor contributing to attrition. She was among the first nurse scientists to propose interventions to reduce job hopping or exodus from nursing practice for new graduates. Reality shock manifests in a variety of ways but has a discernable pattern consisting of four phases: honeymoon, shock or rejection, recovery, and resolution. Upon entry into clinical practice, the honeymoon phase begins. The new graduate nurse is fascinated with the new job; colleagues buffer and intercede in a way of protecting the new nurse from the realities of the job, but only for a little while. Once the new nurses begin to experience rewards and sanctions related to their work behaviors, they begin to experience the conflict between the ideals of school and the realities of work. The shock or rejection phase is the most crucial and pivotal time in the new nurses' experience. The nurse may feel rejected and alone, often wanting to transfer to another unit or leave nursing altogether. New nurses may choose to abandon their school ideals completely and become a "super-efficient bureaucratic technician" (Kramer, 1974, p. 6) or they may feel defeated and even blame themselves when they are not successful. New nurses often demonstrate hostility, anger, depression, withdrawal, vocal criticism, and excessive fatigue during this time. Left unattended to, these graduates are most likely to job hop or leave nursing. The healing process begins in the

third phase; recovery begins when the new nurse experiences less tension and begins to demonstrate a sense of humor. As the nurse gains competence and self-confidence, she is able to assess the situation and objectively evaluate her options in an appropriate manner.

Kramer believed senior staff nurses, nurse managers, and hospital administrators would be better equipped to implement strategies to retain a happy, effective nursing workforce if they recognized the signs of reality shock. Yet over the past 40 years, nurses have continued to leave their nursing positions at alarmingly high rates.

Transition Experiences

As a result of high turnover among newly licensed registered nurses (NLRN), much of the literature pertaining to the early years of practice focused on the transition to practice experiences and the effectiveness of various orientation programs. Even though intervention studies were excluded in the search process, I would be remiss to not mention nurse residency programs because of their proliferation during the past ten years. Nurse residency programs have been recognized as a viable option to affect employee competence, confidence, and job satisfaction while also improving recruitment, retention, turnover rates, and cost for the employer Krugman et al., (2006). For this literature review, I focused primarily on qualitative research studies to better understand NLRN entry to practice experiences that may later influence their decision to stay in or leave their first nursing position.

Four qualitative studies examining various transition experiences in the United States of America (USA) and Australia were selected for this review. Research methods included phenomenology, grounded theory, and appreciative inquiry. I will begin this portion of the literature review by examining a study focused on the transition from school to nursing practice.

Then I will examine two studies focused on the first year of practice then conclude with a single study that extended up to 18 months of clinical practice.

I was not familiar with the theoretical framework of appreciative inquiry (AI), but was intrigued by Chandler's (2012) approach to examine first-year nurses' *success* rather than problems as they transitioned from school to clinical practice. Chandler's research was based on the AI assumptions of Sue Hammond, not the founder of AI theory. Chandler's discussion reflects Hammond's AI assumptions:

- In every society, organization or group, something works.
- What we focus on becomes our reality.
- Reality is created in the moment and there are multiple realities.
- The act of asking questions of an organization or group influences the group in some way.
- People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known).
- If we carry parts of the past forward, they should be what is best about the past.
- It is important to value differences.
- The language we use creates our reality (Hammond, 2013, p. 2)

Five semi-structured questions guided the interviews. Nurses (n=36) from the United States described scenarios from recruitment, orientation, or clinical experiences to indicate they never felt alone. Staff nurses and managers were praised for allowing novice nurses to ask questions and for providing feedback and support while they learned new skills and routines. Preceptors were identified as enthusiastic and intentional with teaching and socializing skills. Both novice and experienced nurses recognized that not asking or answering questions

jeopardized quality patient care; therefore, novice nurses were encouraged to ask questions. The final theme, nurturing the seeds, referred to the new graduate's academic preparation with most of them acknowledging the need for more clinical practice. Participants not only recognized the steep learning curve but also realized skills such as prioritizing, time management, delegation, communication, and critical thinking come with on-the-job experience (Chandler, 2012).

Chandler's research team consisted of one university faculty member and six research student assistants from six nursing programs. There was no indication of faculty expertise nor how student assistants were trained prior to conducting interviews in their respective schools. The fact that students were interviewing other students from their own school has the potential for bias but this was not addressed by the author.

The next two studies examined the lived experiences of NLRN in the USA and Australia during the first year of clinical practice. Zinsmeister and Schafer (2009) used six standardized, sequenced, open-ended questions to interview nine participants on the east coast of the United States. Positive transition experiences during the first 6-12 months were related to: (a) a supportive work environment, (b) positive preceptor experience, (c) comprehensive orientation process, (d) sense of professionalism, and (e) clarity of role expectations. These findings, along with varied levels of self confidence during the first six months, were consistent with Kramer's (1974) Reality Shock theory and with Krugman et al's. (2006) research with nurse residency programs. Researchers reiterated the importance of examining orientation programs and professional development needs for clinical preceptors.

Asking "standardized questions" is not consistent with most phenomenological approaches, which emphasize nondirective interviewing. Otherwise, Zinsmeister and Schafer (2009) adhered to the tenets of phenomenology; interviews were held in a private area, audio-

taped, transcribed verbatim, and underwent an extensive four-level coding process. Both researchers participated in a bracketing interview *prior to data analysis*. According to Van Manen (2014) the researcher should be aware of the inclination to be led by preunderstandings, frameworks, and theories. As such, bracketing interviews would have been more beneficial if completed prior to interviewing the participants. Interviews conducted at the place of employment may have negatively affected the participant's anonymity and confidentiality.

Nine Australian new graduates participated in three in-depth interviews to describe their transition to and through the first year of practice (Malouf & West, 2010). F*itting in* emerged as a primary determinant of their clinical success. During the second interview, the notion of fitting in with staff wrought anxiety for Vanessa as she observed the new ward routine and thought about becoming part of the team: "... Will I be the same as the people here?" "...will I be able to make friends here?" (Malouf & West, 2010, p. 489). The concept of socialization into the workgroup and being accepted by professional peers was a significant component in Kramer's (1974) theory and continued to be a significant finding in Chandler's (2012) study.

In addition to fitting in, Malouf and West's (2010) participants did not want to appear stupid to the new workgroup. Vanessa noted, "... sometimes you question yourself, whether it's too stupid to ask. ... You ... don't want to appear too stupid asking some simple questions..." (Malouf & West, 2010, p. 490). However, another graduate realized it was less stressful to simply acknowledge he didn't know everything than to worry about what other people thought of him. This finding was different from Chandler's (2012) study, wherein NLRN indicated their preceptors encouraged them to ask questions in order to foster quality patient care.

Fitting in, emerged again in Malouf and West's third round of interviews. As participants rotated from familiar to unfamiliar clinical environments as part of their transition to practice

experience, they not only had to learn new skills, but also had to learn how to integrate into a new workgroup. Amanda reported, "So each time when you go to a new place, there is a new set of expectations... ... I think the first month of each new rotation is extremely stressful" (Malouf & West, 2010, p. 491). Participants were allowed to stay in a unit if they felt comfortable and confident enough to withdraw from the transition program. Based on the findings reported in this study, rotating new graduate nurses through the range of clinical specialties was more of a burden than a valued experience for a beginning nurse.

Malouf and West (2010) interviewed nine Australian new graduate nurses on three different occasions. During the first interview, participants were asked to describe any transition experience; in the second and third interviews, participants were asked to describe their transition to and through their first year of clinical practice. Malouf and West identify their study as grounded theory based on criteria set forth by Glaser and Strauss (1967) and described the processes essential to grounded theory, i.e., (a) simultaneous data collection, analysis, and interpretation, (b) selective and theoretical coding, (c) memo writing, and (d) diagram illustrations. However, I would argue the study described was more in line with phenomenology than grounded theory. Aside from all participants experiencing the same year-long transition process, I do not find evidence where the themes have been used to generate either a substantive or formal theory (Glaser & Strauss, 1967). Had the researchers adhered to a grounded theory methodology, a substantive and inductive theory would have resulted from the analytic procedures. There was no evidence of comparative analysis with different groups, and the only theoretical discussion mentioned was used to guide the analysis of the current study. Scheff 's interconnecting systems of communication and deference/emotion along with Cooley's work with role taking and self-sentiments contributed to the analysis of the experiences of the NGN

participants in Malouf and West's 2010 study. Nonetheless, participants provided rich data and proposed the need for clear distinction between transition and orientation. Malouf and West also concluded that multiple rotations to expose new nurses to many clinical areas may conflict with the developmental needs of a beginning nurse. The pervasive need to fit in was also prevalent in the next study.

In the last study, five newly licensed nurses within their first 18 months of employment on a medical/surgical unit in a hospital were invited to, talk about what it's like being a newly licensed nurse (Pinchera, 2012). Relationships and the desire to fit in were crucial for the new nurses survival and significantly influenced their self confidence. This finding provided additional support for Malouf and West's (2010) theme of fitting in. Participants were happy with their career choice but reported emotions such as fear, feeling overwhelmed, powerlessness, lack of confidence, and feeling like they were not academically prepared for the level of responsibility. Initially, participants were challenged in the area of efficiency but over time they learned how to prioritize, delegate, and provide quality care. After a period of adjustment, participants began to enjoy their work and shifted the focus from tasks to holistic practice. Chandler's (2012) participants also reported a steep learning curve but purported certain skills can only be learned on the job.

Interviews were audio-recorded and transcribed verbatim then data were analyzed using the Colaizzi methodology. I noted Pinchera used only five of Colaizzi's (1978) seven procedural steps which accounts for the limitation pertaining to transferability. Pinchera did not validate findings with participants but instead established rigor with Lincoln and Guba's (1985 as cited in Powers & Knapp, 2011) trustworthiness criteria: credibility, dependability, confirmability, and transferability. While these criteria are acceptable for qualitative research, the "Demographic

and other descriptive information" collected by Pinchera was not sufficient for readers to determine whether findings are meaningful to other persons. By not validating findings with participants, Pinchera had no opportunity to revise the final description of the essence of the phenomenon (Colaizzi, 1978, pp. 48-71).

Section Summary

A variety of qualitative study designs were introduced in this section of literature; however, I was concerned with the lack of adherence to the proposed research methodologies. Nonetheless, findings were similar and provided support for previous research. Transition experiences continued to support Kramer's foundational work with the reality shock theory. Evidence of decreased self-confidence midway through the first year of practice and difficulties integrating into a new group continued to be significant concerns for NLRN entering the workforce. The notion of fitting in emerged as a primary determinant of survival for the new nurses in two of the four studies. Thus, NLRN relationships with colleagues and socialization into the workgroup may influence the NLRN decision to stay in or leave their current nursing position.

Predicting Turnover Intent

A large volume of literature pertaining to newly licensed registered nurses fell under the realm of predicting turnover. Since predicting implies a causal relationship, the majority of research in this area was quantitative by design. Seven quantitative and two mixed methods studies aimed at identifying factors related to NLRN turnover within the first one to three years of practice were included in this review. Qualitative findings were retrieved from the mixed methods research. I will start this section with a single quantitative study designed to measure education as a determinant of career retention. Then the remaining quantitative studies aimed at

predicting turnover among NLRN in the USA, Korea, Canada, and Australia will be examined. I will conclude this section with a review of two mixed methods studies addressing NLRN intent to leave.

The first study in this section was specifically designed to measure education as a determinant of career retention and job satisfaction among registered nurses in the state of Vermont. The sample included 379 associate degree (AD) and 499 bachelor of science degree (BS) nurses. Rambur, McIntosh, Val Palumbo, and Reinier (2005) utilized findings from a larger mail survey, "The RN Job Analysis and Retention Study" to examine relationships among various factors, e.g., job design, job satisfaction, intention to remain in nursing. There was no discussion or evidence of a guiding theory. Response rate (56.7%) for the mailed survey was acceptable. Factor analysis narrowed 21 items down to six factors with alpha scores .72 to .88; the six dimensions explained 71% of the variance in job satisfaction (Rambur et al., 2005). Two questions to measure intention to quit were pilot-tested but there was no further discussion on this construct. BSN-prepared nurses started their careers earlier, were employed longer, experienced more job mobility, stayed in their current job at least 10 years, and scored higher in job satisfaction (Rambur et al., 2005). Factors contributing to higher job satisfaction included: greater autonomy, job stress and physical demands, and job security. It was suggested that AD nurses started their career later in life and dropped out earlier; thus BSN-prepared nurses yield a better return on investment (Rambur et al., 2005). There were no significant differences between the cohorts in satisfaction with supervision, career, continuing education, promotion opportunities, pay, or benefits (Rambur et al., (2005). However, in a later study using principal components analysis, Unruh and Zhang (2013) refuted demographic variables such as age and education as significant predictors for professional commitment and intent to leave nursing.

Kovner, Brewer, Greene & Fairchild's (2009) generated an enormous amount of data with a 16-page mailed survey designed to predict satisfaction, organizational commitment, and intent to stay with NLRN (n=1933) across 34 states. Participants had taken and passed the NCLEX in 2004-2005. A very brief overview of an ordered probit model was provided along with nine pages of detailed statistical tables describing each variable, correlating response options, and statistical values. There was evidence of a guiding theory and presentation of a revised theoretical framework. The ordered probit model allowed participants to indicate their preference, e.g., 0-20, for each variable as a means to assign an order to the possible responses rather than being forced to select researcher-defined interval points (McKelvey & Zavoina, 1975).

Participants who intend to stay had higher satisfaction and organizational commitment. Nurses who worked on general medical-surgical units, eight-hour shifts on any unit, and were full-time employees had the highest satisfaction and organizational commitment. Ethnicity and gender were significant predictors of satisfaction, e.g., a white female participant had higher probability of being satisfied, whereas, the size of hospital and increased job opportunities decreased satisfaction and commitment scores. Nurses were less committed to the organization when they were required to work mandatory overtime, had higher patient loads, and had children at home. Concern with higher patient loads was often attributed to higher turnover among NLRN (Bowles & Candela, 2005; Parker, Giles, Lantry, & McMillan, 2014; Simons & Mawn, 2010; Skillman et al., 2010). Although children were not specified, Skillman et al. (2010) cited home and family responsibilities as reasons for not working.

Age and income were significant predictors of intent to stay, e.g., older nurses and those with higher spouses' income were more likely to stay. Participant ages ranged from 19-69, but

Kovner et al. (3009) did not define "older". Work attitudes, i.e., organizational commitment, autonomy, promotional opportunities, and fewer job opportunities were identified as significant predictors for intent to stay. It was also noted that nurses with BS degrees had less intent to stay in their current job than diploma, master's or doctoral-prepared nurses. However, findings in other studies (Bowles & Candela, 2005; Rambur et al., 2005) refuted the notion that the level of education influences NLRN job satisfaction or intent to leave. The demographic table noted 53.7% of the study sample were associate degree nurses yet they were not included in the probit model for intent to stay. Kovner et al. (2009) recommended employers consider opportunities to decrease patient load and mandatory overtime as a means to decrease turnover among NLRN and to control the cost of healthcare.

As I examined the next study, I noted the two lead authors, Brewer and Kovner, contributed to five studies in this literature review; therefore, the findings in the study being reviewed next were similar to their previous research findings. Brewer, Kovner, Greene, Tukov-Shuser, and Djukic (2011) presented a two year longitudinal study to examine factors that affected organizational turnover among NLRN in US hospitals. They found a complex issue with no one solution to fix it. The sample size (T_1 n=3380; T_2 n=2395) was larger than required by the power analysis and number of variables used; and participants were excluded if they had changed jobs more than one time during the study period. Data were collected one year apart, using a 16-page mailed survey. The Brewer-Kovner synthesis model of direct turnover was an expanded version of Price's conceptual framework designed for organizational turnover. At the second report, 1700 nurses worked in a hospital one year after graduation; 47 people were excluded because they were in their third job at year two. The remaining 1653 participants were still in their first or second job, or unemployed at time two (Brewer et al., 2011). Of the 15%

who left their first job, 92% of them still worked in jobs that required RN licensure; only 3% worked in jobs that did not require licensure and 5% were unemployed. The majority (94%) of NLRNs remained employed in a hospital but many changed jobs within the first two years.

As previously reported, nurses who left the hospital most often moved to ambulatory care or public health agencies (Brewer et al., 2011; Kovner, Brewer, Fatehi, & Katigbak, 2014). Further inquiry suggested those who left nursing did so because of physical injuries such as sprains and strains (Brewer et al., 2011; Skillman et al., 2010). Of the NLRNs who left their employer by year two, 40% reported at least one strain or sprain on the first survey and 19% of them left their job by year two. The concept of fit was first introduced in the transition to practice section (Malouf & West, 2010; Pinchera, 2010) but had relevance in the current study. Brewer et al. (2011) suggested that RNs who work full-time wanted a job that fits their needs; therefore were more likely to change jobs until they find what they are looking for. On the other hand, a nurse who feels stuck in her current position, e.g. financial reasons, may negatively affect the workplace and contribute to a culture where others do not want to work.

Brewer et al. (2011) took their research a step further and estimated the employer's financial burden for high turnover rates. Using 2006 salary figures for NLRN, the first year turnover rate of 15% was estimated to cost $728 million. In subsequent years, turnover rates of 26% (year two) and 43% (year three) resulted in an estimated $1.4-2.1 billion in turnover costs to the US healthcare system (Brewer et al., 2011). Brewer et al. (2011) proposed that factors influencing intent, satisfaction, and organizational commitment also affect turnover, and like others (Kovner et al., 2014; MacKusick & Minick, 2010; Skillman et al., 2010) suggested intervention before the nurse forms an intent to leave or starts a job search.

The purpose of the next study was to examine factors related to turnover of new graduate nurses in Korea. Assuming job dissatisfaction to be a greater influence on turnover than a positive attitude (job satisfaction), Cho, Lee, Mark, and Yun (2012) focused on the negative attitude of dissatisfaction among 351 new graduate nurses (75% diploma trained; 25% BSN) working in Korean hospitals over a three year period. The authors used a conceptual model consisting of four areas of turnover predictors to guide this study: (a) individual and family, (b) nursing education, (c) hospital characteristics, and (d) job satisfaction.

Cho et al. (2012) estimated the survival curves of new graduates and examined factors related to turnover using survival analysis. This statistical approach provided important information regarding the timing of turnover whereas other commonly used statistical measures, such as logistic analysis with dichotomous dependent variables would only indicate if the participant stayed or left the job. Survival analysis is a parametric regression statistical procedure used to "characterize the distribution of the survival time for a given population, to compare the survival distributions among different groups, or to study the relationship between the survival time and some concomitant variables" (SAS Institute, Inc., 2008, p. 255).

As a result of this three-year longitudinal data collection, survival analysis was able to show 26% of the sample left by year two and 45% left before the third year survey. Using a 95% confidence level, the annual estimated probability scores for new graduate survival (0.823, 0.666, and 0.537 respectively) indicated a continual departure from nursing each year. The log-rank test was an appropriate indicator for trend because the interval (one year) between each measure was equal (GraphPad Software, Inc., 2013, para. Logrank). Survival curves provided data regarding overall dissatisfaction across three years (0.541, 0.320, and 0.182 respectively) using the log-rank test $p < .001$. With the low p-value, the conclusion was a significant trend

toward dissatisfaction and a higher probability of leaving their first job. As expected, nurses who were satisfied showed significantly higher scores (0.882, 0.738, 0.610, respectively) across the same three year period. Job dissatisfaction leading to turnover was most often attributed to interpersonal relationships, work content, and the physical work environment which was typical of most studies in this literature review. In addition, working in a unionized hospital correlated with less turnover but greater job dissatisfaction. Cho et al. (2012) found diploma trained nurses more likely to leave than BSN-prepared nurses but were not convinced that a study less than four years after graduation was a good predictor for turnover related to nursing education. Cho et al. proposed studies at five and ten year post-graduation may better reflect survival rates.

Laschinger (2012) described work-life experiences of 342 Canadian new graduate nurses to determine predictors of job and career satisfaction and turnover intentions during the first two years of practice during a nursing shortage. Laschinger used a conceptual framework, "New Graduate Nurse Worklife and Retention Model" from management literature. Multiple regression analysis indicated situational and personal factors explained significant amounts of variance in the new graduates' job satisfaction (59%) and turnover intent (40%). Negative work experiences found in this study were congruent with findings, e.g., incivility and bullying (Budin, Brewer, Chao, & Kovner, 2013; Simons & Mawn, 2010), burnout; work engagement, and poor mental and physical health (Brewer et al., 2011; MacKusick & Minick, 2010; Skillman et al., 2010), all of which contributed to low job satisfaction and turnover intent. Laschinger (2012) was encouraged to find relatively low levels of incivility and bullying in the current study but noted higher levels during the first year of practice contributed to higher dissatisfaction and turnover.

Cynicism was identified as a factor of "burnout" and was reported to be a strong determinant of job dissatisfaction and a strong predictor for both career satisfaction and turnover intent in the second year of practice (Laschinger, 2012). Organizational support (e.g., amount of time in orientation and number of clinical preceptors) was also significantly related to job and career satisfaction and turnover intent. In addition, Laschinger (2012) found the more preceptors associated with a NLRN during the first year of practice, the greater intent to leave. Laschinger also suggested nurse managers improve the *fit* (Brewer et al., 2011; Malouf & West, 2010; Pinchera, 2012) for nurses by addressing work load, job control, rewards, sense of community, fairness, and values in order to retain them in the workforce.

Next, Brunetto et al. (2013) used the Social Exchange Theory as a lens to examine the impact of workplace relationships on engagement, well-being, organizational commitment, and turnover intentions among nurses in the USA and Australia. Self-report surveys using previously validated scales were used to measure six constructs: 1) quality of relationship with supervisor; 2) satisfaction with teamwork; 3) perceived organizational support and well-being; 4) employee engagement or state of fulfillment; 5) organizational commitment; and 6) turnover intention. Study limitations were appropriately addressed along with efforts to reduce method bias. Structural equation models predicted 13 of 17 factors for Australian participants (n=510) whereas only 10 of 17 factors were predicted for USA participants (n=718). Confirmatory factor analysis (CFA) determined the best fitting models and were presented in table and text. Brunetto et al. (2013) provided a detailed discussion of factor loading, cross validation, and invariance testing. Seventeen hypotheses were projected at the beginning of the study, presented in table format, and discussed in text. For this review, findings were limited to factors predicting organizational commitment and turnover.

Turnover and organizational commitment were predicted by nurses' perceived organizational support, engagement, and well-being. Organizational commitment also predicted turnover. Supervisor-subordinate relationships and teamwork were significant predictors for turnover or organizational commitment in Australia, but not in the US population. Perceived organizational support predicted employee engagement, organizational commitment, and turnover intentions in both countries. However, none of the paths related to supervisor-subordinate relationships nor paths from teamwork to organizational commitment or turnover were significant in the US. This finding was contradictory to other USA studies in which teamwork and relationships with coworkers and managers were important to participants (Bowles & Candela, 2005; Chandler, 2012; Pinchera, 2012; Zinsmeister & Schafer, 2009).

Engagement was not clearly defined; however, "most scholars agree that engaged employees have high levels of energy and identify strongly with their work" (Brunetto, 2013, p. 2788). Well-being was described as, "attitudes about the work context" (Brunetto et al., 2005, p. 2789). Engagement and well-being predicted organizational commitment and turnover for nurses in the US but not Australia (Brunetto et al. 2005). Chandler (2012) described positive attitudes among NLRN through the use of appreciative inquiry; however, most researchers emphasized negative attitudes expressed by NLRN (Budin et al., 2013; Cho et al., 2012; MacKusick & Minick, 2010; Malouf & West, 2010; Pellico, Brewer, & Kovner 2009; Simons & Mawn, 2010; Skillman et al., 2010). Many recommendations have been proposed throughout this literature review to decrease turnover among NLRN, yet nurses continue to leave. Brunetto et al. (2013) recommended nurse managers consider employee engagement and well-being as antecedents to organizational commitment and turnover.

In the next two mixed methods studies, both qualitative and quantitative data relevant to retention of NLRN will be examined. The first was a pilot study designed to explore NLRN expectations, perceptions, satisfaction, and intent to leave at the end of their first year of employment in a Level 1 trauma academic hospital (Gill, Deagan, & McNett, 2010). The Price Mueller conceptual framework, used extensively to examine employee turnover, was evident in this study. Each participant was interviewed after one, six, and 12 months of employment. Interview questions were structured, but open-ended; all sessions were audio-recorded, transcribed, and coded according to Miles and Huberman (1994) approach. After each interview, participants completed a 10-item job perception and satisfaction survey. Instrument reliability and validity were discussed; findings were reported in text and table formats.

Two qualitative themes emerged from the data: 1) establishing relationships and 2) learning the job (Gill et al., 2010). New nurses expected to be viewed as a contributing team member of the healthcare team by the end of the first year; therefore establishing relationships with various members of the healthcare team was important to each of them. This finding mimics those of participants in earlier studies who were concerned about fitting in with their colleagues (Brewer et al., 2011; Malouf & West, 2010; Pinchera, 2012). In addition, new nurses expected a challenge while learning their job which involved learning roles and responsibilities, being able to manage the workload, finding equipment, scheduling, and knowing how to act in a crisis (Gill et al., 2010). Typically nurses moved from a task-oriented perspective to becoming more comfortable with new roles/responsibilities by the end of the first year. The quantitative data demonstrated NLRN satisfaction with physicians improved over the first year while satisfaction with the nurse manager and coworkers declined. Responses to the intent to leave question revealed most nurses considered leaving their unit or the organization a few times per

month, but very few considered leaving nursing altogether. Gill et al. (2010) recommended staff development professionals develop programs to ensure positive experiences and smooth transitions from school to practice.

A mixed-methods cross sectional design was used to identify factors that impacted new graduates' experiences upon entry into practice, satisfaction, and likelihood of retention (Parker, Giles, Lantry, & McMillan, 2014). There was no evidence of a guiding framework; the survey instruments were designed by the researchers and modified after content validity by expert reviewers. A total of 282 new graduate nurses in Australia responded to an online survey and 55 attended one of seven focus group sessions. In general, new nurses were clear about their roles and responsibilities but were not clear about what other people expect of them. Participants (10%) indicated an intent to leave the nursing profession because of the negative workplace environment; on the other hand, 55% indicated an intent to stay at least five years. There was a pivotal 32% who did not know how long they would stay in nursing and 3% anticipated staying less than two years (Parker et al., 2014). When describing the workplace, 93% reported their work was emotionally challenging; 94% reported a heavy workload; and 93% acknowledged their work was physically demanding. Only 30% of participants rated nursing morale as good; 77% attested to high stress levels with over half of the respondents acknowledging supportive colleagues and teamwork. Respondents were satisfied with education opportunities (47%), career development (41%), personal praise and recognition (32%). Participants were least satisfied with workload (20%), work life balance (19%), and pay (20%). Parker et al. (2014) recognized that new graduates were unrealistically expected to be ready to assume their role in the workplace from the very beginning and that new graduate satisfaction was contingent upon a collective experience not a single event. For most new nurses, the experience was negative and

may have been attributed to the lack of experienced nurses in the workplace. Therefore, nurse managers were encouraged to develop a stronger support network for new nurses and a career path to keep highly skilled nurses in those support roles.

Section Summary

Most NLRN were staying inside the hospital but were changing jobs within the first two years. Orientation for NLRN varied in program content and length of time, but all NLRN entered a physically demanding and emotionally challenging work environment right after school. The NLRN expected challenges during the first year as they learned their roles and responsibilities, time management, delegation, and how to deal with patient care crisis, but they also expected respect and to be accepted as part of the team within the first year. Often, NLRN perceived less support from their staff nurse colleagues and nurse managers near the end of the first year. On the other hand, as the NLRN adapted to their professional role, they became more comfortable and satisfied with physician relationships. When the NLRN experienced unprofessional behaviors or did not fit-in with the work group or unit culture, they often considered leaving their unit or organization a few times per month. NLRN who expressed an intent to leave perceived decreased organizational support, unprofessional behaviors, bad moral, high stress, too many preceptors, and overall job dissatisfaction. Income, age, hospital size, and unit type were inconsistent factors to predict NLRN turnover. Whatever the cause, turnover among NLRN resulted in astronomical cost; nurse managers and hospital administrators need to improve efforts to retain NLRN.

Workplace Environment

Up to this point in my review of literature, workplace environment was evident as a contributing factor to NLRN turnover, but the individual studies were not focused solely on the

work environment. Typically, quantitative data revealed more negative workplace experiences (Cho et al., 2012; Laschinger, 2012; Parker et al., 2014); whereas Zinsmeister and Schafer's (2009) qualitative study suggested a supportive work environment. Six additional studies purposely designed to address NLRN workplace experiences were examined in this section. I will first discuss three quantitative studies which addressed characteristics of nurses most likely to experience verbal abuse and the influence of the hospital work environment on commitment and intent to leave nursing. Next, I examine two qualitative studies with nurses in the USA. I conclude this section with a qualitative comparison between NLRN and nurse managers perception of factors affecting NLRN during their first year of practice.

The first study provided demographic characteristics of nurses most likely to experience verbal abuse. Forty-nine percent of early career RN participants (n=1407) reported verbal abuse in the form of being ignored or spoken to in a condescending manner by a colleague at least one time in three months (Budin, Brewer, Chao, & Kovner, 2013). Nurses most likely to experience verbal abuse were described as unmarried; working in a hospital; exhibiting decreased autonomy, low job satisfaction and organization commitment, and little intent to stay in their current position. These characteristics were descriptive of most NLRN entering the workforce for the first time and provided support or rationale for high turnover within the first two years of practice. There was no reference to a guiding framework yet Budin et al. (2013) boasted of working "in the context of a methodologically rigorous survey design" (p. 310).

Two studies compared nurses perception of the work environment in Magnet and non-Magnet status hospitals in the USA. In Budin et al's. (2013) study of 1407 early career RNs working in Magnet (n=305) and non-Magnet (n=710) hospitals, nurses reported moderate (Magnet 22.9% ; non-Magnet 47.4%) and high (Magnet 14.9%; non-Magnet 52.7%) levels of

verbal abuse. In Hickson's (2013) study of 1165 new graduate nurses (226 Magnet, 939 non-Magnet), there was only marginal positive differences in Magnet hospitals in regards to exposure to hostility and job satisfaction. Hickson's study was guided by the Oppression Theory, developed by the theorist who presented the term horizontal violence. In both studies, there was an inverse relationship between verbal abuse and job satisfaction, organizational commitment, and intent to stay. Job satisfaction was higher in Magnet hospitals yet participants from both settings agreed on the top four contributing factors: physicians, delivery of care method, social contact at work, and interact professionally with other disciplines. Significant differences were found in the Magnet nurses' satisfaction with professional comfort, confidence, and support; however, communication with patients/families scored the highest for both Magnet and non-Magnet nurses (Hickson, 2013).

Hickson (2013) identified low satisfaction scores among all new graduates. NLRN indicated they were not receiving support from nurse managers and peers, thus their confidence and comfort were low. Likewise, Budin et al. (2013) found new nurses were most vulnerable to the effects of verbal abuse from nurse colleagues during the orientation. In Hickman's (2013) study, nearly half of Magnet and non-Magnet nurses self-reported being a victim of bullying several times a week to almost daily. Being "exposed to an unmanageable workload" was the most frequent negative act and "given tasks with unreasonable deadlines" was the second most frequent occurrence (Hickman, 2013). Support for these findings was evident in other research, e.g., support of colleagues (Brewer et al., 2011; Cho et al., 2012; Gill et al., 2010; Parker et al., 2014), and unreasonable expectations, including patient load (Cho et al., 2012; Kovner et al., 2009; Unruh & Zhang, 2013). However, Budin et al. (2013) found that even though many nurses were not satisfied with their workplace conditions, they were not deterred from continuing their

careers in nursing. Nurses who experienced no abuse (57.4%) and those who experienced moderate (50.4%) or high (27.1%) levels of abuse reported no plan to leave within the next three years.

Even though there was a correlation between poor working conditions and verbal abuse, Budin et al. (2013) did not assume a causal relationship. Instead, Budin et al. suggested many nurses may not be aware of their behaviors, the effect of their behavior on their colleagues, or the behaviors have become ingrained and accepted as part of the workplace culture. Budin et al. (2013) and Hickson (2013) recommended hospital wide education and training to inform all employees that negative, disruptive, or bullying behaviors will not be tolerated. Hickson (2013) suggested the principles of and appropriate responses to horizontal violence be incorporated earlier, in the academic environment. Nonetheless, there was consensus to develop strategies and interventions to decrease workplace abuse.

The focus of the next study was to assess the influence of the hospital environment on NLRN commitment to nursing and their intent to leave (Unruh & Zhang, 2013). Magnet status was not a factor in this study. The Dillman (2000) Tailored Design Method was used to distribute surveys to 414 NLRN licensed in the state of Florida (n=3027) in the year 2006. Unruh and Zhang performed principal components analysis (PCA) with an oblique rotation on the two dependent variables, professional commitment and intent to leave nursing, and on the three independent variables: job difficulty, job demand, and job control. These three constructs (job difficulty, job demand, and job control) served as the conceptual framework and were evident throughout the study. Coefficients of determination (R-squares) explained the amount of variance among the variables.

Most nurses had positive attitudes about nursing and 53% wanted to stay in nursing even if they did not have to work (Unruh & Zhang, 2013). This finding was a stark contrast to nurses who already left or reported an intent to leave their job within one to five years (Brewer et al., 2011; Cho et al., 2012; Parker et al., 2014). Significant predictors for higher professional commitment and lower intent to leave nursing were: RNs who were white, in better health, perceived orientation to be good, worked day shift, worked more hours, perceived less job difficulties and demands, and more job control. Factors that contributed to lower professional commitment and greater intent to leave were discussed for each independent variable: job difficulties, job demands, and job control.

Job difficulties were related to organizational rules and procedures, interruptions, incorrect instructions, inadequate help, and lack of supervisor support. The second variable, job demands, included having to do more than can be done well, having no time to get things done, working very hard, and working very fast. The third and final variable, job control, included the ability to act independently of others, including supervisors, and the ability to make decisions and carry them out. Unruh and Zhang acknowledged but refuted limitations such as generalizability and low response rate (18%) because the bias analysis found the study sample demographics to be fairly representative of all 2006 NLRN in the state of Florida and Florida was representative of the USA nursing demographics - but not internationally. Therefore, Unruh and Zhang recommended more international studies to determine if NLRN in other countries perceive similar workplace environmental challenges.

Findings of Unruh and Zhang were consistent with findings throughout this literature review. Numerous reports of working in a stressful environment (Bowles & Candela, 2005; Cho et al., 2012; MacKusick & Minick, 2010; Parker et al., 2014; Skillman et al., 2010) and lack of

support from colleagues and managers (Bowles & Candela, 2005; Cho et al., 2012; Laschinger, 2012; MacKusick & Minick, 2010; Parker et al., 2014; Simons & Mawn, 2010) emerged in this literature review. Participants in other studies also reported heavy workloads and too much responsibility too soon (Bowles & Candela, 2005; Parker et al., 2014; Pellico et al., 2009). Self-confidence, which would enable NLRN to act independently and increase opportunities for them to influence decisions was addressed in numerous studies (Chandler, 2012; Laschinger, 2012; Parker et al., 2014; Pinchera, 2012; Walker, Earl, Costa, & Cuddihy, 2013; Zinsmeister & Schafer, 2009).

A secondary analysis and open-ended comments on a large national study were utilized by Pellico, Brewer, and Kovner (2009) to solicit NLRN perceptions of their work environment. A secondary analysis of data was not as strong as working with original data but the response rate of 56% (n=612) was credible and included nurses from all levels of education and across the United States. The procedure describing content analysis corresponds with Krippendorff's six steps: design, unitizing, sampling, coding, drawing inferences, and validation (Krippendorff, 1989). Participant comments of near 25,000 words were typed into an excel spread sheet, reread for accuracy, coded and clustered, then collapsed into five themes: colliding expectations, the need for speed, you want too much, how dare you, and change is on the horizon.

New nurses experienced colliding expectations between their personal ideal and the reality of clinical practice. NLRN expected "to be appreciated and respected with adequate resources and support" (Pellico et al., 2009, p. 196). The participants referred to the need for speed, e.g., being "forced off orientation early" (p. 197). New nurses perceived stakeholders wanted too much from them - too much work, responsibility, and pressure with too little reward while also dealing with incivility and hostility among colleagues and superiors. One participant

wrote, "my workload is the same as a veteran 20 year nurse..." (p. 197); another wrote, "...at the end of a shift, it is this group (mean, unsupportive) who has the ability to alter one's perception of job satisfaction...it is difficult always to work in a culture of negativity and mean spirit" (p. 199). Although new nurses expected challenges during the first year, most of them anticipated things would improve over time. One participant wrote, "after the first six months, these struggles subsided. I love my job and it is very rewarding but those first six months came very close on many occasions as making or breaking me" (p. 199). Pellico et al. (2009) noted widespread dissatisfaction among nurses and expressed concern that many of the findings reflect conclusions made by Kramer three decades earlier.

Bullying, described as unfair or punitive actions by supervisors in regards to scheduling, patient assignments, workload, or use of paid time off, has been associated with poor retention rates among nurses (Simons & Mawn , 2010). This study was not designed as a mixed methods study, until 36% of the participants provided such rich commentary to an open-ended survey question asking about actual or witnessed bullying among nurses. Content analysis of narrative responses from 148 newly licensed US nurses (139 victims; 14 witnesses) suggested nurses were the most vulnerable targets of bullying behavior during the first three months of orientation. This finding coincided with Budin et al's. (2013) report that new nurses, in general, were most vulnerable to bullying. In the current study, 38 nurses wrote about leaving their job during orientation. One nurse wrote, "During my 3 month orientation, I was bullied quiet often. It was seen as proving yourself to your fellow employees. I was often set up to fail purposefully. I considered leaving almost daily" (Simons & Mawn, 2010, p. 308). Others (n=19) wrote of unmerited hostility and fear, e.g., "it's like working in a pool with a pack of barracudas that ate their young" (Simons & Mawn, 2010, p. 308). Feeling alienated or out of the clique was

common. One nurse wrote, "...I was left alone with 40 [long-term care] patients constantly" (p. 308). Findings from this study were consistent with studies that reported nurses had considered leaving because of a negative workplace culture (Gill et al., 2010) and will be explored in greater detail in the next section, *Reasons for Leaving*.

The last study in this section included perspectives from both nurse managers and new graduate nurses in Australia. Walker, Earl, Costa, and Cuddihy's (2013) longitudinal study explored workplace factors that affect graduate nurses during their first year of practice. Data collected from both groups at two intervals (new nurses: T_1 n=38; T_2 n=31; managers: T_1 n=12; T_2 n=13) underwent content analysis based on graduate nurse stressors identified in the literature. Data were coded, categorized, and placed into themes. Inter-rater reliability was established at greater than 80% then content was compared between the two participant groups. Two overarching themes with correlating sub-themes were identified: 1) job-related stressors, which included unprofessional workplace behavior, shift work, workplace support, and 2) personal stressors which included confidence and coping with death and dying.

Most all new nurses reported being victim of or witnessing unprofessional behaviors that impaired their self-confidence, relationships, and made them question their career choice. Victims reported, "being treated like a child..." and "...walking on eggshells..." (Walker et al., 2013, p. 293); witnesses reported physician tantrums and abrupt nurses acting out in front of patients. Yet, most nurse managers reported being unaware that unprofessional behaviors were a significant problem in their units. The few managers that did acknowledge unprofessional behaviors talked about negative criticism and how it hurts the new nurse's self-esteem and confidence. Yet, in an earlier study, Hickson (2013) suggested that NLRN "must be informed *by organizational leaders* [emphasis added] that negative, disruptive, or bullying behavior is neither

tolerated nor accepted in the workplace setting" (p. 299). Walker et al. (2013) suggested that managers may become accustomed to unprofessional behaviors and accept it as part of their culture. This finding takes Budin et al's. (2013) suggestion that behaviors have become ingrained and accepted as part of the workplace culture, thus no longer aware of unprofessional behaviors or the effect on their colleagues.

Both graduate nurses and managers acknowledged shift work, especially night shift, presented challenges for new nurses. While the nurses learn to adapt and overcome, managers tend to dismiss the issue that shift work may have a negative impact on employees health and well-being. Most NLRN reported invaluable workplace support from a range of people. Only a few participants had received formal support from employee assistance programs (EAP) or counselors. Interestingly, in the first data collection period, managers were unaware of the support services available for NLRN, but by the second year, all managers reported some form of support, e.g., preceptors and EAP.

During a second year, personal stressors outweighed the previously identified job-related stressors. Personal stressors related to the NLRN confidence in nursing abilities and successful integration into the workplace. NLRN and managers identified colleagues, preceptors, and program coordinators who provided support and positive, constructive feedback helped build confidence. Managers added praise, regular evaluations, and increasing responsibility as a means to help new nurses feel confident. In other studies, NLRN supported the need for praise and recognition (Pellico et al., 2009; Wilson, 2006; Zeller, Doutrich, Guido, & Hoeksel, 2011) but were overwhelmed with too much responsibility (Parker et al., 2014; Pellico et al., 2009; Simons & Mawn, 2010; Unruh & Zhang, 2013). Only a few NLRN reported difficulties dealing with death and dying but acknowledged support from colleagues was very helpful. Nurse

managers suggested debriefing and counseling programs were beneficial for new nurses learning to cope with grief, death, or dying. The gap between NLRN and nurse manager perceptions of unprofessional behavior and the experience of coping with death and dying demonstrated the need for additional research to better understand the implications for practice.

Section Summary

Factors contributing to high turnover among NLRN were attributed to negative workplace environments wherein participants either experienced or witnessed verbal abuse on a regular basis. The demographic characteristics of a NLRN positioned them as easy targets for bullying during the first year of practice, but they were most vulnerable during the first few months. NLRN who expressed an intent to leave were pulled off orientation too early and expected to function the same as a veteran nurse. NLRN perceived staff nurse colleagues, nurse managers, and patients expected too much from them, that is, too much work and too much responsibility in the midst of a hostile environment. NLRN often felt unsupported or alienated within the workgroup and suffered from lack of self confidence. However, the most alarming realization was the discrepancy between NLRN and nurse manager's perception of unprofessional behaviors in the workplace. Nurse managers have been charged with educating and informing NLRN about policies and procedures related to workplace violence and unprofessional behaviors, yet they were not aware of the issues that push NLRN out the door.

Reasons for Leaving

In this section, I reviewed four studies that provided insight on why nurses in the USA leave their jobs or let their license expire. I presented with three studies that sought reasons for taking the first job, why the participant left or would leave that position, and circumstances under

which the participant may return to practice. I concluded with a recent study comparing two cohorts and the shift away from hospital nursing.

In the first study, nurses licensed in the state of Nevada looked retrospectively at why they chose their first nursing position and why they left it (Bowles & Candela, 2005). There was no evidence of a framework or lens guiding this research. A researcher-designed instrument, The Survey of Nurses' Perception of First Job Experience, was piloted on 12 RN students prior to the current study; Cronbach alpha (.89) indicated the survey was good (Dane, 2011). Reasons for leaving the first job were obtained from an open-ended question. The responses (n=353) were analyzed using content analysis and factor analysis was used to identify four dominant concepts or the most frequently cited reasons for leaving the first job: patient care, work environment, moving, and employment factors.

As in previous studies (Cho et al., 2012; Kovner et al., 2009; Parker et al., 2014), nurses chose to leave their first RN position because they were dissatisfied with workplace conditions, especially patient care issues pertaining to acuity levels, nurse-patient ratios, and unsafe care. Findings related to the work environment (e.g., management issues, lack of support or guidance, and being given too much responsibility) were also corroborated in other studies (Gill et al., 2010; Pellico et al., 2009; Simons & Mawn, 2010). Bowles and Candela (2005) cited other reasons for leaving involved moving either to another area in nursing, a geographical relocation, and employment factors such as salary, schedule, and benefits. Similar variables were most often reported in research studies focused on extrinsic factors affecting job satisfaction (Brewer et al., 2011; Kovner et al., 2009; Parker et al., 2014; Simons & Mawn, 2010). However, Unruh and Zhang (2013) refuted findings by reporting that schedules and wages were non-significant

predictors for NLRN intent to leave. To a lesser extent, Bowles and Candela (2005) found nurses left to purse higher education or more challenging work.

In the current study, Bowles and Candela (2005) reported first-year turnover rate (30%) was higher than the national average (21.3%) and within two years the turnover rate had grown to 57% of nurses leaving their first jobs. In light of such high turnover, it was worth noting that only 38% of participants worked in medical/surgical units for their first jobs. Participants reflected the trend for new graduate nurses to enter practice directly into highly specialized units where historically, only experienced nurses were hired. Entering a highly complex healthcare setting to care for very sick patients requires a higher level of learning and may contribute to low retention rates. Bowles and Candela (2005) suggested high turnover rates negatively impact patient care, staff morale, productivity, and replacement costs which was in line with seminal works of Kramer (1974) and Krugman et al. (2006) to develop structured intervention programs.

This quantitative study offered insight into reasons why nurses leave nursing and the characteristics of registered nurses in the state of Washington who let their licenses expire. Skillman, Palazzo, Hart, and Keepnews (2010) surveyed 1,177 nurses with an initial 21% response rate. The researchers attested to additional sampling of non-respondents and excluded deceased and those unreachable by mail yielded a 64% adjusted response rate. Skillman et al. indicated low response rate as a limitation for the study; however, I disagree since 60% has been recommended as the minimum for health education manuscripts (Price, Murnan, Dake, Dimming, & Hayes, 2004). There was no discussion of a guiding framework for this study. The complete list of characteristics of non-practicing, non-retired RNs with expired licenses was displayed in table format. The majority of nurses held staff nurse positions (52.8%); the next highest was head nurse / nurse manager (12.5%). Most nurses worked in a hospital setting

(43.1%) or ambulatory care (9.7%). The number of years since last working was equally distributed across four categories: ≤ 5 years (39.6%), 6-10 years (22.1%), 11-15 years (22.1%), and > 15 years (39.6%). Satisfaction with last nursing position was similar to the continuum discussed in the job satisfaction section. Participant responses ranged from extremely or moderately satisfied (45.7%) to extremely or moderately dissatisfied (41.5%). The top three reasons for not working as a registered nurse were: disability/illness (23.6%); job too stressful and/or exhausting (18.1%); and needed to take care of home/family (12.5%). Personal reasons (e.g., caring for a child or parent, marriage, and disability) remained the number one cause for voluntary termination from hospital employment in 2013 (NSI, 2014). Other less frequent reasons for not working as an RN included issues also raised in previous studies, e.g.: patient safety, hours/shift work, and salary (Bowles & Candela, 2005; Kovner et al., 2014). Outdated nursing skills and job eliminations were additional reasons for not working as an RN but were not prevalent in other studies.

When Skillman et al. asked participants what might lead them to seek nursing employment, participants responded: none of the factors (30.9%); change in personal situation (20.6%); or greater availability of flexible hours (11.7%). The notion that nurses were not interested in seeking nursing employment was slightly less than the 41% reported by Kovner et al. (2014). Unfortunately, 62% of the participants in this study indicated they would never practice nursing again; and half of the respondents would not advise young people to pursue nursing as a career because of undesirable working conditions. Skillman et al. (2010) suggested employers consider retention efforts such as, lower nurse-patient ratios, family-friendly policies, and flexible hours versus the cost of continually recruiting and replacing nursing staff.

MacKusick and Minick (2010) used a snowball sampling technique to discover ten nurses willing to talk about experiences that lead to their decision to leave clinical practice. Participants had provided at least one year of direct patient care in a hospital setting, primarily in the southeastern United States but had not worked within the previous six months. The research question, "What is the experience of RNs who leave clinical nursing?" was appropriately stated for a phenomenological study to elicit the participants' meaning or experiences (Creswell, 2013). Unfriendly workplace, emotional distress, and fatigue/exhaustion significantly influenced new graduates' decision to leave clinical nursing, so much that none of the participants were willing to return to clinical practice (MacKusick & Minick, 2010).

Nurses described an unfriendly workplace and an overwhelming sense of aloneness: "I was totally alone... ...all alone, all the time. Yet I was responsible" (MacKusick & Minick, 2010, p. 337). Similar findings were reported in another study by new nurses who felt alienated or out of the clique (Simons & Mawn, 2010) and when the new nurse felt she had too much responsibility (Bowles & Candela, 2005; Pellico et al., 2009). Just as verbal abuse was identified as a key factor affecting job satisfaction in prior studies (Budin et al., 2013; Hickson, 2013; Simons & Mawn, 2010), it likewise appeared in the current study. One nurse described an ongoing abusive experience as a hazing process for all new nurses and no one, not even the manager, made efforts to stop the behaviors. Others described sexual harassment or hostile behavior from physicians, but were more debilitated by the lack of concern from administration than the horizontal hostility. Similar findings were reported earlier wherein the nurse managers were unaware of unprofessional behaviors in their units (Walker et al., 2013).

Nurses described emotionally laden decisions that lead to their choice to leave nursing. One nurse said, "... what kind of job do you have where you cry everyday? ..." (MacKusick &

Minick, 2010, p. 338). Another described futile care experiences: "We were playing God...keeping babies alive ... all the while pretending like it was ok, when we knew, I knew, it wasn't ..." (MacKusick & Minick, 2010, p. 338). Nurses described themselves as "always on" which led to insurmountable fatigue and exhaustion which has been corroborated in numerous studies (Parker et al., 2014; Skillman et al., 2010; Walker et al., 2013). One interpretation suggested the constant vigilance in clinical nursing can only be understood by another nurse and is often overlooked or unrecognized because providing holistic patient care is emotionally and physically demanding (MacKusick & Minick, 2010).

Nurses acknowledged a sense of regret associated with the loss of interaction and a sense of guilt for no longer practicing; yet consistent with other studies (Kovner et al., 2014; Skillman et al., 2010), none of the participants were willing to return to clinical practice because of workplace environmental factors. Evidence from this study suggested nurses who leave nursing were not likely to return; therefore, healthcare leaders were encouraged to improve retention efforts as opposed to relying on nurses who have left clinical practice to return to the workforce.

A recently published research study provided evidence that fewer NLRN in the USA work in hospital settings (Kovner, Brewer, Fatehi, & Katigbak, 2014). Researchers compared personal characteristics, work attributes, perceived work environment, and job opportunities between NLRN from 2004-2005 (n=774) and 2010-2011 (n=1613). However, there was no evidence of a guiding theory. The latter cohort was more likely to work in nursing homes, ambulatory care, and non-nursing settings and were more likely to leave their first job within one year (16% versus 10%). Patient safety was a common concern in the current and previous studies (Bowles & Candela, 2005; Kovner et al., 2014).

The 2010-2011 cohort took their first RN job for a variety of reasons: hours supported work-life balance; short commute; organization's reputation; only full-time position available; worked there as a student or had a friend who worked there. There was no significant statistical difference between the cohorts in regards to intent to stay and job satisfaction. Employment differences between the two cohorts were attributed to the 2011 Institute of Medicine's recommendation that 80% of the nursing workforce hold a BSN. Nurses with BSN were more likely to be employed in hospitals within six to 18 months after graduation (92.9%) as compared to ADN graduates (67.1%). Additionally, fewer ADN from the 2010-2011 cohort worked in hospitals than in the 2004-2005 cohort. Nurses in the latter cohort were more likely to pursue nurse practitioner training, held more manager positions, and indicated a stronger organizational commitment despite significantly fewer benefits such as health insurance and tuition reimbursement (MacKusick & Minick, 2010). The majority (71.4%) of the 2010-2011 cohort planned to pursue additional formal education; 20% had already enrolled; 40.5% plan to return within five years, and 35.5% within one year. This finding alone demonstrates a shift since Bowles and Candela's 2005 report of less than 20% of NLRN left nursing to pursue formal education.

Fewer than 10% indicated salary, hours, and management were factors that might have kept them employed. In a previous study, Rambur et al. (2005) also reported greater job mobility and organizational commitment among BSN-prepared nurses. Nonetheless, 413 nurses (26%) in the latter cohort had already left their first job, which was similar to the 30% reported by Bowles and Candela (2005). However, the most alarming discovery was the 42% who said there was nothing the employer could have done to keep them.

While employers monitor workplace conditions and employee benefits, policymakers and employers alike should to pay attention to the changing trends among NLRN entry into practice. Most often, the shift away from the hospital bedside is perceived negatively; however, Kovner et al. (2014) concluded the move away from the hospital may not be a negative indicator but instead, may help meet the demands for more community and primary care services as outlined by the Affordable Care Act.

Section Summary

Based on my review of literature, the reasons for leaving nursing have not changed significantly in the past 40 years and turnover rates have continued to escalate as high as 57% during the first two years of clinical practice. In addition, nurses left their first jobs when they experienced: unfriendly and stressful environments that were not conducive to safe patient care; verbal abuse and bullying behaviors from colleagues; and overwhelming emotional or physical exhaustion. Most nurses who left their job or the nursing profession were adamant there was nothing management could do to persuade them to return to clinical practice. Numerous recommendations were made for nurse managers to improve patient care and workplace conditions in order to retain the current workforce. There was very little research addressing NLRN who have stayed in nursing, the gap that my research seeks to address.

Why Stay in Nursing

As noted throughout this literature review, much has been written about the negative aspects of nursing and numerous efforts to predict the intent to leave. I will conclude this literature review with two qualitative studies from England and the USA. Both studies were designed to elicit why nurses stay in nursing.

Facing a national nursing shortage in England and a 14.4% job vacancy at one hospital, Wilson (2006) asked ten nurses, "What are your reasons for staying in nursing?" Although Wilson did not identify the research method, she described a phenomenological study in which she asked one open-ended question, further questioning was based on the participant's initial response, there was no effort to control for extraneous variables, and she had no follow-up with nurses who declined to be interviewed. In addition, the presentation of themes and supporting documentation were consistent with phenomenology (Creswell, 2013). All levels of nursing seniority were represented in the sample; therefore findings were not specific to new nurses. Four themes emerged from Wilson's (2006) data: job content, work environment, balancing responsibilities, and recognition.

As in other studies (Cho et al., 2012; Laschinger, 2010), nurses in the current study enjoyed their job and patient contact. One participant reported,

> The most satisfying, I think is when you have got somebody who is really ill and you tend to nurse them for a few days and you see them turn the corner and go home. That gives me an enormous amount of satisfaction, to think that I have been part of that. And that 's what I like. (Wilson, 2006, p. 27)

Nurses in the current study appreciated a cohesive work environment where they could provide quality patient care. A participant stated, "the people keep me here. If you've got a good crowd, you're halfway there, aren't you?" (Wilson, 2006, p. 28). Another commented, "There's a good atmosphere here, part because we all work hard and work together; nobody would say: 'You sort it out, it's your problem" (Wilson, 2006, p. 28). In addition to Wilson, numerous researchers (Brunetto et al., 2013; Chandler, 2012; Zinsmeister & Schafer, 2009) supported the

importance of a supportive work environment in order to provide quality patient care. Senior nurses reported greater dissatisfaction when they felt their jobs distanced them from patient care.

Wilson's participants expressed the need for flexibility to balance personal and professional responsibilities. One participant stated, "We are quite lucky in some respects with our shifts because we do long days and normal shifts as well. It's my choice and I've got more freedom" (Wilson, 2006, p. 29). Likewise, participants in other studies cited balance between home and work life as a key factor in reasons for leaving nursing (Kovner et al., 2014). Wilson reported greater dissatisfaction among nurses who stayed in their job for financial reasons.

Finally, being recognized by patients, colleagues, and managers was also reported in the current study as well as previous studies (Pellico et al., 2009; Walker et al., 2013; Zeller et al., 2011). Wilson's participants shared thoughts on being recognized by a patient: "there's nothing better than when a patient says, 'you have really helped me today' or something like that. That is the best feeling of all". (Wilson, 2006, p. 29). Another just needed recognition: "I like to be told when I have done a good job. At the end of the day, you know when you have done your job well and that is satisfying, but it is nice for someone else to notice" (Wilson, 2006, p. 29).

Wilson's findings provided further evidence of a linear relationship between enjoying the job, job satisfaction, and intent stay. However, she purported the need for multidimensional policies rather than single uncoordinated efforts. Wilson challenged employers and policy makers to intervene at a national, trust (state), and ward (local) levels to affect nurse retention.

The final study in this literature review focused on the perspectives of six new graduate nurses in western Washington and why they stayed in their initial positions for at least two years. Zeller, Doutrich, Guido, and Hoeksel (2011) provided a seemingly good overview of the study design, Heideggerian hermeneutic phenomenology, which allowed participants to describe their

perceptions and lived experiences. However, Zeller et al. asked, " *Why* do many new nurses leave nursing within 2 years?" (p. 411) which is a significant design flaw and will be discussed in the next section, *Studies that Influenced my Research*. Confidentiality and ethical concerns of working in the same facility along with approval from the institutional review board were addressed. The hermeneutic phenomenological process appeared to be appropriately implemented as verbatim transcripts were read for understanding and reviewed with an analytical team of nursing and non-nursing members. Meaningful segments were identified, indexed, and coded; as patterns and relationships emerged, a paradigm case was identified. Zeller et al.'s (2011) findings were consistent with those presented throughout this literature review; however significant phenomenological design flaws limited their credibility. Three themes emerged from the data: culture of mutual support, it's who you are and how you persevere, and go in with your eyes open.

All six nurses agreed they stay in nursing because of the people they work with; they refuted the cliché, "nurses eat their young" (Zeller et al., 2011). Participants felt supported and never alone, which increased their desire to learn and to perform well for their team. One participant reported, "There has to be so much support. When you are a new nurse, everybody wants to jump in and help you. I think that is the key. You never feel as if you're alone" (p. 411). Support from colleagues was a common theme among nurses in their early years of clinical practice (Chandler, 2012; Zinsmeister & Schafer, 2009). However, this finding is in opposition to those who reported lack of support or an overwhelming sense of aloneness (Bowles & Candela, 2005; Cho et al., 2012; MacKusick & Minick, 2010, Unruh & Zhang, 2013), unrealistic role expectations (Pellico et al., 2009; Unruh & Zhang, 2013), or unprofessional behaviors (Hickson, 2013; MacKusick & Minick, 2010; Simons & Mawn, 2010).

Zeller et al. asked participants to speculate about a cause rather than talk about their own lived experience. Participants were asked, "why do many new nurses leave nursing within 2 years?" Van Manen (2014) suggests a phenomenologist does not pose "why" questions and advises researchers to avoid asking for opinions, beliefs, or perceptions. Thomas and Pollio (2002) adhere to Van Manen's teaching and also suggest, the phenomenological interview allows participants to share unreflected experiences as a means to help others understand the first-person account of a phenomenon.

Life experience was the most frequently cited reason for leaving nursing. Emotional and mental maturity, not age, were identified as a contributing factors to NLRN success. Zeller et al. also suggested, a key to success was, "the ability to live by a standard of ethics and not 'spend mental energy' on negative 'back-talking or back-stabbing' " (p. 411). Participants noted that it takes time to build confidence, so perseverance emerged as a theme, along with the need to take care of one's self. "You need to take breaks. They're so important. ... They help you to center yourself for the rest of the day and ... provide better care" (p. 412). Emotional and mental maturity were not key measures in this body of literature; however, age was found to be a non-significant predictor of turnover intent (Unruh & Zhang, 2013).

Only one of six participants felt prepared for the reality of being a nurse. Others commented on their academic preparation: "No one explains how hard this job can be"; "I don't think that schools adequately prepare you for all that this job entails"; "I think you get the basics, but you don't get to learn how to deal with people as individuals" (Zeller et al., 2011; p. 412). This finding can be traced back to 1988 when Stewart-Dedmon found only 31% of baccalaureate-prepared nurses felt prepared and knew what to expect in clinical practice. However, more recent research also supports the perception that NLRN are not prepared for the

realities of nursing (Chandler, 2012; Pellico et al., 2009; Pinchera, 2012). Participants made strong recommendations for schools of nursing to require volunteer or work experience in a healthcare setting in order to help student nurses know what to expect, so they can "enter with their eyes open" (Zeller et al., 2011). However, the notion of not knowing what to expect goes all the way back to Nahm's research in 1940 when she reported 54% of nurses entered nursing school with little or no knowledge about the realities of nursing practice. Other findings (Bowles & Candela, 2005; Unruh & Zhang, 2013) refuted the notion that academic preparation affected job satisfaction, turnover intent, or retention.

In addition to the three themes, Zeller et al. found that receiving gratitude from patients or families was a motivating reward and influenced NLRN desire to continue nursing. Other researchers (Pellico et al., 2009; Walker et al., 2013; Wilson, 2006) cited praise and recognition as informant factors for NLRN success in clinical practice. One participant stated, "I like helping people. This is my job. This is what I do. I need to care for patients; this is like a part of me... It's become a part of my identity" (Zeller et al., 2011, p. 410). Zeller et al. (2011) concluded with a challenge to nurse educators, administrators, and staff development professionals to look at areas of clinical practice "where new nurses feel as if they are being let down" (p. 413) in addition to enhancing existing residency or orientation programs. Zeller et al. proposed future collaboration among nurse educators and administration regarding the community or culture of support for new nurses.

Section Summary

Helping others, making a difference, and giving back to the community were common reasons for becoming a nurse and were instrumental factors in why nurses stay in their initial positions. However, some participants felt let down by their academic institutions and did not

feel like they were ready for the realities of hospital nursing. It was the relationships with coworkers, teamwork, and the ability to provide quality patient care that contributed to new nurses' job enjoyment and ultimately affected their intent to stay. Nurses who experienced supportive cultures in which preceptors and staff nurses nurtured or supported them during the early years of practice were more likely to remain in their nursing position. New nurses work hard and they want other people to notice. New nurses often expressed the need for recognition and praise from patients, colleagues, and managers. In the end, a supportive environment was crucial to the new nurses success.

Studies that Influenced my Research

As I reviewed the literature, there was an overabundance of research addressing the negative image of nursing with emphasis on high turnover rates and why nurses leave nursing. Being an optimist, I was delighted to find Chandler's (2012) study using the theoretical framework of Appreciative Inquiry. "A core assumption of the Appreciative Inquiry framework is that solutions already exist and can be identified by addressing what is working, describing moments of success, and harnessing the resulting positive attitude to build strengths" (Chandler, 2012, p. 104). I began searching for nursing research that might explain why nurses stay in nursing as opposed to drawing more attention to those who leave. I questioned how retention efforts would be affected if nurse educators, managers, and administrators knew what was keeping nurses at the bedside. What would happen if we knew what was working rather than focusing on what was broken? I wondered if unreflected descriptions and the meaning of the NLRNs experiences would confirm or add to the recommendations made by other researchers.

I thought I had found the perfect phenomenological study with an article titled, *A culture of mutual support: Discovering why new nurses stay in nursing*, but the purpose of Zeller et al's.

study was to understand why new nurses *leave* within the first two years of clinical practice. Nonetheless, there were major design flaws with the methodology. Zeller et al., asked participants a "why" question which violates the edict of phenomenology. Asking *why* triggers an analytical response rather than a true phenomenological question which would allow the participant to describe "what" or "how" they experienced a given phenomenon (Creswell, 2013; Van Manen, 2014). The phenomenological interviewer should not ask for interpretations, explanations, generalizations, or speculations (Van Manen, 2014). This finding alone devalues the credibility of the author's understanding of phenomenology. In addition, Zeller et al. did not specify the amount of time set aside for interviews, but reported interviews lasted approximately 30 minutes. Phenomenological interviews employ reflective thinking in order to elicit a deep understanding of the phenomenon (Van Manen, 2014). Therefore, short interviews may have limited disclosure of rich, meaningful data. Although, Zeller et al.'s (2011) findings were similar to those reported in other studies, Zeller et al.'s study warrants replication adhering to the research methodological guidelines prescribed by Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002). My research study attempted to overcome the design flaws of Zeller et al.'s (2011) study by adhering to the guidelines of existential phenomenology while interviewing newly licensed nurses who remain in their first hospital job.

Literature Gap

In this literature review pertaining to retention of newly licensed registered nurses in hospital settings supports the idea that this phenomenon continues to be a significant concern within the nursing discipline. The review highlighted gaps that exist related to NLRN who have stayed in their first nursing job. A significant concern is the absence of a theory to guide research or, in some cases, not adhering to the specified theoretical or philosophical lens.

According to Creswell (2009), a theory or philosophical framework guides the questions or hypotheses and data collection procedures. Four quantitative and mixed methods studies (Bowles & Candela, 2005; Kovner et al., 2014; Parker et al., 2014; Skillman et al., 2010) did not have a theoretical or conceptual framework; qualitative researchers often described a specific approach but did not adhere to the methodology. Zinsmeister and Schafer (2009) had bracketing interviews prior to data analysis thus, according to the Thomas and Pollio (2002) method, risked guiding or leading questions during the phenomenological interviews. Malouf and West (2010) proposed a grounded theory, yet there was no discussion of theory after data analysis. Pinchera (2012) was not explicit with a particular method, but used five of Colaizzi's seven procedural steps then established rigor with Lincoln and Guba's trustworthiness criteria. While Lincoln and Guba criteria are among the most reputable trustworthiness criteria, I think Pinchera devalued Colaizzi's method by introducing Lincoln and Guba's trustworthiness criteria. Zeller et al. (2011) asked a *why* question which violated the tenets of phenomenology. Using the lens of Merleau-Ponty's existential phenomenology for my study helped fill the gap related to the phenomenon of newly licensed registered nurses who have stayed in their first hospital nursing job beyond the first two years of practice.

Chapter 3

Methodology

This study examines the meaningful experiences that may keep newly licensed registered nurses in nursing. Nurse researchers have studied job satisfaction primarily utilizing quantitative methods to determine why new nurses leave nursing. Despite this sizeable body of literature, there is a gap in our understanding of experiences that affirm new nurses' career choice, especially within the first one to two years of practice. This study seeks to illuminate meaningful experiences for newly licensed registered nurses working in acute care settings. The findings of the study will be useful to nurse educators and nurse administrators as discussed in chapter 1. The research design, sample, protection of human subjects, data collection, data analysis and interpretation are presented in this chapter.

Design

New nurses entering a complex healthcare environment experience a variety of situations and circumstances that either reinforce their decision to become a nurse or deter them from their chosen career path. By implementing a qualitative method such as existential phenomenology, the researcher may discover aspects of new nurse's experiences that have not been explicated in quantitative studies. Merleau-Ponty suggests describing human experience from a first-person perspective, using the participants' own words and without trying to rationalize or find a causal explanation. Van Manen (2014) cautions, "it is much easier to get a person to tell about an experience than to tell an experience as lived through" (p. 315). The interviewer must be attentive to the need to obtain lived experience material and realize a small number of detailed, concrete examples is better than overabundance of poorly managed interviews (Van Manen, 2014).

Existential Phenomenology and the Thomas-Pollio Procedural Approach

The procedure developed by Thomas and Pollio (2002) was inspired by the existential-phenomenological philosophy of Merleau-Ponty as previously discussed in Chapter 1. As shown in Figure 2, each step of the procedure has a specific focus.

The study begins with the researcher focusing on *self,* not to make the researcher "objective", but to increase awareness of personal thoughts, feelings, biases, and prejudices. Two questions are asked: 1) "what about the topic was important enough for me to make it the major concern of an investigation? and 2) in what ways and situations have I experienced the phenomenon?" (Thomas & Pollio, 2002, p. 44). During this phase, the researcher engages in a bracketing interview to give a direct description of her own experience of the phenomenon in order to identify and temporarily set aside preconceptions that may influence data collection and analysis.

The second focus is the *participant*. The researcher must create a comfortable and safe environment in which the participant feels free to talk about personal life experiences. The purpose of a phenomenological interview is to gain insight into the participant's first-person experiences related to a selected phenomenon. In phenomenology, the researcher co-constructs the dialogue; therefore a major concern is not to lead the participant on the basis of personal or theoretical pre-conceptions. When the researcher responds with sensitivity, respect, curiosity, and openness to the participant's descriptions, the uniqueness of individual perspectives add depth and richness to the study (Thomas & Pollio, 2002; Van Manen, 2014).

Next, the *texts* are interpreted. All meaning and themes must be located in the text. Participant's own words are used to capture the essence of the phenomenon because their words are often more powerful and meaningful than the researchers' paraphrase. When deciding what

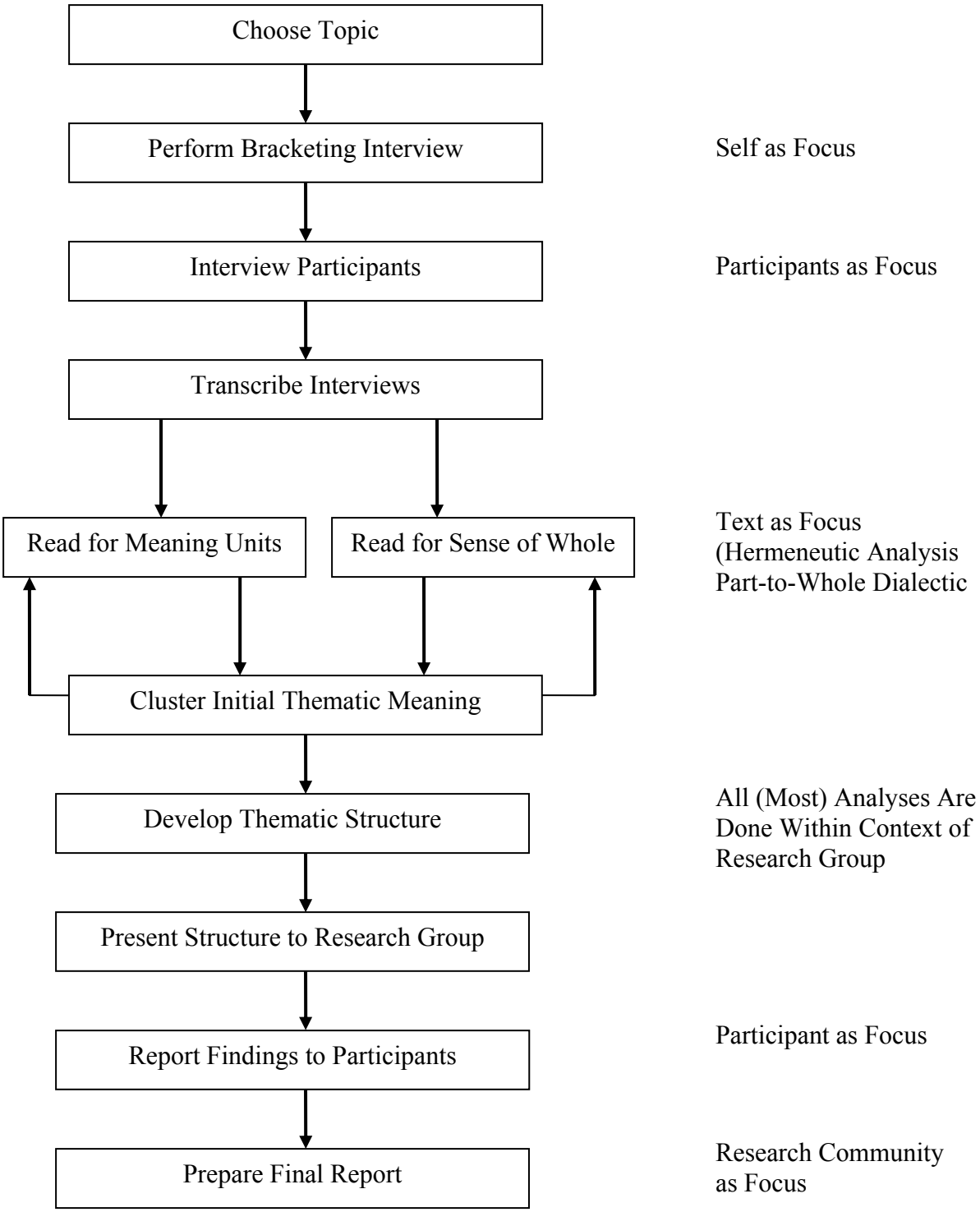

Figure 2. Summary of Steps in Conducting an Existential-Phenomenological Study. From Thomas, S.P. and Pollio, H.R. (2002). *Listening to patients: A phenomenological approach to nursing research and practice.* New York: Springer Publishing.

is thematic, the researcher looks for recurring patterns in the data (transcripts) and determines a coding system. After all the transcripts have been analyzed, the interpretive research group looks for common themes across interviews - not to produce generalizability, but to improve the development of an overall thematic structure which may be in the form of a diagram. Finally, some participants receive a copy of the thematic structure and a summary of the overall findings to determine if the researcher has captured the meaning of their individual experiences (Thomas & Pollio, 2002; Van Manen, 2014). Neither the researcher nor the participant has interpretive authority or priority because all results are co-constructed from open dialogue, back and forth between researcher and participant until it is right.

The final phase is the public report to the *research community*. It is customary to report themes from the bracketing interview, significant findings, and implications for practice. Thomas and Pollio (2002) suggest a brief explanation for the type of research procedures, i.e., methodology and method. In this study, the methodology is existential phenomenology and the method is the systematic sequence of steps as outlined in the Thomas and Pollio procedure. Once the study is complete, it must be published in order to advance the science of nursing and to affect positive change in the world of practice. Findings from this study may have implications for staff development educators, clinical preceptors, mentors, and nurse administrators.

Procedure

Bracketing Interview

The epochè (bracketing) is a critical component of phenomenology (van Manen, 2014). Bracketing is "an intellectual activity in which one tries to put aside theories, knowledge, and assumptions about a phenomenon" (Thomas & Pollio, 2002, p. 33). Bracketing is an ongoing process that begins prior to participant interviews and continues throughout the data analysis

phase. The researcher's task is to maintain an open, nonjudgmental attitude when conducting and interpreting interviews (Thomas & Pollio, 2002). Realizing, as Merleau-Ponty suggested, one cannot be completely free of presuppositions, I was able to learn about my personal biases and thoughts regarding positive nursing experiences in order to temporarily set them aside during dialogue with participants.

Prior to conducting participant interviews, I was interviewed by an experienced phenomenologist. She asked me to "think of a time when you were a nurse that you had positive experiences". As the interpretive group read and analyzed the bracketing transcript, several things stood out. For me, nursing was a spiritual calling and I was most pleased with being a nurse when I was able to spend non-task-oriented time with my patients. I was less satisfied with the busy-ness of nursing which I perceived as distancing me from patient care. In addition, relationships with patients, co-workers, and students were important to me.

With input from the interpretive research group and faculty advisors, my research question was modified prior to conducting the two pilot interviews. I did not want to assume that all nurses who remained in their first jobs had positive experiences, nor did I want to lead them to only discuss positive experiences.

Pilot Study

I conducted two pilot interviews in order to practice the skills of phenomenological interviewing and to see if there was evidence that my former students may possibly bias the proposed study in the way they responded to the research question. I asked each participant to "tell me about some experiences from your first years of clinical practice that keep you in nursing". The first participant was one of my former students; I did not know the second participant prior to the interview. Both participants were recruited by word of mouth and

volunteered to participate in the pilot study. The interviews were scheduled in a private room at a local library, audio-taped, then transcribed verbatim. Even though findings from the pilot study were not to be used in the aggregate study, the interpretive research group read the full transcripts and searched for meaning units. The interview question elicited the kind of responses I anticipated, and there was no indication of bias in the interview conducted with my former student. This finding was consistent with van Manen's research experience:

> I have often obtained experiential descriptions from my past students through interview but more often by asking them for written experiential descriptions. From the point of view of phenomenology, this does not matter at all—as long as you are able to obtain concrete and detailed experiential descriptions of whatever lived-experience/phenomenon you are investigating. (personal communication, October 9, 2015)

Sample

Criterion or purposive sampling was used to gain "examples" of experientially rich descriptions from participants who met the study criteria (Creswell, 2013; Van Manen, 2014). Newly licensed registered nurses who graduated from an accredited undergraduate nursing program between May 2012 and May 2013 and remain in their first nursing position in the acute care setting were invited to participate in this study. Recruitment occurred by word of mouth or snowball sampling wherein one interviewee told me of other individuals who met the eligibility criteria (Creswell, 2013). Participants were excluded from the research study if they voluntarily or involuntarily terminated their first position as a licensed registered nurse. When determining sample size, I contemplated the number of examples of concrete experiential descriptions that were appropriate in order to explore the phenomenological meanings of the phenomenon (Van Manen, 2014). The estimated sample size was 10 to 12 persons, but was adjusted as the study

proceeded and recruitment of participants continued until the point of data saturation or redundancy was evident.

Protection of Human Subjects

Following written approval by the University of Tennessee Office of Research, recruitment for the research study commenced with me verbally informing personal professional contacts about the study. Word-of-mouth recruitment began through my personal and professional contacts. An "Invitation to Participate" (see Appendix A) and the "Information About the Research Study" (see Appendix B) were provided for potential participants. E-mail was not used to solicit or recruit potential participants; however, the invitation and information sheets were mailed or e-mailed to personal contacts and potential participants upon request. My office telephone number was included in the information sheet. All future communication with potential participants was conducted via telephone or face-to-face.

After reviewing the recruitment materials, if the individual desired to participate in the research study, he/she was to call my office telephone number. I explained the study purpose, informed participants that the research was in partial fulfillment of the requirements to obtain a PhD in Nursing, and answered any questions. Then, I used the "Eligibility Verification Questions (see Appendix C) to determine if the caller met the inclusion criteria for the research study. The eligibility verification questions were used only as a tool. No personal identifying information was recorded on the document. If an item on the eligibility verification form was not met, the participant was not eligible for participation in the research study. If all inclusion/exclusion criteria were met, I then allowed the participant to select an alias name from the "Pseudonym Roster" (see Appendix D) to avoid potential duplication that may occur with self-selected alias.

All possible efforts to maintain strict confidentiality of all phone calls, interviews, transcripts, and research notes was undertaken. Participants communication through voice mail was deleted once data had been collected to protect participants from risk of exposure. Minimal risks were anticipated with this study; however, talking about personal experiences could have upset a person. No one was unduly upset during the interview. Participants were informed of their right to refuse or terminate participation at any point during the research study and their personal data would be destroyed. I retained the demographic data sheets and transcripts in confidence, and they were not shared with members of the research group or doctoral dissertation committee. Transcripts, audiotapes, and other research material were maintained in a locked file cabinet in my office. I had the only key and sole access to the files.

Setting

I scheduled an interview with each participant at a mutually agreed upon date, time, and location. The setting for the face-to-face or telephone interview was in a quiet, private place such as a private meeting room or my office. Interviews were not conducted at the participant's place of employment in an effort to protect the participant's anonymity and confidentiality.

Data Collection

Informed consent (see Appendix E) was obtained from each participant prior to beginning the interview. To protect the participant's identity, the PI used the assigned pseudonym during the interview. The Informed Consent contained both the participant's name and the assigned pseudonym. In addition, participants were asked on the consent form if they wanted to review the findings of the study once data analysis was complete. The purpose of asking participants to review the summary of overall findings is to determine if the report captures the essence of their personal experiences (Thomas & Pollio, 2002). All participants agreed to review

the final summary, although there was no penalty for refusing to review the summary of overall findings.

An open-ended unstructured interview format was used to collect data. There was only one interview question and it was: *"When you think about your early years of nursing practice, what stands out?"* Thomas and Pollio (2002) suggest, "Once you have asked your open-ended question to begin the interview, do not interrupt the participant except to ask for clarification and to make sure that you are understanding the meaning of the words" (p. 28). To obtain rich descriptions of the first-person experience, I used "what" questions and listen closely to the participant's words. Throughout the interview, I validated understanding by summarizing what the participant had said and sought to ask clarifying questions when necessary. I was careful to avoid leading questions and introducing concepts not verbalized by the participant but did ask probing questions, such as *"tell me more about...",* to encourage the participant to elaborate on a previous statement. Each audio-recorded interview lasted 45 to 60 minutes and continued until the participant indicated they had nothing else to contribute. No interviews were terminated prematurely by the participant.

After the interview, participants were asked to fill out a short demographic data form (see Appendix F). Specific demo graphic data included: age, gender, ethnicity, level of education, data of graduation, employment status, clinical specialty, and usual shift. Upon completionof the demographic form, participants were given a $20 gift card as a token of appreciation for participating in the study. No other compensation was offered. Participants signed a "Gift Card Receipt" (see Appendix G) using their assigned pseudonym.

Field notes were written before and immediately following each interview. I documented information to augment the interview transcripts, e.g., details of the environment, participant's

nonverbal behavior, and interruptions. My specific thoughts regarding the interview were included in the field notes. Note-taking can be distracting; therefore was used minimally during the interview. Participants were informed prior to the interview that I may take a few notes to capture key words or phrases to guide the discussion. Field notes did not contain personal identifiers and will be maintained in my personal research journal.

Data Analysis

Data analysis occurred using the existential phenomenological method derived from the philosophy of Merleau-Ponty. Interview transcripts were transcribed verbatim by a hired, professional transcriptionist. A confidentiality agreement (see Appendix H) was obtained from the transcriptionist prior to submitting the data files. The participant was assigned a pseudonym prior to the interview; all other personal identifiers, e.g., people and places, were changed to pseudonyms or otherwise blinded during the transcription process. Notes were added to indicate pauses, inflections, or to indicate certain words emphasized by the participant. The printed transcripts were authenticated with the corresponding audio file. I read and analyzed all the transcripts; selected transcripts were reviewed by the interpretive research group using the Thomas-Pollio existential phenomenological approach. Each member of the Interpretive Research Group signed a confidentiality agreement (see Appendix I) prior to receiving a copy of the verbatim transcript and instructed not to discuss the transcript outside the group setting. The transcripts did not have personal identifiers and the doors to the meeting room were closed during group sessions; therefore minimal to no risk in breeching confidentiality while reading the transcripts aloud. Reading aloud while paying attention to the meaning of words, phrases, and metaphors was consistent with the Thomas-Pollio (2002) data analysis method. After meaning units were identified, I decided what was thematic. In this phenomenological approach, the

researcher reflects on the recurring patterns in the data, the context in which they were used, and their relationship to the participant's narrative as a whole (Thomas & Pollio, 2002). After all the transcripts were read and analyzed, I identified commonalities across the interviews. Significant statements were grouped into larger meaning units to begin identifying themes. I also reviewed and reflected on field notes during the data analysis process.

The Interpretive Research Group assisted me by considering whether the themes were supported by the data from individual texts and if the themes were a clear portrayal of the new nurses' experience. I looked both within and across interviews for similarities and differences. Global themes were common across all interviews with evidence present in the individual transcripts. In this phenomenological approach, specific words or phrases used by the participants are often used for names of themes rather than assigning abstract terms. I presented the thematic structure to the interpretive group along with the specific textual support. The interpretive group examined the proposed themes and helped to identify the best descriptive terms for the thematic structure. A diagram was used to depict themes and the interrelationships of major grounds and figural aspects of the phenomenon. The final step was to validate the thematic structure with the study participants to determine if the thematic structure reflects their own individual experience. All participated agreed to review the final summary but only two participants responded back to me with the following statements: "it's perfect" and "you nailed it".

Scientific Rigor

Reliability refers to the consistency and repeatability of research findings. It is reasonable to expect thematic consistency if the study were replicated (Thomas & Pollio, 2002). However, reliability in the traditional sense of the term is not an expectation in phenomenology.

Phenomenological studies of the same phenomenon may result in very different results thereby illuminating new insights into an area that has been previously addressed in the literature (van Manen, 2014).

Validity suggests the researcher has confidence that the investigation described the phenomenon which she desired to investigate and the evidence to support the study has been brought forth (Thomas & Pollio, 2002). The following questions were used to test the level of validity for a phenomenological study:

- Is the study based on a valid phenomenological question? Does the study ask, "What is the human experience like?" "How is this phenomenon experienced?"
- Is analysis performed on experientially descriptive accounts, transcripts?
- Is the study properly rooted in primary and scholarly phenomenological literature - rather than mostly relying on questionable secondary and tertiary sources?
- Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other non-phenomenological methodologies? (van Manen, 2014, p. 350)

In addition, I participated in a bracketing interview to identify pre-conceptions. An interdisciplinary interpretive research group served as an external auditor and provided peer debriefing throughout the data analysis phase. Finally, member-checking occurred with participants providing feedback on the thematic structure.

Phenomenological *generalizations* are not the same as empirical or quantitative generalizations that draw conclusions. Van Manen (2014) suggests two kinds of phenomenological generalizations: existential and singular. *Existential generalization* makes it possible to recognize recurring aspects of the meaning of a phenomenon; whereas *singular*

generalization looks for what is unique about a phenomenon. Mottern (2013) creates an image of a centripetal spiral to demonstrate how thoughts move from the general and coalesces into the singular then reduced to essence or a symbol, at which point, the ideas may spiral outward to be generalized to a wider population. Thomas and Pollio (2002) describe phenomenological generalizability not as a means of "proof" but rather a judgment on the usefulness of the data as determined by the sole reader.

Chapter 4

Findings

The purpose of this existential phenomenological study was to describe the lived experiences of newly licensed registered nurses (NLRNs) who have stayed in their first nursing job in an acute care hospital for at least 18 months. Following an analysis of my bracketing interview, face-to-face interviews were audio recorded and transcribed verbatim. Participants were asked, "When you think about your first few years of clinical practice, what stands out?" Narratives of nine NLRNs provided rich descriptions of their individual lived experiences. The Interpretive Research Group assisted with analysis of six transcripts and I analyzed all nine transcripts extensively in order to identify a thematic structure. Based on feedback from the participants and the research group participants, the thematic structure (see Figure 3) presented in my study is believed to be true and representative of the study population. The figural themes that emerged from my study will follow a brief discussion of the study sample and an overview of the contextual grounds experienced by the nurses in the study.

Sample

Nine NLRNs, recruited by word of mouth and snowball sampling, volunteered to participate in this research study. All nine participants were Caucasian, BSN-prepared, and held positions as full-time employees working 12-hour shifts. There were two male and seven female participants ranging in age from 24 to 43. Graduates from the classes of 2012 (n=4) and 2013 (n=5) were equally represented as were both acute (n=3) and critical care (n=6) nursing units. There was one pediatric nurse in the sample. Day (n=5) and night (n=4) shifts were equally represented. Four participants worked as a student nurse prior to becoming an RN (see Table 1). All nine participants were my former students.

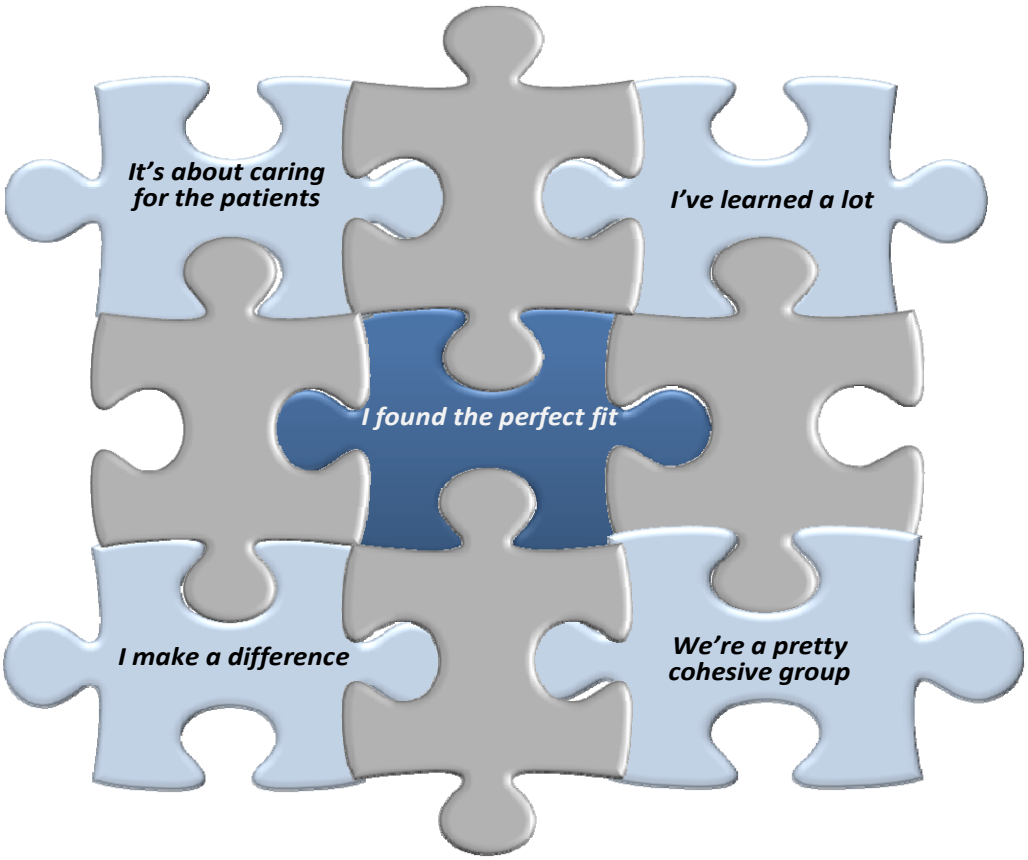

Figure 3. Experiences of newly licensed registered nurses who stayed in their first jobs.

Table 1

Demographics

Participant (Alias)	Gender	Age	Class of	Clinical Specialty	Usual Shift	Worked as student nurse
Ava	F	25	2012	Cardiovascular Step-down	Days	Yes
Chandler	M	25	2013	Oncology	Days	Yes
Emily	F	26	2012	Intensive Care Unit	Days	No
Emma	F	43	2013	Pediatric Oncology	Nights	Yes
Jacob	M	33	2013	Intensive Care Unit	Nights	No
Mia	F	25	2012	Neurology/Neurosurgery	Days	No
Olivia	F	25	2012	Intensive Care Unit	Days	No
Rose	F	24	2013	Oncology Step-down	Nights	Yes
Sophia	F	29	2013	Intensive Care Unit	Nights	No

Contextual Grounds

For the NLRN, the hospital workplace is the contextual ground in which all other experiences occur. In my study, the workplace was perceived as supportive of new nurses; however, while recalling their individual lived experiences, participants shared both positive and negative experiences of their early years of clinical practice. Participants related experiences of being *thrown* into situations beyond their wishes. Free to choose their attitudes toward their individual situations, the NLRNs in my study chose to stay in their jobs as opposed to leaving like so many other NLRNs. The four existential universal themes of body, time, world, and others were experienced by the participants.

Body

Participants were both physically and emotionally engaged in their experiences as NLRNs. They used feeling words such as overwhelmed, exhausted, frustrated, and scary to describe their *body* responses to their first years of clinical practice. Several participants initially felt thrown into an overwhelming sense of responsibility. Jacob described being "thrown right into the mess" while also trying to help other new nurses: "you try to help 'em but it's frustrating when you're having to do a lot of stuff for them and you got your own workload to do." Emma took the NCLEX soon after graduation and started working one week later; she had such high expectations for herself that she quickly became frustrated and overwhelmed: "I felt like I should be further along than I was, I was frustrated with myself...and then you get overwhelmed with it, like I was exhausted and [my] sleep schedule was off." The experience of 12 hour shifts wrought unexpected physical and emotional burdens for some participants.

Olivia was so emotionally vested in and overwhelmed by her new job that she could not sleep; however, she was perceptive enough to recognize the vicious cycle of stress and

productivity: "the more I get stressed, the less the patient gets taken care of, and the more I'm just frantic". Olivia had already experienced the physical stress: "it can be really hard on your body...you're standing up for a long period of time or bending over." Chandler agreed, "it's definitely harder than I thought it was gonna be"; he pointed out that as a male, he was frequently called upon to lift and move patients, "you don't realize the toil that it takes on...your lower back and just your body in general.... It is more exhausting." In addition to the physical demands, the emotional weight off working on an oncology unit is sometimes hard to shed, "you are around people who are in a sense dying, it humbles you and it keeps your perspective and priorities in life, but sometime you carry that home."

Time

Nurses in my study described how things changed as they learned what they were capable of doing in their new jobs. Participants described their experience of working night shift, coming off orientation in a shorter amount of time than expected, and transitions from being the new nurse to now working with newer new nurses. Although Sophia had oriented on dayshift, she recalled, "I was only on nights orienting for about a week, and then I was on my own." Sophia, like many others, had trouble adjusting her sleep patterns, "I think on night shift, people...think they can be zombies and sacrifice on sleep...being on nightshift for...a solid year and half, I'm...struggling with that.... That's really wearing on me." Chandler's hospital normally provided three months nursing orientation, but he recalled, "I actually...had orientation in half that time...then you're suppose to have a few weeks of orientation on nights but I only had two shifts...it was a little scary."

Many of the new nurses hit the ground running; they confessed to working extra shifts in the first year of practice in their quest to learn as much as they could in a short amount of time.

However, all of the NLRN who talked about picking up extra shifts during the first year were no longer doing so on a routine basis because of the physical and emotional toil of 12-hour shifts. Emma admitted, "I think I said 'yes' to too many things my first year...so you learn...to balance the extra stuff you do...for the hospital, but the first year you just want to do it all." Ava declared, "I could work six days when I first started, 'cause I liked having my patients multiple days in a row. Now, on day four, I'm exhausted."

Other nurses described the fast tempo of their jobs and the negative effects on patient care. Olivia proclaimed, "It's fast paced" and Rose confessed, "a lot of times...we have a lot of patients and not enough nurses. ... It was stressful to know that I was responsible for four of those patients on my own without any help." Similarly, Jacob recalled, "when we first started we were...within a month or so, I was being tripled in the unit.... You're just doing everything you can to keep your head above water with three patients". Mia perceived her situation to be an unsafe patient care scenario:

> A hard day is whenever you have seven or more patients. Whenever nightshift leaves you stuff to do...and I have my own stuff to do. I've had days where I...start off behind.... When you've got patients that are really confused and they set their bed alarm off every 15 minutes or you've got those confused patients that won't stay off the call light, those are very hard days. I don't mind a steady day but whenever it gets to the point where I have ten things to do at one time, that's just, it's too much. It...really is and sometimes...it's unsafe.

Others

The NLRN were keenly aware of social order and relationships as they described day to day interactions with various other people. Participants described both positive and negative

patient care experiences and expressed dismay with coworkers, managers, physicians, and even family members who interfered with their ability to do their job. Family members were judged as either good or bad in regards to the NLRNs interaction with them. Reactions to family members covered both ends of the helpful-unhelpful spectrum. The unhelpful family members were accepted as part of the job they just had to learn to deal with. Emma, being a pediatric nurse, often felt frustrated with social situations that were out of her control: "I knew she had been abused.... I had heard and I had documented everything I had heard the mom say on the phone.... Two weeks later they came back...then it was shaken baby, so that was frustrating."

Mia and Olivia identified family members who had been "medically trained", specifically nurses, as "the most difficult ones to deal with". Olivia confessed, "it can be intimidating if they've been an old ICU...or OR [operating room] nurse, I mean, they know a lot, so...I just try to include 'em as much as possible." Mia agreed, "you kind of feel like you have to prove yourself to 'em cause...they do know what's going on."

Coworkers made a big impression on the NLRNs and were judged by their ability to meet the needs of the new nurse. While most participants perceived their coworkers to be good team players, the NLRN described some coworkers as unhelpful and unsupportive. Mia suggested, "you have to learn your coworkers"; she encountered a nurse who "holds a very high role" and makes the nurses' schedule. Mia did not agree with her peer's tactics: "She would change her own schedule.... She's kind of lazy and she likes for it to be very staffed on the day she works." Mia perceived her relationship to be better after calling her peer out for the schedule change: "I think she actually has a little more respect for me because I did stand up to her." Rose suggested, nurses "that don't fit are less willing to work as a team...more just wanting to get ahead and do their own thing." Ava noticed, "two people in particular who will just sit there while you're

drowning.... One will sit in the back and clip her fingernails...[while] you've got other people running around."

Often the NLRNs were "yelled at" or "talked down to" when interacting with physicians. In a frustrated tone, Mia acknowledged, "we are at the hands of the doctor; we can only do so much.... It's hard whenever you have doctors that won't cooperate". Rose agreed:

> You have to suggest things but if they don't take it, then you just have to wait it out and if there's any changes then push for it again.... You feel helpless because when you've...used everything that you can do as a nurse under your scope of practice and try to elevate to the doctor and have them intervene in a way that you think is correct...and they don't follow that...it makes you feel helpless because really you feel like something's going on and if they don't, then nothing will be done about it.

World

The hospital workplace was a source of identity for the NLRN as they began to develop a sense of self. Participants identified themselves by the type of unit where they worked, e.g., an oncology nurse, a pediatric nurse, or a critical care nurse. The individual work unit was also a place where NLRNs experienced connections with other people and formed professional relationships based on their role as nurse and as a new member of the workforce. Participants described both positive and negative relationships; the supportive relationships were certainly figural for every participant and will be discussed in great detail later in this chapter. Episodes of bullying and passive-aggressive behaviors were essentially accepted as part of the job. Sophia perceived the bullying to be a result of "old school versus new school" and believed that "a few people...are strong-willed, and they have their own opinion about everything", but she also realized how to overcome those people: "you...just have to either redirect or not focus your

energy on that person." Emma described her hospital as "a very cliquey place to work" and felt like she was "in middle school" when she overheard nurses talking about her in the break room. Chandler and Emma noted "passive aggressiveness" between day and night shift. Chandler admitted he was not a victim of this passive aggressive behaviors but had witnessed "female to female aggression" originating from nurses who had been there for awhile toward the newer nurses: "They sometimes don't have a lot of grace for new grads so even a little mistake can be blown up to look like it's a huge problem." Emma also witnessed passive aggressive behaviors:

> A lot of the reporting to tell on each other is excessive and vindictive sometimes.... I've caught a night nurse going through [a chart], I said, 'What are you doing?' she was like, 'I'm just going through all her charting to see if there's something I can catch her in.' That kind of attitude...makes me really nervous cause then not only do you have to watch for yourself...but you gotta worry about who you're reporting to... It's depressing...it's... stressful so not only do I have the stress of patients and families and trying to get everything done...I've also got to worry about who I'm handing off to 'cause they're not for me...they're not on my side. - Emma

Participants in my study witnessed alarmingly high turnover among new and veteran nurses during their early years of clinical practice. Poor staffing, incompetence, and being treated unfairly by management were speculated causes for their peers to leave. Jacob believed many of his peers didn't know what they were getting in to: "a lot of 'em don't make it.... From our class...we had 10 or 12 but three-fourths of them are gone. Two didn't make it out of orientation...some...quit before they were off precepting." Emma, on the other hand, experienced a mass exodus of veteran nurses:

> I've watched nurses leave that have been there for 14 years and one that had been there 20 something years. That made me nervous when they all left at the same time.... What that did is made me one of the more experienced ones on the floor at night and that scared me...I wadn't ready for that.

The participants in my study experienced all the same issues that nurse researchers have attributed to high turnover rates; so what kept these NLRNs at the bedside? Mia said it best: "I've seen a lot; I've learned a lot; I've overcome a lot of hard days.... There are days that I love it, but it's a love/hate relationship. It is very hard work. I would do it all over again." Over time, the NLRNs in this study adapted to their new roles and responsibilities and chose to stay in their first nursing jobs as opposed to leaving.

Figural Themes

The figural themes discovered in this research study were those that overshadowed the negative grounds which have been profoundly discussed in nursing literature. For the purpose of this study, a figural theme was experienced in some capacity by all nine study participants. NLRNs who stayed in their first nursing job beyond the first two years of clinical practice shared five experiences: 1) I found the perfect fit, 2) we're a pretty cohesive group, 3) it's about caring for the patients, 4) I've learned a lot, and 5) I make a difference.

Theme One: *I Found the Perfect Fit*

Nurses who remained in their first RN position attributed their steadfastness to finding the perfect fit. Patient populations, coworkers, entire hospital systems, and being called by God were credited for new nurses' tenure in their first hospital nursing job. Nurses who were passionate about nursing were able to focus beyond the physical and emotional demands of the

job. Olivia alleged, "This job is both physically and mentally demanding...you really have to love it. It has to be a passion to be a nurse. It's not a job for everybody." Often nurses who had experienced their workplace as a student nurse developed a passion for a particular patient population and knew they wanted to work there. Ava stated, "it's the only place I wanted to work when I graduated." Sophia was attracted to the hospital in general: "I love this hospital and as long as I'm an RN, I would probably work here...because of the people." Chandler felt he was fulfilling God's plan, "I'm there because God wants me there... and it's my calling, my mission..." Even after the newness of the job faded, passion and desire to help other people overshadowed the physical and emotional demands experienced by the new nurses.

> I wanted to be a cardiac ICU nurse from the beginning...and one of the few places I applied for. I can't see myself doing anything else. ...it's my passion. You have to have...the passion and... want to help other people cause if you don't you will get burned out quickly... I could see how it would be very hard to stay somewhere that your...heart's not in it. So you have to be passionate about it from the beginning. - Emily

Finding the perfect fit was a two-way venture for Rose, the only participant hired into a nurse residency program. Rose described the process in which she and her managers identified the perfect fit. Rose perceived that the staff nurses and managers were willing to invest the time needed to select the right nurse for the right unit because they wanted to retain their new nurses. For Rose, finding a good fit was important because she would spend a lot of time with these people. To find the perfect fit, the new nurses rotated through each clinical area to see which unit culture best fit their personality. Rose avowed,

> I'm placed on this unit...because it really is...a perfect fit for me. I really enjoy going to work everyday...and feel that the nurses that I work with...try to be the best nurses that

> they can be... I was on each unit for two days...we could...see the area that we thought we fit best and the nurses on those areas could also see if we fit well with their culture.... it's just...a personality thing where you can assess...are these the people that I want to work with and want to spend my...36 hours a week with or do I not really fit in with these people? ... it...makes for a happier floor and a happier nurse when you can find the right fit.

Several participants served on committees to hire new employees and were now involved in identifying personalities that best fit their workplace culture. As a new committee member, Emily stated, "you can tell when a person is passionate about something or...just...trying to get a job. So as long as we...pick those people out and find...the best personality fit for our unit...then you...say night shift or day shift". Participants realized day and night-shift managers look for the same professional qualities in a new nurse but further described the personalities that best fit day or night shift. A new nurse who is more confident making decisions and working autonomously was supposed to be a better fit for night shift; whereas a nurse who seemed insecure, nervous, or lacked critical thinking skills was placed on day shift so they had access to more resources. Emma shared:

> I got to be on the committee to hire.... Some...looked great on paper but I could tell not gonna work for our dynamic on the floor and you really could tell the difference between a day nurse and night nurse...where they were gonna probably fit in better. ... for nights, we looked for more autonomy and that they feel more comfortable making decisions without a doctor there cause you just have to make quick decisions...then call later.... If they seemed really...bright, they'll be a good nurse but a little more nervous, we sometimes put 'em on days... if they were just nervous about skills, maybe nights...we

really do get to practice a lot more skills at a slower pace, but critical thinking, I think sometimes they have more resources...during the day.

A Less than Perfect Fit.

Emma had a less than perfect fit. She did not fit-in with her coworkers, but she loved making a difference in the lives of her patients and families. Emma did not "fit into...the demographic age of a new grad" and couldn't "do a lot of the out of work socializing". Family responsibilities hindered Emma's ability to get to know her coworkers on a more personal level. Emma was subjected to workplace bullying by one of the nurse managers; however, as an older nurse, Emma was comfortable confronting the nurse manager. She said, "some of that comes with experience of life, you know, and age". Emma's workplace was also filled with passive-aggressive and vindictive nurses who caused her to worry and be nervous about someone reporting her. Nonetheless, Emma was passionate about nursing, pediatrics, and nightshift; she said, "I think what keeps me grounded is I love the field I'm in.... I live to help people.... If I was not passionate about pediatrics it would be hard to stay."

Mia completed an eight-week clinical rotation on the nursing units where she was hired, so she had experienced the job and the people prior to accepting a job offer. Mia acknowledged, "I've made good relationships and I think that's what's made me comfortable as...a new graduate." However, she also confessed that she "don't see eye to eye" with coworkers on her unit, because "they don't have the same [Christian] values". For this reason, Mia frequently entertained the idea of transferring to another floor, but she had a "fear of the unknown" and was "afraid of change", so she preferred to stay in her "comfort zone". For Mia, the thought of building new relationships as a NLRN was so stressful that she chose to stay in an environment where she had clinical experience but did not fit perfectly with her coworkers.

On the other hand, Jacob found the perfect fit with his coworkers, but he did not convey any enjoyment in his job. In fact, Jacob was the only participant I perceived as lacking passion for nursing. Jacob declared, "the thing I like most about where I work is the people.... I can honestly say there's not one person that I dislike.... That's by far the biggest positive that I have...right now." As a NLRN, Jacob witnessed a high volume of turnover among his peers and made a personal two-year commitment to stay in his first job:

> The way I looked at it was if somebody gives me the opportunity to work for them and they invest all this money in the training and everything...well...stay there guaranteed for two years then reevaluate my options, because it's just a big waste of money and resources.... Obviously most people don't see it the way I see it.

At the time of the interview, Jacob eagerly awaited his two-year anniversary, so he could reevaluate his current position and begin "looking around". Jacob's motivation was money; he claimed, "we're severely underpaid". Jacob had not requested a pay raise yet, and was apprehensive because he had perceived the "head guy" allowed some of his friends and coworkers to walk out when they requested a pay raise:

> They won't give you a raise even if you go in there, and they've invested all this time, and they're gonna have to hire a new person, and invest all this time and money where they could just give you a little raise...and keep an employee.... You basically have to skip around jobs to get your pay increased, which I don't think is the best...use of resources.

Some participants reported working with nurses who did not fit into the unit culture. Jacob suggested, in the following passage, the interview process contributed to new nurses being hired into units where they can barely keep their head above water.

> I interviewed with a lot of people and...out of...six or seven interviews I went on, I only got asked one question that actually involved...any type of competency in nursing. Everything was all these BS questions...where you could just make up an answer, like Are you on time? Do you think this and this? There was nothing to actually...let them know that you knew what you were doing. ...if you could present yourself well, you didn't even have tell the truth...you could be hired in and they would have no idea if you're an idiot... ...in Critical Care, you can...sink really fast if you don't know what you're doing...but they do...make it in there and once they've invested all that money in you, they do their best to keep you around for a while...and some of 'em do...recover.

In addition to finding the perfect fit, several influential people supported NLRNs' decision to stay in their current jobs. Even when patient care and administrative decision created difficult work days, it was their relationships with coworkers that stood out. In the next section, NLRN discussed their personal relationships with coworkers, preceptors, managers, and physicians.

Theme Two: ***We're a Pretty Cohesive Group***

Coworkers, preceptors, managers, and even some physicians made lasting impressions upon the NLRN in my study. As stated in the grounds, participants had accepted bullying and incivility as part of the job, but the participants agreed the people they worked with were supportive. Jacob found it easy to go to work because he related to his coworkers as "a big group of friends" and a "cohesive group". Generally, participants wanted to do a good job and were energized by working with nurses who also exhibited similar work ethics. Emily affirmed, "the work ethic of the people I work with makes you want to do a good job, also, when you have other people that care about where they work and care about the people they work with".

Several new nurses equated work relationships to that of being like family and doing things together outside of work enhanced their relationships. Sophia acknowledged, "I'm friends with many of them outside of work and.... I feel very thankful that I have the coworkers that I do." Earlier, Chandler was shocked that coworker relationships were as significant as those he formed with patients. Here, he shared a special bond with a coworker that evolved outside the workplace: "I lead a small [church] group throughout the week...one of the guys...starts going with us and hanging out so that's been really cool to see us not only bond in a coworker atmosphere but also in a...spiritual environment". Emily corroborated these sentiments:

> It's like a family...we do other stuff outside of work together...and you really get to know your nurses and you are more likely to pick up a shift for them or switch shifts...if you are able to bond with them other than being at work and... [it] will help morale and help teamwork.

Coworkers who shared their knowledge and expertise with new nurses made an impact on the NLRN. Chandler admitted, "having older and wiser coworkers who have a lot of experience who have been able to bless me with their knowledge and their expertise has been really, really cool." Participants described personal connections and supportive relationships in which teamwork was evident and they had each other's back. Several participants discussed coworkers and preceptors.

> the bond with my coworkers has been...a surprising benefit...I...thought I was there for the patients...but when you spend 12 hours a day with...someone, there's a bond and connection there that you...don't normally get in other jobs... ...when you're in a stressful environment and you're handling problems together and you're getting each other's back, there's a connection that grows there. - Chandler

> You grow very close to your coworkers. You...see a lot together and even personal stuff that happens...in the middle of shift...we'll stop and pray together.... That's a different camaraderie than I've had with other people I've worked with in other professions.
>
> -Emma

> I have a good team on my floor some people that have had experience but they don't eat their young like some nurses do...they really try to build us and...make us good nurses.... The stepdown nurses...took us in and protected us...told us what to look for...and all the things to have before you call the physician.... At no point did I ever feel like I was abandoned in my unit which is really important 'cause we take care of some sick patients.
>
> - Olivia

> Your coworkers are the ones that make the difference.... making sure you have food to eat before the cafeteria closes.... They have your back, whether it's bathing, turning patients there's no hesitation, problems with a procedure or something that happened that you've never heard or seen before, they...are there to explain or answer questions or research it with you. - Sophia

On the other hand, Mia had more anxiety about building new relationships and fitting in with staff than with patient care concerns. Over time, Mia found she had nothing in common with her coworkers: "I just don't see eye to eye with people I work with. They don't have the same values that I do.... I would not consider them friends but just acquaintances". Essentially, Mia chose to stay in a job that was comfortable as opposed to starting over which would not only require learning a new job but also building new relationships with new people.

Preceptors.

Olivia's preceptor was "patient and kind and just really helpful"; Olivia said, "she let me take things at my own pace but...helped me to learn how to prioritize". Emily described her preceptor as "motherly and protective". Emily felt secure in knowing that she was "not going to be thrown to the wolves" when they told her, "if you don't feel comfortable being on your own, we won't put you out there". On the other hand, Chandler's preceptor released him early:

> I started out on dayshift...in orientation with a preceptor; I felt...prepared and they thought that I was prepared so they took me off early and then put me on my own on nightshift.... It was a little scary, but looking back, I'm glad I was able to and...[they] had the comfort in letting me go.

In addition to clinical preceptors, having consistent shift leaders or charge nurses contributed to NLRN successful entry into practice. Olivia stated, "we have a consistent shift leader... He works during the week. ... He's really good. ...he was really helpful for me as a new grad". On the other hand, nurse manager's had opportunities to influence the NLRN entry into practice decisions from the time they were students, conducting their first interviews, and deciding which job to take. Managers also influence NLRN decision to stay or leave when they become overwhelmed with the physical and emotional realities of their new job.

Managers.

In my study, some managers were like magnets drawing the NLRN toward them. Ava said this about her manager: "I think if my manager left, I would probably leave. She's the reason I wanted to work there." Often, participants recounted experiences wherein the manager recognized their contributions to the team and incidents where the manager stood up for them in a difficult situation. Nurse managers made a lasting impression by role modeling desired

behaviors, investing time and energy into training new nurses, and making sure they had the resources they needed to be successful in their first jobs.

> It's good to know your nurse manager will go to bat for you...he told me he knows what kind of nurse I am. ... It just lets me know that he has faith in my decision making skills and...it was a good feeling that he was supportive of me. - Mia

> My nurse manager...she's great. I've never seen her in business clothes; she will...dive in, help you turn your patients, help you clean your patients.... I know my manager will always stand up for me even if it's an issue with me and a family member, me and a patient, or me and a doctor. She always looks at both sides of the story but in the end she'll always be there to support me and to tell me what I need to do and help me with the best decisions. - Emily

> My manager's great. I feel like our manager was wanting to retain us...and she was willing to work to retain us and to educate us. ...but she wasn't throwing it at us to the point where we became overwhelmed.... I think that's what helped keep me.... You have to put in a lot of work with new grads to keep them and to make them feel confident.... She doesn't ever make you feel dumb or...not respected. - Olivia

Emma did not get off to a good start with one of her managers; she stated, "she's kind of a bully". Emma recognized the negative effect the nurse manager's behavior had on her patients and families, so she confronted the nurse manager. The participant acknowledged that her age and life skills contributed her boldness when asking the manager to stop undermining her authority, because none of the nurses on the unit had ever stood up to this bully manager. From that point forward, Emma never trusted the nurse manager even though her attitude changed.

Emma said, "she's been very complimentary of me and wrote me a great review...but I watched her move on to the next person".

Sophia connected management styles and employee morale. She described a "micromanager" who does a lot to boost morale and a "not so controlling" unit manager that does very little to boost employee morale. Sophia suggested, when employees are encouraged and energized by their managers, they tend to band together and get things done.

> We have two different units...I can see how one manager does things to...boost morale... ...she's a micromanager but she...does a lot more things for our unit. Our...other manager is not so controlling. ...as long as we're...doing what we're supposed to, she...lets us have a say and...lets us be the judge of things. However, she doesn't necessarily do things to boost morale so I just feel like certain things could be done differently...from administrative standpoint in order to maybe get your employees to...band together.

Numerous times, nurse managers served as gate-keepers between NLRN and physicians. The most feared relationship among NLRN is that of the physician.

Physicians.

Physician relationships were described as "hard-earned" and often got off to a slow start because the new nurses felt like they had to prove themselves to the doctors. Ava described a "love/hate relationship". Several participants agreed that talking to physicians was stressful at first, but overtime, most participants found they could learn a lot from their physician counterparts and relished those relationships. Chandler shared, "I've made a lot of good friends with residents [and interns]; you learn a lot through them.... They're almost always willing to share their knowledge...it's new and fresh to them and they want to show how much they know".

Physicians also had the ability to affirm nurses by reinforcing patient education and reiterating concepts the nurse learned in school. Participants willingly shared positive and negative physician experiences.

> One of our doctors in particular, you have to...catch him on a good day. He follows his patients very well after surgery but it's always his way or no way. This doctor will...pick on the newer nurses...It's like you have to prove yourself to him. My manager says that if he doesn't pick on you, he doesn't like you and I'm like, 'oh well that's awesome because he picks on me all the time (laugh)' But...we get along fine now.... He's very good at explaining things. He's one of my favorite doctors and we just go at it all the time. - Ava

> The bond that we have with our doctors...they're real skeptical of new people at least from what I've encountered. The vast majority of them are...if they don't really know you, they don't really trust you and they want...to micromanage you or...just ignore you all together but as they work with you over a long period of time, they start building that trust...and they start giving you more leeway and also giving you more insight into what they're thinking and even in some cases asking you what you would do or what...you think the patient needs...that's really honoring to me, when I have those relationships and some of my favorite relationships...probably because they're...so hard to earn. - Chandler

> When a physician tells you you're doing something well...the fact that he's concerned...about me learning stuff makes me feel that he's confident in me...that I can grow enough in this environment...to be a good nurse. - Olivia

> The physicians I work with are great. I know that most, if not all of them, would have my back if there were any issues...if it's appropriate. It's very reassuring. It makes you feel

> like you're doing the right thing and all the stuff you learned in nursing school actually does help the patient whenever you have a physician backing you up. - Emily

In addition to coworkers, managers, and physicians, patients and family members were influential in NLRN early years of clinical practice. In the next section, NLRN unreservedly share experiences of providing nursing care and caring for patients and families.

Theme Three: *It's About Caring For the Patients*

Building a trustworthy relationship and bonding with patients and family members was significant for the participants in my study. The new nurses recognized their own demeanor and confidence level affected patients and families. For example, when an anxious nurse enters a patient's room, the patient and family may feel insecure and react negatively. Chandler described his efforts to neutralize negative responses: "I just walk in with a smile and a kind word and a calm spirit, it...almost always calms them down too because when we come in with an anxious spirit or uptight...they'll sense that...and react". Several participants described patients as "vulnerable" and recognized their job was to provide quality care for each one. Chandler declared, "no matter what the patient is there for...it's about caring". Mia took her job very seriously and felt responsible for providing a positive patient care experience:

> You have people's lives in your hands literally. You make one mistake and you know that could cost them their life... ... It's nothing to play around with...it's to be taken seriously. Nursing is nothing to be taken lightly because these people come in with life changing events. ... These patients are very vulnerable...and they are reaching out for you to help them. That's why most of 'em are there; they want help...and it's up to us to...make it a good and positive experience for them. Recognizing, 'oh there's something going wrong' and getting on top of it before something really bad happens. - Mia

Participants described numerous patient-care scenarios in which their keen assessment skills and gut intuition were instrumental in determining appropriate patient care interventions. Several participants described an "instinct" that allows the nurse to look at a situation and say, "this is not good". Rose described "a pretty intense situation" when she responded to a patient's request to go to the bathroom:

> Her blood pressure...was 52/30...I...had her lay back [in bed]...and called a rapid response. I took her blood pressure again and it's...30/16 so...we called a code... Meanwhile, the patient was still talking to me... When the doctors got in there, they were kind of confused as to why this had...happened and I noticed...there was some blood on her bed sheets and it wasn't there previously. ... We...took her...to the CT scan and found out that she had a massive abdominal bleed due to her bone marrow biopsy.

Ava described an incident with a confused, demented, 90 year-old patient while she was still orientating in the step-down unit. The patient had a STEMI (ST segment elevation myocardial infarction) and had one stint put in; he was "very sick". Ava's intuition told her "there's something going on", but her lack of experience caused her to think the patient was having a GI bleed rather than reoccluding a stint. Here's what Ava said about her first code experience:

> I walked in at 6:40...I didn't think he was re-occluding his stint. He looked like somebody who had aspirated or had a GI bleed ... I kept telling our charge nurse...'there's something wrong with this guy'... 'I don't know exactly what it is but there's something wrong with him'. ... [After awhile he] was like no response and so he vomits blood and goes PEA (pulseless electrical activity)... We coded him for like 40 minutes. ... The family...ended up wanting...a DNR...but we didn't have any paperwork. That was awful.

Nurses demonstrated keen patient advocacy skills and occasionally put themselves in precarious situations to make sure the patient received proper care. NLRNs in my study willingly took extra time to make sure the patient understood their diagnosis and treatment plan; requested special assignments when they perceived another nurse might provide substandard care for a particular patient; and questioned physician orders when they did not agree with the plan of action. Rose understood the importance of her role:

> When...patients are going through...emotional times it's important for us to show them that they're a priority and that we're not rushed...we have time to sit down and talk with them and make sure...they understand fully what kind of care...or what treatment they're receiving and sometimes all that requires is us...standing in their room for an extra few minutes.

While Rose may have gotten behind on medications or treatments, she had a supportive environment which enabled her to spend extra time at the bedside. On the other hand, being a patient advocate came with some risk for other NLRNs. Emma jeopardized relationships with her coworkers and managers for questioning staff assignments, and a physician tried to get Mia sent home for questioning her authority and trying to "go over her head".

> You get...protective of how vulnerable they [patients] are. ... I have requested patients not have a certain nurse...because I don't think they'll be kind with 'em or take the time to teach 'em...how to feed their baby...but really that mom just doesn't know they're supposed to eat every three hours. - Emma

> I disagreed with the path that we were taking for this patient. ... I felt like...the doctors were writing this patient off because he was a drug abuser and that's not what I was

> taught. We treat everybody the same regardless of faith, ethnical background, lifestyle choices cause that's none of my business and they are there for me to take care of them. I felt like we had jumped a few steps in terms of...doing a swallow eval. - Mia

Emma avowed, "the patients...that is why you do what you do. I live to help people..."; for that reason she found it more difficult to deal with social issues than physical ailments:

> The social stuff is what gets you...and learning that poverty is not a crime. It doesn't make 'em bad parents. They're just poor so...we get frustrated cause we know they're going home and not be cared for as well as we care for them, but that doesn't necessarily mean they're not loved, they just don't have the resources...so we try to send 'em home with as much formula as we can... The babies...are some of the harder, watching 'em leave...knowing they're not going to a great situation.

NLRN would frequently depict family members as negative characters. Jacob confessed, "sometimes the family members will make the situation way harder and they're the most difficult ones to deal with...more so than the patients". Yet most often nurses treat the family as an extension of the patient. Olivia suggested, "you...become a caretaker for the family. I've known wives that won't eat for a...full day because they don't want to leave their husband because he's so sick. I tell them, 'you have to take care of yourself...to take care of him'". It is not uncommon for family members to sacrifice their own health when a loved one is ill or hospitalized. With prolonged lengths of stay, the NLRN may find themselves deeply vested in both patient and family care.

Caring for the dying patient and their family.

Several nurses described deeply emotional connections with family members actively experiencing the end of life with a dying patient. Without fail, nurses shared their first experience with death and not being prepared for the emotional weight that ensued. As Chandler recalled a patient he had taken care of for over a year and a half, he claimed:

> As he [the patient] deteriorated, his family also deteriorated... It was tough having to devote the care for him but also caring for the family.. ... I...deal with a lot of post-mortem care and pronouncing and I didn't expect the weight of that either 'cause when you walk into a room and...they think the patients passed and they look at you for an answer.... Everyone's eyes are on you. You definitely feel that weight of...being close to someone for so long and caring for them... that's been something that you...can't prepare for either. - Chandler

> I'll never forget his face; he was very sick. He was dying. He was dying fast too.... It was really hard to...overcome that concept as a new nurse 'cause most of the patients I took care of...got well and went home or went to rehab. It's a hard, death is a hard concept. ... It's hard too because you become attached to those patients...you know their habits. You know where they like their side table...and if they like to have their head propped.... it's never easy to let somebody go like that. ... [Now] I only allow myself to review it a couple time, otherwise I won't let it go..... You have to learn how to let those things go.... I have to have an outlet for the stress.... I run a lot. - Olivia

> I remember the first time... I had to walk in with the doctor to tell them their two-month old was not gonna make it, and did they want... the baby to die at home or... here. We

> walked out and I just walked straight to the med room and started crying. ... If that doesn't make you cry, something's wrong, you know, watching a mother deal with that - Emma

On the other hand, Jacob found it difficult to form a bond with patients in critical care. He spoke of unresponsive, sedated, and intubated patients and believed this was why he was less emotionally involved when a patient died:

> The sickest patients in our unit are ventilated and you're not like forming a bond with them so it's...still rough but it's not as difficult if they pass cause you're not like connected with them. ...definitely makes it easier if you don't have a bond or a semi-friendship with these people when that happens. - Jacob

Throughout the early years of clinical practice, patient care experiences provided numerous opportunities to practice skills and to apply the knowledge the NLRN learned in school. In the next section, segments of transcripts are presented regarding participants' perceptions of significant growth in their self-confidence from entry into practice upward to their current situation.

Theme Four: *I've Learned a Lot*

Participants realized just how much they had grown as they described transition experiences from student to newly licensed registered nurse, from new nurse to preceptor, and from bedside nurse to various leadership roles. Several students expressed a commitment to lifelong learning and have either already enrolled in graduate studies or plan to do so in the near future. Five sub-themes emerged from the text: 1) from school to practice, 2) I don't have to know everything, 3) from asking to answering, 4) beyond the bedside, and 5) a drive to go back to school.

From school to practice.

Several participants shared patient-care experiences to demonstrate their keen assessment skills and their growing intuition. Most of the nurses reflected on their unique school experiences and being able to see the whole picture once they entered clinical practice. Ava said, "I can tell that I have grown a lot. ...I remember starting out being so scared...and then it takes you a good year and half almost two years to get comfortable in what you're doing". Only a few participants perceived real life nursing to be very different from their nursing school experiences. Chandler told me, "I feel like school inherently has...this...cushion where you, you feel the pressure and you feel everything, but you don't really feel the pressure of taking care of someone's life". Mia and Jacob were the most vocal about the transition from school to practice experiences.

> When we were in nursing school...you feel like an accomplishment...you had three patients and you gave all their meds during six hours or so, you thought you'd actually done something and that's...the least of what you're actually doing during a nursing shift. ... [You're] looking at the whole picture and making sure they're getting the best care available and...what their problems are that day...what the doctors going to address...make sure everybody's communicating correctly.... Basically we are just managing a lot of information about the patient and make sure everybody's on the same page which is something we didn't do in nursing school. We didn't talk to the doctors... You didn't know what you were missing in nursing school 'cause you didn't know it was there. - Jacob

> I do remember thinking, 'this is not at all like nursing school. This is a lot harder' and...it's true whenever they say, 'textbook nursing and real life nursing are not the same thing'. I

> was very nervous. I was very unsure of myself because...not only do I have to learn new things, I have to make new relationships with new people and that's hard. ... I told myself that I was in over my head and I didn't even want to be a nurse. ...I'm not sure if it was just anxiety to the point that I wanted to quit, but I think experience, experience is always the best teacher and just doing it yourself. After I got used to it...I was really excited whenever we started getting nursing students because I could remember what it was like. - Mia.

Olivia started work on her unit the same time two other NLRNs were hired. She continually compared her lack of confidence with direct patient care to the fact that she did not work in the hospital as a student nurse while she was in school. Olivia perceived her peers' skill level far surpassed hers upon entry into practice:

> I didn't work anywhere in a hospital [as a student nurse] which...would have been more beneficial...'cause I was just awkward with things.... it was harder for me to grasp things...even bathing a patient, turning them, positioning them.... I think school prepared me for a lot of things to see but once you finally get your hands on the equipment and on the patient, you just learn a lot more. - Olivia

Most of the participants in my study agreed their school prepared them for clinical practice but still experienced challenges as a NLRN. These new nurses were like sponges during the first year, but realized they still had a lot to learn. Over time, the NLRN learned they did not know it all nor did they have to know everything in order to be a good nurse.

I don't have to know everything.

The NLRN in my study realized they were "still learning everyday" even though they had been out of school for two or three years. All of the participants reported increased self-confidence and the ability to think on their feet. Rose said, "it's gotten easier to manage situations that are emergent...without freaking out or without having to ask for...help. ... I've been able to address those situations with...more knowledge...and much more confidence". Emma described her learning "like peeling an onion" and acknowledged, "I'm still learning what I don't know". Chandler interjected humor when he described intermittent episodes of self-assurance and uncertainty:

> There's been points where I've...felt like, 'oh man! I'm really starting to get this...I got...this thing down...' and then...there will be a case or a situation where it just completely knocks me out of left field...and I'm like, 'oh wait, no I don't, I just thought I had this'. I am still learning everyday...learning that I don't have to know it all and neither does anyone else.

Mia understood the importance of lifelong learning when she stated, "I'm always gonna be learning. If I ever stop learning that's whenever I need to change careers because it's an ever changing field and I have to realize I must change along with it." Other participants were encouraged by experienced nurses who readily admitted they *still* don't know it all. Emma avowed, "I see people who've been there ten years and don't know what to do so it's...reassuring in an odd way, but everything changes - medications...and protocols change every time you turn around. Chandler shared similar sentiments:

> I work with nurses who have been nursing for some...of 'em 30 or 40 years and they're a wealth of knowledge...and they've seen almost everything, but there are times when they

> have never seen it...that...makes me feel good in knowing that there will always be those cases where...we can constantly learn...it's encouraging to me that I don't have to know everything or have it all together to still do a good job. - Chandler

When a patient was sent to the pediatric intensive care unit (PICU), Emma questioned her own knowledge, skills, and ability to be a good nurse. She beat herself up emotionally for days before receiving affirmation from the unit nurse that they did not think she was at fault:

> I had a patient go to the PICU...you beat yourself up for that too, 'did I send that kid to the PICU? What did I miss? Could I have caught...a symptom earlier?' ...that's hard to let go of, too. ...it...just messed with my thinking. 'Am I even a good pediatric nurse? Should I even be doing this?' I totally missed that kid...he was in fluid overload and I missed it... ...but...the PICU nurse that got the patient...said, 'oh we didn't think it was you.' ...so here I had been beating myself up thinking everybody thought I was just a horrible nurse and you think everything's about you and it wasn't. - Emma

NLRNs described unending learning opportunities and their transition experiences from school to clinical practice. In the next section, NLRNs recounted the shift from being the new nurse asking questions to now being the one to answer questions for the newest nurses. Eight of the nine participants had served as a clinical preceptor for at least one newer nurse; Jacob had worked with newer nurses but was not assigned as a clinical preceptor.

From Asking to Answering.

New nurses described their transition experience from being the one asking all the questions to now being the one to answer the questions. Many of the participants remembered what it was like to be the new nurse so they were willing to answer questions and help the

newest new nurses. Often participants recalled experiences with their preceptors and saw opportunities to give back what had been given to them. When asked to serve as a preceptor for a new nurse, Olivia stated, "I felt like that was a sign that I had grown enough to where my manager felt like I was capable of teaching somebody." The NLRN described their preceptor experiences as exciting, enjoyable, and a little scary. Scary when they realized they were the "go to person" or when they don't have the answers. Being responsible for someone else's success was scary for Rose:

> I think that just sometimes when...you're responsible for how...the new nurse functions on their own can be a little bit scary, just because everyone learns in a different way.... that part is scary trying to figure out...how to best teach the person to be able to be confident by themselves.

Emma was comfortable in her role as a NLRN, but came to a sudden realization that she was the *go to person* when the newer new nurses arrived:

> I can tell you where things are, and I can tell what the policy is, and I can tell you different things.... ...but when they're, 'hey come look at this kid with me', I'm like.... 'how am I suddenly the person that comes to look'.... it's just different being the... go to person. You think it's gonna be great but then, it's kind of scary too. It's a little of both I guess.

All participants shared responsibility for teaching the newer nurses and were willing to do whatever was needed - even if it made their day more difficult. Ava was more critical of her role as preceptor; she confessed, "I should never be a teacher 'cause I'm so OCD that I like to do things myself so it's really hard to had the stuff over". However, Ava described herself as "a big

sister" when she perceived her trainee was being picked on by the physician who had picked on her as a new nurse. Ava told him, "I'm teaching her things; leave her alone".

Mia thought "the best [way] to provide quality care is to be educated". When the newer nurses ask Mia for help she said, "if I don't know the answer, I...look for it. ...it makes work harder because if I don't know the answer I will continue to try to find the answer". Rose was a bit astonished that she was already in a position to answer questions for the newer nurses and shared the same work ethic as Mia. Rose apprised:

> I'm the person answering...questions for our new nurses which is pretty incredible to me...I don't feel like I've been a nurse for that long. ...I really like it because I like to teach people and like to help people out...it's scary at times if I don't know the answer but I always...find resources to appropriately answer the questions, or I will...go into the patient's room with that nurse and try to figure out...the correct action to take.

Within only two or three years of graduation, participant's job responsibilities had evolved beyond bedside patient care. The NLRNs working in acute care settings had already been selected by their managers to serve on committees or placed in shift-leader positions.

Beyond the bedside.

Within just one or two years, several NLRNs had been selected by their managers to serve on various committees and in leadership roles. Chandler, Emily, and Emma served on new hire committees; Chandler, Mia, and Sophia were shift leaders. When participants were singled out by their managers, they felt validated, and realized their academic preparation and clinical experience were leading them to new opportunities. Chandler claimed, "since I was bachelor-prepared...I have a leadership focus as well as patient care focus so I feel like my expertise is becoming bigger than just at bedside which is a good feeling." Sophia's goal was to one day

become a nurse manager, but she "didn't realize...this soon that [she] would have to start taking a charge nurse role...especially in a critical care unit". Sophia realized that once she started to feel more comfortable in her role as a NLRN "that it's really not such a big deal" and she believed, "you can only voice your opinion so much until you finally have to be...part of the decision-making [process]".

For some participants, these initial assignments were merely stepping stones toward becoming future managers or advanced practice nurses. Mia was also surprised that within two years she held a leadership role:

> My manager...asked me if I wanted to be a relief shift leader... ... ...that...made me feel really good. ...it justifies all your hard work. ...that was one step closer to accomplishing what I want to do which is eventually going into management.

Although career advancement opportunities had already begun for several participants, most of them attested their desire was not to return to school soon after completing their undergraduate BSN program. In the next section, participants discuss factors that contributed to their desire to go back to school.

A drive to go back to school.

The desire to go back to school after completing an undergraduate nursing program was inconsistent. Most participants said they would *never* go back to school, but after working alongside physicians and nurse practitioners for a couple of years they changed their minds. Mia confessed, "after nursing school...I told myself I'd never go back to school. I said, 'this is the end of the road for me', but then I decided after I'd been a nurse for two years I wanted to go back." Whether for the love of learning or a means to escape the physical demands of bedside nursing, Mia had already enrolled in graduate school at the time of her interview. Other participants

could foresee returning to school to become a nurse practitioner or to enter the ranks of hospital administration. Chandler shared the impetus for his decision to return to school:

> It was always my hope that I would go back and...become a nurse practitioner.... [my experience] has ignited in me a drive to go back to school and further my education. I didn't expect it to be so soon, but just being around the doctors and the environment of teaching, of learning patient care, I definitely have...a new...urge to do that sooner.

Olivia spoke earlier of getting off to a slower start than her peers because she did not have as much clinical experience. Here, she talked about the benefit of not going directly into a graduate school program because she was able to learn so much during the first two years. Olivia believed a couple more years of clinical practice will be good *if and when* she does go back to school. After completing her BSN program, Olivia, like all the other NLRNs, asserted, "no, I'm done! but after... having NPs in the unit...and working with them, it makes me realize that I would like that job eventually." During Olivia's interview, she spoke frequently about the physical demands of her job and now realizes that an NP job "wouldn't be as physically demanding".

Jacob lost his drive to go back to school after experiencing bedside nursing. He confessed to picking up extra shifts in the first year but eventually lost his motivation to work more than the required shifts. Jacob shared these thoughts as he contemplated his future in nursing:

> I initially...had planned on going to either nurse practitioner or nurse anesthetist school. I do not ever want to go back to school again now (laughing); but that being said... one of us...either me or my fiancé...*is* going to go back to school. I really want it to be her. If it

> ends up being me...I'll have to do the CCRN [critical care registered nurse certification exam] and a bunch of other stuff that I don't want to do.

Reasons for returning to school were inconsistent among the study participants, e.g., more money to raise a family, less physically demanding role, career advancement, and family-friendly schedule. For the most part, NLRNs in my study remained excited and anticipated a positive future in nursing. The final theme demonstrates the NLRNs deepest desire to know they had a positive influence or made a difference in someone's life.

Theme Five: *Knowing I Make a Difference*

Some participants became nurses because of a personal or family experience in which they encountered exceptional care or perhaps not such good care while in the hospital. Chandler talked about his reason for becoming a nurse and reiterated Mia's inspiration to turn a negative situation into a positive one: "I...got into nursing because...my mom...wasn't treated well from a nursing staff and...my goal is to come in...with the opposite viewpoint...to always make a positive impact." Nurses in my study were encouraged and affirmed by a simple 'thank you' and appreciated patients who came back to see them. Chandler said it like this: "there's a lot of stories with open ends that we don't get to see, but...lately...they've been coming back and sharing their story and telling us...how they've grown and everything so that's been really encouraging". In addition, NLRNs were energized when patients verbalized satisfaction with their care. Mia shared:

> That's always a good feeling...whenever you have a nurse or a patient that praised you to your manager.... It lets you know that all your hard work has paid off...and even just three short years...in the same unit have paid off and you have built yourself up to a certain

> point that you have a reputation where you know I can...trust what she says...that's a really good feeling, to help others, not only your patients but your coworkers as well.
>
> Hearing our patients brag about us...our unit...our physicians...really helps and makes you proud of working here. That just makes you feel good, because you're working with these people and you're taking care of the patient and you know they are happy with their care. - Emily

NLRNs recounted numerous stories detailing when they felt like they had made a difference in the lives of patients and their family members. Rose remembered "a very nice compliment" when a patient told her, "I've been so lucky to have such a great nurse. Ya'll are so great to me, and I feel blessed to be here." She continued, "it was nice to have that kind of trust with the family...I felt like it...gave them relief to know that he was with a nurse that they knew and trusted while they went home." Emma's bi-lingual skills provided opportunities that other nurses were not equipped to handle. She recounted a time when she prayed over a Hispanic child with his mother: "A mom was reading *Power of a Praying Parent* in Spanish...so...we would read it together in Spanish over her son which was really sweet, so stuff like that I love to know that I did make a difference." Chandler's experiences were grounded in his faith; he realized that what he considered routine was very meaningful to the family of his dying patient:

> I was able to...be there with the family and comfort them. ... They're a family of believers so with their permission, I was able to share some hope, a word of God's truth with them, and...it was just another day for me, but to them, it meant the world.... The week after that, they searched me out and...would tell me...how it had just calmed the

> situation and that's not of me, that's of God, In the time of their most utter need and turmoil, to bring God's calming peace was....definitely fulfilling.

Emma perceived herself as "a little peacemaker"; she saw opportunities to make a difference in the lives of her coworkers and was pleased when they were recognized by patients, peers, and managers, because it shows "they actually do notice". Emma's workgroup established a survival guide to help nurses who were floated to their unit and made assignments congruent with the float nurses expertise. In return, other nursing units implemented similar strategies.

> We give 'em candy...with...a little goody bag, 'thank you for floating to our floor'... Now when NICU comes, we only give them babies...[if] I had a baby and I saw a NICU person had a seven year old, I'm like, 'hey do you want to switch?' So...that seems to be going better. I've not heard of anybody getting a bad assignment when they go to NICU. We even have people...requesting to be floated to our floor because...we've made a difference in how we treat 'em.

All the NLRNs wanted to know they made a difference to their patients and family members, but when the nurse manager recognized their efforts, they were somewhat validated. Emma's hospital gave "I made a difference" coins whenever a patient mentioned a nurse by name. Emma confessed the employee recognition program was not very consistent but agreed "it does feel good" when you or a coworker are recognized. When the parents and managers offer praise and recognition, Emma said, it "let you know...hey, they do notice.... It makes you a little more confident". Mia said this when her manager asked he to assume a leadership role:

> I hadn't even been there two years yet and my manager approached me...and asked if I wanted to be a relief shift leader.... That was a big step for me and my career.... I

> remember being excited. I called my dad and said, 'Dad, you'll never guess what [happened]' and it's just a proud moment. It kind of...justifies all your hard work.

Sophia loved her hospital and spoke favorably about her coworkers and their willingness to pick up extra shifts when staffing was low; but she did not speak of praise and recognition from management. Instead, Sophia offered a couple simple suggestions for management to let the employees know they are appreciated and that their hard work does make a difference:

> I feel like management could maybe...put a 'thank you' card on the wall...just something to let their employees know that, 'Hey, bear with us. I know it's hard right now but...we appreciate everything you're doing', or maybe a meal for that shift...just let people know that they're appreciated, it's just a small gesture really, any kind of gesture...other than, 'guys we have to sacrifice another night'.

Emily shared a personal experience which lends support to Sophia's contemplation that a simple gesture carries significant weight with nursing staff:

> She [nurse manager] sent me a card...and said, 'you're doing a great job, I just want to let you know I'm proud of you and how far you've come so far, and always know I'm here for you if you need me'. Just out of the blue a sweet little card like that was awesome to get at your home, not even in your mailbox, she mailed it to my house so that meant a lot.

Summary

A generally supportive workplace was the contextual ground in which the NLRNs endured the complexities of bedside nursing. A total of five interconnected themes emerged from the nine participants interviewed. In the theme, *I Found the Perfect Fit*, NLRNs described their passion for a particular patient population, relationships with coworkers, entire hospital systems, and being called by God. Nurses were able to look beyond the physical and emotional

demands of the job because they were passionate about nursing and believed they were in the right place. *We're a Pretty Cohesive Group* included relationships with nursing peers, preceptors, managers, and physicians. NLRN described personal connections and supportive relationships being "like family" both on the job and outside the workplace. Participants often used the phrase "have your back" to describe the supportive nature of coworkers, preceptors, and managers. Physician relationships were "hard-earned" and got off to a slow start, but the NLRNs were now comfortable and confident with their interactions.

Participants demonstrated both the art and science of nursing in the theme, *It's About Caring for the Patients*. NLRNs were passionate about helping the most vulnerable patients; they took on challenging situations, and confronted managers and physicians if they thought patient care was compromised. Family members were seen as an extension of the patient; some were helpful and others were simply "in the way". Almost without fail, NLRN shared their first experience of caring for a dying patient and their family. While not prepared for the emotional weight of losing a patient, NLRNs accepted death and dying as part of their job. In the theme, *I've Grown a Lot*, participants described a remarkable growth in their clinical knowledge, skills, abilities, and self-confidence. Some participants felt their academic preparation had adequately prepared them for the realities of nursing; whereas, others felt unprepared for or disillusioned with professional nursing practice. Eventually, participants accepted that they did not know everything nor did they have to know everything in order to be a good nurse. Participants were moving beyond the bedside to serve on committees and to function as shift leaders or charge nurses. While most NLRNs said they would never go back to school, as participants contemplated management positions or advanced practice nursing roles, the drive to go back to school was rekindle. In the end, *Knowing I Make a Difference*, allows the NLRN to endure the

most difficult days. NLRN recounted meaningful stories where they felt like they had made a difference in the lives of their patients and their families. Yet, nurses also desire praise and recognition from patients, families, coworkers, and physicians, but ultimately, they want their manager to recognize their hard work and accomplishments.

In the next chapter, each figural theme will be cross-referenced with other research data to look for similarities and differences. Each theme will be discussed along with nursing implications and recommendations for future research.

Chapter 5

Discussion

Most newly licensed registered nurses (NLRN) go to work in acute care hospitals where they experience staffing shortages, high nurse-patient ratios, bullying and incivility. As nursing graduates transition from student to registered nurse, they become victims of the ever-widening education-practice gap. Chief nursing officers and nurse educators have different perceptions of what it means to be fully prepared to provide safe and effective care (Greene, 2010). It is imperative that hospital administrators pay attention to factors affecting patient outcomes and nurse attrition, but also establish policies and procedures to retain competent staff nurses at the bedside. The difficulties associated with the first year of practice and the resulting high turnover rates have been well documented in nursing literature. Nurse researchers have focused primarily on high nurse-patient ratios, workplace violence, and nurses intent to leave nursing. What was lacking in nursing knowledge was the perspective of NLRN who had endured the early years of bedside hospital nursing and continued working in their first nursing job. Therefore, the purpose of this qualitative phenomenological study was to understand what keeps some nurses at the bedside. The specific research question was: How do nurses who have stayed in their first hospital nursing job for 18-36 months perceive and describe their experiences? The figural themes that emerged from the participant's descriptions of their experiences are discussed in relation to previous literature and implications for nursing education and practice. The chapter concludes with strengths and limitations of this study and recommendations for future research.

Themes and The Literature

The phenomenon of the enduring nurse was the central focus of this study. To endure means "to undergo (as a hardship) especially without giving in". Based on my data analysis and

the review of literature, there was a dichotomy of positive and negative experiences that attributed to nurse retention. Every nurse in my study experienced hardships and described feeling overwhelmed, exhausted, frustrated, or scared yet something kept them from leaving their first job. Regardless of gender, age, class, clinical specialty, or usual shift, participant responses were similar.

One can argue that research findings pertaining to high turnover or attrition rates are simply the opposite of retention, so shedding light on reasons for leaving should help with retention. I surmise that countless nurse researchers have in fact documented and made recommendations to counteract the negative effects of high turnover rates with little or no avail. Therefore, my analysis of the data was influenced by Cooperrider's philosophy of appreciative inquiry. By nature, leaders look for and attempt to fix problems in the workplace, but leaders who focus on the positive aspects and look for what is going well have a better chance to change the workplace culture (Cooperrider, 2015). Five figural themes represented the overall experiences of nine NLRNs who stayed in their first nursing job beyond the typical transition to practice period of one to two years.

Theme One: ***I Found the Perfect Fit***

Nurses who remained in their first nursing job attributed their steadfastness to *finding the perfect fit;* however, the perfect fit meant something different to each participant. Some participants spoke globally about their love for nursing while others spoke specifically about the people and places. Passion was a key attribute discussed by the participants in my study. Passion is defined as "a strong feeling of enthusiasm or excitement for something or about doing something" (Merriam-Webster, 2015). Participants who used the term, passion, spoke with enthusiasm and their responses supported the phenomenon of the enduring nurse. Participants

described nursing as both physically and emotionally demanding and believed one would have to love it or be passionate about nursing to stay. Passion was not discussed in the literature pertaining to NLRN reviewed in Chapter 2. However, *passion and love for nursing* was a theme identified in a study of nurses aged 55 to 67 years old who continued bedside practice for 26 to 30 years (Spiva, Hart, & McVay, 2011). Therefore, there was a precedent supporting the notion that nurses who are passionate about nursing may become frustrated in their day to day activities, but continue to be personally and professionally gratified in their role as a nurse.

Terms such as, job content, job enjoyment, and job satisfaction were more often found in the reviewed literature. To enjoy something means "to take pleasure in (something)" (Merriam Webster, 2015), so this verbiage is less enthusiastic than the passion described by some of the study participants. Wilson's (2006) participants also acknowledged negative aspects of nursing work, but reportedly stayed in clinical practice because they enjoyed their nursing job. Enjoyment, like passion, has not been studied nearly as much as job satisfaction; however strong correlations between job enjoyment, job satisfaction, and intent to stay in nursing have been reported in nursing literature.

Participants in my study, like those in the Kovner et al. (2014) study, often found their perfect fit during academic clinical rotations; they either loved the patient population, manager, nursing staff, or had a friend who also worked there. The notion of fitting in with staff was instrumental in NLRNs transition experiences; several participants worked with classmates or had friends who worked on the same unit. NLRNs had learned to recognize personalities that best fit their workplace culture. Recall Emma's differentiation between a day and night-shift personality. The one participant hired into a nurse residency program attested to the value of rotating through different clinical units as a means of finding the right nurse for the right unit.

On the other hand, NLRNs like Mia, finds building new relationships in new places to be very stressful. Although nurse residency programs improve retention rates, the negative effect of clinical rotations within residency programs have not been fully explored or discussed in nursing literature. Malouf and West (2010) also found participants were concerned with fitting in with staff and starting over each time they rotated through different clinical units.

Finding the perfect fit had different meanings for each participant. Some NLRNs chose to stay in their first jobs with *a less than perfect fit*; passion, personal commitment, or the desire for a somewhat predictable workplace overshadowed negative influences. In my study, passion for nursing and the desire to make a difference overshadowed extreme behaviors of passive-aggressive nurses and a nurse manager bully. Perfect coworkers and a two-year personal commitment to stay surpassed job enjoyment and passion for one participant. Clinical expertise and the comforts of a familiar and somewhat predictable workplace prevailed over relationships with coworkers. Each NLRN had to find their own perfect fit based on their unique passions and desires.

Theme Two: *We're a Pretty Cohesive Group*

Participants discussed personal connections and supportive relationships with coworkers, preceptors, managers, and even physicians. The NLRNs in my study did not display unique experiences with either physicians or preceptors. Physician experiences were described as love/hate, hard earned, and slow to start. Participants confessed to be fearful and intimidated at first but had established effective working relationships by the end of the first year, which was congruent with Pinchera (2012) and Zeller et al. (2011). Only one participant acknowledged a personality conflict with her preceptor; other described preceptors as patient, kind, helpful, and "motherly and protective". When participants perceived a supportive relationship with their

preceptor and realized "your preceptor has your back", they felt secure and wanted to do a good job. Some participants in my study were told they would not be "thrown to the wolves" but could progress at their own pace, and were encouraged to ask questions. Other participants were released from orientation much sooner than expected. While these NLRNs were proud of their accomplishments, they spoke less about their preceptor and more about their emotional response to being on their own. It was the cohesive team of coworkers and managers that helped the NLRNs feel as if they had found the perfect fit for their first RN job.

Most participants in my study felt like coworkers protected them and wanted them to be successful. Because nurses spend a lot of time on the job together in high-stress situations; it was important they fit in with the workgroup. NLRNs often described coworkers as being "like a family" or "a big group of friends". One participant claimed, "we're a pretty cohesive group.... It definitely helps going into work not dreading working with somebody". When NLRNs were surrounded by coworkers with similar work ethics, they were inspired "to do a good job". They did not want to disappoint their coworkers so they pushed themselves to learn more and to work harder both during and after orientation. The importance of teamwork was made known when numerous participants used the phrase, "they have my back" when talking about coworkers. Participants believed "if you are able to bond with [coworkers] other than being at work...it will help morale and help teamwork".

Then there was Mia who referred to coworkers as mere "acquaintances" even though she had worked with them for three years. For Mia, having just one close personal friend at work kept her grounded, and she confessed, "that's kind of one of the reasons I have stayed". NLRNs in my study were not isolated from negative experiences; they too encountered coworkers and managers with poor work ethics and unprofessional behaviors. What was different with the

NLRNs in this study was their willingness to endure difficult coworkers and choosing to stay in their first jobs.

Most NLRNs in my study described supportive workgroups, as did Zeller et al. (2011) and Zinsmeister and Schafer (2009); whereas Chandler (2012) and MacKusick and Minick (2010) described unfriendly and competitive work environments with little to no support and a greater propensity for nurses to leave their first jobs. Teamwork and "having each other's back" were common findings in many studies and often precipitated decisions to stay in nursing (Parker et al., 2014; Wilson 2006; Zeller et al., 2011). Additional studies by Gill et al. (2010) and Phillips, Kenny, Esterman, and Smith, (2014), reported NLRNs desire to be accepted by their coworkers and considered a valuable member of the team. Brunetto et al. (2013) contradicted the value of teamwork for American nurses when reporting that teamwork was not linked to organizational commitment and turnover intention.

Managers.

Of all the relationships presented by the study participants, nurse managers were perceived as the most influential character for NLRNs. In my study, nurse managers were actively engaged in the lives of the employees, helped with patient care, and carried out administrative duties - they were part of the "cohesive group". Most participants in this study were in awe of their nurse managers, and readily identified examples of support and going out of their way to be helpful. Participants recognized their managers contributions to their success, and praised the managers for supporting them in difficult situations. NLRNs recognized when nurse managers role modeled desired behaviors and were willing to help with direct patient care. Nurse managers looked at both sides of a situation, supported staff, and helped the NLRN learn

how to make the best decisions. Participants valued mutual respect and recognized the amount of work the managers invested to help them feel confident.

Participants in my study also experienced unprofessional behaviors and high nurse-patient ratios, as noted in the contextual grounds and figural themes. If you recall, Ava's manager was what drew her to the job, but in her discussion involving an influential physician, the manager dismissed her complaint saying, "if he doesn't pick on you, he doesn't like you", and the episode where Mia became disgruntled when she found her peer manipulating the staff schedule; Jacob being "tripled in the unit"; and Emma's bullying nurse manager. These were disturbing issues since NLRNs expect support and guidance from nurse managers, not to become their next victim or scapegoat. Nonetheless, participants in my study persevered through the bad times.

In the 2004 study by Manion, successful nurse managers were able to create a culture of retention by putting staff first and forging authentic connections. Participants in the current study confirm the very things managers suggested in Manion's (2004) research, e.g., care about them, meet their needs, listen and respond, treat with respect, appreciate and recognize, and support them. Manion (2004) also reported that managers who retain employees believe that when employees perceive they are cared about and treated with respect, they will do the same for their patients. In a later study, Perry (2008) suggested "when nurses feel satisfied with the care they provide and patients feel well cared for, patients are likely to express gratitude" (p. 21). Perry proposed this "positive cycle" that would benefit both nurses and patients. Overall perceptions of participants in the present study were consistent with Zeller et al's. (2011) *culture of mutual support* which required support from the manager to the staff nurses.

Much of the literature painted a very different picture of nurse managers. In Simons and Mawn's 2010 study, the term *structural bullying* was coined to represent "perceived unfair and punitive actions taken by supervisors" (p. 307); these activities included scheduling, unmanageable workload, and use of paid time off. Nursing literature was replete with research showing that unprofessional behavior and hazing rituals were accepted as the norm, and new nurses do not feel empowered to break the cycle of abuse, especially when the nurse manager turns a blind eye to an obvious infraction (Bowles & Candela, 2005; Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012; MacKusick & Minick, 2010). For participants who perceived a less than perfect work group, the opportunity to help someone else provided the incentive they needed to persevere.

Theme Three: *It's About Caring for the Patients*

Participants avowed they do what they do for their patients. Providing safe quality patient care and establishing a trustworthy relationship were important to the participants in my study, as noted throughout the literature. According to Spiva et al. (2011) and Wilson (2006), patient care interactions were the leading cause for nurses of all ages as well as pay grades to stay in bedside nursing, so this was not a new finding. However, without fail, participants in this study shared stories of their first patient death or a clinical scenario that remained vivid in their mind years later.

Caring for the dying patient and their family.

Participants in my study were not fully prepared for the emotional challenges of nursing, especially the weight of death and dying. On occasions, when the NLRN had cared for a patient over an extended period of time they would report "taking it home" with them. Recall Olivia's reaction, "death is a hard" and Chandler saying, "everyone's eyes are on you...you definitely feel

that weight". However, none of the NLRNs in my study indicated long-term or disabling effects from their emotion-laden clinical experiences, but rather perceived they had dealt with each situation effectively. While death and dying was never easy, over time, participants became more confident in their roles and responsibilities. In a 2013 study by Walker et al., contradictory data emerged from nurse managers and NLRNs in regards to the impact of death and dying on the new nurse. Nurse managers believed most new nurses had a hard time coping with death and dying; whereas NLRNs felt like they were dealing with it effectively.

Theme Four: *I've Learned a Lot*

Participants described transition experiences from student to NLRN, from new nurse to preceptor, and from bedside nurse to various leadership roles. Participants realized they were still learning everyday. If you recall in the subtheme, *I don't have to know everything,* Emma suggested learning nursing was "like peeling an onion". In addition, participants were relieved when they realized they didn't have to know everything, and were reassured and encouraged when seasoned nurses with 10, 30, or even 40 years experience confessed they still don't know it all. The NLRNs in my study experienced intermittent episodes of self-assurance and uncertainty, but consistently reported, "I've grown a lot".

Self-confidence with assessment skills, time management, prioritization, and communication grew throughout the early years of nursing practice. The NLRNs recounted times when they began to feel confident in their new roles and began to expand their focus beyond procedural tasks and skills. Participants had learned from their own experience and knew when their patients' condition was changing, even without the assistance of monitors or other technological devices. Rose and Mia described the importance of keen assessment skills in order to detect subtle but critical changes that can occur with neurology and oncology patients.

According to Benner's (1984) novice to expert model, participants in my study were on track. They had progressed from advanced beginners where they focused on aspect recognition, discriminating among multiple variables, and setting priorities to the third stage of nursing development, the competent nurse. Competence typically occurs after two or three years of experience in the same job or similar clinical situations (Benner, 1984). However, participants in my study showed continued growth and advancement by developing and relying on nursing perception, a characteristic of the proficient nurse (Benner, 1984). As noted in various other studies (Pinchera, 2012; Hickson, 2013; Zinsmeister & Schafer, 2009), lacking or varied degrees of self-confidence was evident among most NLRNs. While this was not a unique finding, it sets the stage for the transition to practice experiences discussed in the next section.

From school to practice.

Participants were divided in regards to whether or not school had prepared them for the realities of nursing. This finding was particularly interesting considering all participants graduated from the same nursing program one year apart. Nonetheless, the findings were not unique to my study; difficulties transitioning from education to practice have been prevalent since the 1970's. The discussion was included here for the purpose of continuing to explore ways to close the education-practice gap. In the previous section, participants appeared to progress on the novice to expert trajectory as planned. With that in mind, consider whether the education-practice gap is in the NLRNs ability to function in the role of professional nurse, or if perhaps the gap is in our way of thinking and the expectations we have for NLRNs. According to Benner et al. (2010), NLRNs should enter practice ready to integrate knowledge, skilled know-how, and ethical behaviors, but it is unrealistic to expect students to be prepared for the full range of complex practice issues.

Three of the NLRNs in my study perceived school and professional nursing to be vastly different. Recall Chandler who perceived his "cushion" was gone and now he was responsible for "taking care of someone's life"; or Mia who said, "this is not at all like nursing school; this is a lot harder"; or Jacob who realized, "you didn't know what you were missing in nursing school 'cause you didn't know it was there". Participants agreed the best way to learn nursing was through more hands-on experience.

In the literature review, the notion that NLRNs were not adequately prepared for the reality of nursing emerged from managers, preceptors, and NLRNs themselves. If you recall from Chapter 1, Greene (2010) reported a wide gap between chief nursing officers (10.4%) and nursing school leaders (89.9%) in regards to NLRNs being fully prepared to provide safe and effective patient care. In Pellico et al's. (2009) study, participants described a collision between their image of nursing and professional practice. In Hickey's 2009 study, preceptors claimed that academic programs were not adequately preparing NLRNs for the reality of nursing, because they continued to see weaknesses in psychomotor skills, assessment skills, critical thinking, time management, communication, and teamwork. In a later study by Chandler (2012), NLRNs acknowledged processes such as assessment, prioritizing, time management, delegation, communication, and critical thinking were essential for the NLRN. Thus, preceptors and NLRNs agreed on essential entry-level skills. Participants in the current study and those represented in nursing literature called for nursing academia to introduce more realistic clinical experiences.

From asking to answering.

Participants recognized they were no longer the newest new nurse and were excited, shocked, and pleased that they were able to impart their knowledge and wisdom onto a new generation of nurses. Recall episodes from Rose and Emma who admitted they were "a little

scared", because they now shared in the responsibility for teaching the newer nurses, and Ava's confession, that her OCD was not ideal for training a new nurse. Nonetheless, participants remembered what it was like to be a new nurse and were eager to do their part for the newer new nurses. There was no indication that participants attended a formal preceptor training class prior to serving as a clinical preceptor.

As noted in Chandler (2012), Hickey (2009), and Zinsmeister and Schafer (2009), clinical preceptors were instrumental in helping with the socialization of new nurses by role modeling desired behaviors and serving as a teacher and confidant. Clinical preceptor must be properly trained to identify the right time for the NLRN to begin independent practice. According to Benner's (1984) novice to expert model, during the first three years of practice, the NLRN is still learning aspects of their own job; they are not proficient or expert nurses. Pellico et al. (2009) and Pinchera (2012) also found NLRNs were expected to hit the ground running, and do not benefit from a formal clinical preceptorship. As a result, NLRNs experienced high stress and fear when they were forced out of orientation and pushed into the role of RN with a full patient load too early (Pellico et al., 2009; Pinchera, 2012). Clinical preceptors must serve as both patient and organizational advocates to promote safe and quality patient care. Preceptors must stand firm with nurse managers when NLRNs are ready for independent practice, but more importantly when the NLRN does not demonstrate safe clinical practice or critical thinking abilities.

Beyond the bedside.

It was encouraging that participants in my study had remained at the bedside beyond the typical one to two year transition period. Yet some participants were ready to step away from the bedside to take on more challenging roles. As BSN-prepared graduates, most participants

expected to either move into management roles or eventually go back to school. Several participants in this study had already started the evolution by serving on committees and filling shift leader or charge nurse roles, but remained at the bedside. Participants provided no discussion about leadership training classes.

Unruh and Nooney (2011) and Unruh and Zhang (2013) suggested that BSN-prepared nurses leave hospital nursing because they have unmet expectations and desire jobs that offer more autonomy and professional fulfillment. According to the IOM (2011), serving on committees allowed nurses to learn leadership and collaboration skills, and to develop respect for diverse perspectives in healthcare which is vital to the future of nursing. Unlike participants in Pellico et al's. (2009) study, the NLRNs did not feel pressured to take a charge nurse role, but saw an opportunity to move one step closer toward achieving their goals. Hospital administrators should be concerned that nurses advance into leadership and management roles before they become proficient or expert nurses themselves. However, in Wilson's (2006) study, senior nurse managers were reminded that excellent clinical skills do not liken to being a good manager. Wilson also suggested that bad management had a trickle-down affect on nurses' job enjoyment and retention. In a 2004 study, Cowin and Hengstberger-Sims suggested the added stress of being in an administrative role may contribute to higher turnover among managers themselves. Recommendations for retaining managers were: work/life balance, strong physician/nurse relationships, socialization and education, designated mentorship, compensation to reflect contribution and diminish stress, and reduction and division of workload (Zastocki & Holly, 2010).

A drive to go back to school.

It was not uncommon after graduating from nursing school for participants to say they would *never* go back to school; however, after experiencing nursing and working with nurse practitioners many participants anticipated going back to school. Participants realized the role of nurse practitioner builds upon their foundation of knowledge and skills, but was perceived as less physically and emotionally demanding, and offers a more flexible work schedule. Most participants were pleased with their decision to wait a couple years before returning to school. Recall Olivia's episode where she described how the clinical experience will help her in the future. Mia had already enrolled in graduate classes, but maintained full-time employment and remained at the bedside. By the time Mia finishes her masters program she will have been at the bedside for five years. According to Benner's (1984) novice to expert model, characteristics of a proficient nurse usually emerge during the three to five year window, thus providing a good foundation for an entry-level nurse manager.

Many NLRNs leave bedside nursing within the first two years to go back to school. In Zeller et al's. (2014) study, as many as 85% of the participants who left nursing within the first two years of graduation did so to pursue a higher degree. In other studies (MacKusick & Minick, 2010; Skillman et al., 2010) the unexpected emotional and physical demands of nursing often prompted NLRNs to consider an advanced degree. The final themes, *knowing I make a difference,* provided a nice summary and demonstrated the NLRNs motivation for enduring the highs and lows of clinical practice.

Theme Five: *I Make a Difference*

Being acknowledged, praised, or recognized for their hard work and accomplishments was important to NLRNs in my study. Participants were emotionally rewarded when patients

came back to their workplace for an unofficial visit, because they did not often know outcomes once the patient left their area. Others described the toil of end-of-life care, but realized, what was "just another day" to the nurse was often very meaningful to the surviving family members. When NLRNs perceived they were not doing a good job, they focused on negative outcomes rather than things they have done well. Recall the episode in *I don't have to know everything* when Emma transferred a patient to PICU; she questioned her own knowledge, skills, and ability to be a good nurse. A simple "thank you" reinforced and validated that the NLRNs were doing what should be done and that they were meeting expectations. Participants shared experiences wherein they perceived they had made a difference in the lives of patients, family members, and coworkers, and in return, they were grateful when those individuals acknowledged their efforts. However, the desire for praise and recognition from their nurse managers validated their hard work. Recall the episode where Mia was asked to be a shift leader and Emma talked about the "I make a difference" coins.

Numerous studies (Chandler, 2012; Gill et al., 2010; Pellico et al., 2009; Pinchera et al., 2012; Wilson, 2006) support the NLRNs need for acknowledgment, praise, and recognition; however, making a difference was not unique to the younger generation of nurses. In retention studies that included older and experienced nurses (Friedrich, Prasun, Henderson, & Taft, 2011; Kirgan & Golembeski, 2010; Spiva, Hart, & McVay, 2011), the desire for leaders to recognize their expertise and to acknowledge a job well done was affirmed. In Zeller et al's. 2011 study, nurses who have stayed in nursing were committed to making a difference in the nursing community; yet they do not know if their efforts pay off if no one tells them. In Parker et al.'s (2014) study, only 74% of the NLRNs were confident they were meeting others' expectations. Wilson's (2006) participants also focused on negative outcomes rather than things they had done

well when they perceived they were not doing a good job. In Manion's 2004 study of nurse managers with low turnover and high employee satisfaction, managers echoed the importance of staff appreciation and recognition through cards, newsletter announcements, or education opportunities.

Nursing Implications

The findings of this study offer insight into the enduring nurse phenomenon from the perspective of the newly licensed registered nurse. Finding *the perfect fit* meant something different to each nurse, so there was no definitive solution for the problem of high turnover among NLRNs. However, knowledge gained from this research study adds to the nursing literature and has implications in nursing education, practice, and policy. The ensuing recommendations are applicable to student nurses, nursing faculty, NLRNs, clinical educator/preceptors, nurse managers, and hospital administrators.

In order for my research findings to be useful to a wide-ranging audience, the themes needed to be easy to remember. I developed an alliteration using the letter "p". I transformed the five figural themes into the *5 P's of Nurse Retention*: passion, professional partners, patients, progress, and performance. To ensure the right nurse gets to the right clinical unit, apply the *5 P's of Nurse Retention* as follows:

- *Passion* - What excites you about being a nurse? Nurses who are passionate and enthusiastic about their work endure the physical and emotional demands of nursing. Nurses may be passionate about a particular patient population, nursing staff, manager, or an entire health system. There is no right or wrong answer.
- *Professional partners* - Are the nursing staff and managers a cohesive group? When coworkers have similar work ethics, they inspire a higher level of performance. Nurses

spend a lot of time together in high-stress situations; teamwork and support are essential. It is also important for the new nurse's personality to mesh with their coworkers and managers; consider what you have in common. Doing things together outside of work enhances morale and helps build team spirit. Consider whether the manager role-models desired behaviors and engages with nursing staff. Nurses leave a manager more often than they leave nursing, so the nurse - manager relationship is pivotal for job retention.

- *Patients* - Which patient population interests you most? Patient care and opportunities to make a difference in the lives of other people are the most common reasons for nurses to stay at the bedside. Consider which skills are necessary for nurses to provide safe, quality care with the chosen patient population. Consider whether adequate resources are available for staff to do their jobs effectively. New nurses are not fully prepared for the emotional challenges of nursing, especially death and dying. Consider what resources are available to help nurses cope with emotion laden events such as death and dying.
- *Progress* - What are your one-, three-, and five-year career goals? Nursing school only provides the foundation for entry into practice; there is no way for a new nurse to be fully prepared for the full range of complex practice issues. Consider if the chosen job will promote or hinder your transition to practice experience. Nurses are first and foremost patient advocates; do not take on too much responsibility during the first two years. Focus on becoming a competent nurse before serving on committees or accepting leadership responsibilities. Insist on proper training before assuming preceptor or management responsibilities. Commit to life-long learning; nursing is an ever-changing

profession with something new to learn everyday. Value bedside nursing and direct patient care opportunities. Advanced practice nursing builds upon the foundation of knowledge and skills acquired through academic and personal clinical experiences.

- *Performance* - How will you know you make a difference? Nurses want to be recognized for their hard work and contributions to the team. Consider the unit's culture; do coworkers and managers provide authentic praise, send appreciation cards, feature employees in newsletters, provide a free meal or an education opportunity? Consider how you will measure success - even if no one ever tells you.

Education

In the theme, *I've learned a lot,* the need for student nurses to be better prepared for the realities of nursing practice was emphasized by several participants. Suggestions for nurse educators to promote retention of NLRNs are supported by the findings of my study. Nursing faculty, clinical educators, and nurse managers can use the 5 *P's of Nurse Retention* that I developed to inform nursing students and NLRNs of the attributes of the perfect fit before beginning their initial job search.

Another recommendation is to require pre-nursing students to preview nursing by working or volunteering in a hospital setting before being accepted into nursing school (Zeller et al., 2011). Study participants also recommended student nurses work in hospitals during school to improve time management and direct patient care skills. In both of these recommendations, future and potential nurses can experience the realities of a complex work environment first-hand, and see if they fit into the current culture of healthcare before they commit to a career path that may not be a good fit.

An additional way to decrease NLRN retention and better prepare student nurses is for nursing faculty to collaborate with nurse managers, clinical preceptors, and NLRNs to determine the expectations for entry-level nurses. Expecting the NLRN to hit the ground running is unrealistic, but there are things nursing faculty can incorporate into the clinical courses to improve the students' readiness for practice. Nursing faculty can incorporate more 12-hour shifts on more sequential days into the clinical rotation schedule, actively participate in shift report, learn and use the clinical documentation system, and make rounds with physicians. By increasing student-patient ratios during the later clinical courses student nurses can begin learning how to prioritize patient care needs and time management skills prior to entering professional practice. At the beginning of the final semester of nursing school, faculty can provide student nurses with an entry-level RN job description. Students can use the job description as a self-assessment tool to identify opportunities for improvement as they progress through the final clinical rotation or preceptorship. At the end of the semester, students can submit the final self-evaluation of their readiness for practice. Nursing faculty can use aggregate student self-evaluations to identify potential weaknesses within the program curricula.

One final education recommendation involves training needs of clinical preceptors. It is an undesirable standard of practice for any nurse to be charged with the responsibility of training another nurse without having the benefit of formal preceptor training. It is even more absurd to consider a nurse with less than two years experience can precept an even newer new nurse. Hospital administrators, nurse managers, and clinical educators can ensure preceptors are appropriately trained to work with NLRNs. Working with NLRNs is an added stressor for an already busy and stressed nurse, so it is unfair to both parties if the preceptor does not understand their clinical role. In the theme, *we're a pretty cohesive group*, findings support the need to make

sure preceptors and NLRNs are a good match; nurse managers can assess individual personalities and preferences for teaching before assigning the role of preceptor. If a nurse does not want to be a preceptor but gets "stuck" with a new nurse, learning will suffer and both nurses may leave if their individual needs are not met. The NCSBN Transition to Practice Model program includes a module for preceptor training. In Squillaci's (2015) dissertation titled *Preceptor Training and Nurse Retention,* a 14-module program was recommended.

Practice

The findings in my study have numerous implications for clinical practice; hospital administrators, nurse managers, and clinical preceptors may use these recommendations to improve retention of NLRNs. Nurses leave managers more often than they leave nursing (Kovner, 2014); therefore managers have a major impact on nurse retention The first recommendation is for nurse managers to create a safe place for NLRNs to learn and grow. Strategies to support this recommendation include but are not limited to those provided in this discussion. Managers can: allow NLRNs to ask questions and to offer constructive feedback; be visible and approachable; treat all employees fair and be aware of other's perceptions; never threaten an employee with their job as this will only encourage a job search. In addition, nurse managers can provide necessary tools and training for NLRNs to do their jobs effectively and to grow professionally by sending NLRNs to workshops or seminars pertaining to issues encountered during the transition to practice period. Motivated employees want to use their skills and to contribute beyond their basic job description. Nurse managers can encourage nurses to learn new skills, but only after they have demonstrated competence with their entry to practice skills and have met all clinical expectations.

Although not fully supported by the current study, the image of nurse managers portrayed in the literature is quite negative. Nurse managers can compare themselves to the characteristics of managers who have high retention rates to discover opportunities for self-improvement. The following nurse manager skills and strategies are recommended to promote retention: flexibility, coaching, team construction, fairness, risk taking, humor, patience, self-confidence, honesty, fiscal knowledge, communication skills, conflict resolution, listening, leadership, and patient focused (Anthony et al., 2005). Findings from the theme, *we're a pretty cohesive group,* lend support for these characteristics.

Another recommendation is that nurse managers receive proper training and resources to do their jobs effectively. Since nurse managers are responsible for implementing and enforcing policies and procedures pertaining to workplace violence, they need to be re-educated about incivility and bullying. Nurse managers can review the ANA online resources and assess their own actions and behaviors. Nurse managers can use the ANA policy statements and guidelines along with internal organization-specific policies and procedures to further educate all staff; however, providing education is only the beginning - nurse managers must adhere to the policy statements. NLRNs can identify effective and credible nurse managers when policies and procedures, especially those related to unprofessional conduct, are consistently enforced at all levels. NLRNs may think the manager is turning a blind eye toward a complaint or dismissing an issue brought to the managers' attention if there is no acknowledgement or follow-up. Nurse managers can privately and respectfully acknowledge employee complaints without violating another persons' confidentiality. All nurses can adhere to the ANA's (2015) Zero Tolerance policy and organization-specific policies in an effort to create a more positive work environment.

Another recommendation to affect NLRN retention applies to nurse managers and their proxies for new hire interviews. When interviewing NLRNs, managers and their proxies can seek out candidates who fit in with the unit culture and workgroups' personality. Shift preference is a motivating force for NLRNs; but ideal candidates demonstrate a passion for nursing, are excited about patient care, and have a compatible personality with the workgroup. The *5 P's of Nurse Retention* can also serve as an interview guide to increase the likelihood of placing the right nurse in the right unit. In addition, I recommend personality inventories not be used as the primary determinant for hiring NLRNs. Although it is difficult to manipulate personality assessments, there is literature supporting this idea (Beaz, 2012). Similarly, one participant in my study suggested NLRNs can fake their way through an interview. Finding the perfect fit warrants a multi-faceted approach.

The next recommendation can be implemented by hospital administration in anticipation of a trickle-down or ripple effect from top administrators to front-line managers to staff nurses to patients. Perry (2008) described a *positive cycle* wherein the nurse feels safe and is able to provide high quality patient care. When a patient feels satisfied with his care, he will likely express gratitude toward the nurse. This gratitude satisfies the nurses' internal motivation, so in turn, the nurse continues providing high quality care. Hospital administrators can initiate the positive cycle by providing authentic praise and recognition to the front-line managers. In return, the nurse mangers can provide praise and recognition for staff nurses efforts and contributions to both patient care and organizational activities. When the staff nurses are satisfied with patient care opportunities and with their nurse manager they tend to stay in their jobs. The power of the positive cycle can improve nurse retention as well as patient care outcomes. When nurse managers appreciate and recognize staff and make sure they have the

resources they need to provide high quality patient care, the managers find that staff take better care of the patients.

In addition, nurse managers can role model desired behaviors and uphold the core values of their organization, because NLRNs look to them for leadership and guidance. In the theme, *I make a difference,* praise and recognition are very important to NLRNs; they need to be affirmed and encouraged in order to build their self-confidence. NLRNs want to know that what they do makes a difference and is meaningful not only in the lives of their patients, but in the life of the organization. Meaningful recognition means, "nurses must be recognized and must recognize others for the value each brings to the work of the organization" (American Association of Critical-Care Nurses [AACN], 2005, p. 7). There are numerous recognition programs provided through Human Resource departments that allow patients, visitors, and coworkers to submit written notes of praise for an employee who has done something extraordinary. Hospital administrators and nurse managers can review literature on how to give authentic praise, so that it is meaningful to the recipient and not perceived as cookie-cutter praise. The administrators and managers can spend time getting to know the nurses that report directly to them and when appropriate, provide on-time and meaningful recognition.

Managers and hospital administrators can also consider external motivators such as a hand-written thank you card, a free cup of coffee from the cafe, or a free meal to express gratitude when staff picks up an extra shift or consistently goes above and beyond the call of duty. Nurse managers who consistently use formal praise and recognition programs experience greater employee productivity, improved relationships among coworkers, higher patient and employee satisfaction scores, and ultimately higher retention rates (Anthony et al., 2005; Manion, 2004). The current study supported this finding. On a larger scale, hospital

administrators can assess incentives such as paying off student loans for NLRN and compensating managers for obtaining advanced degrees. To improve retention of bedside nurses, hospital administrators can compensate nurses who stay at the bedside at a higher rate than nurses who take jobs in other departments. However, hospital administrators can also consider the pivotal role that nurse managers play in nurse retention and consider reevaluating the managers' workload.

Policy

Nationally, NLRNs enter a very complex healthcare system and are expected to take care of a diverse, chronically ill, and aging population. In 2010, Greene reported only 10.4% of chief nursing officers perceived NLRNs were prepared for the complexities of the current healthcare environment. The NCSBN reported hospitals with formal transition programs have experienced decreased turnover and improved patient outcomes. NLRNs in my study reported inconsistent findings regarding readiness for practice and length of time in orientation. First, hospital administrators, nurse managers, and clinical preceptors can clearly define expectations for the NLRN. Provide written job descriptions during the interview process, outline the orientation or transition to practice experience including classroom content, roles and responsibilities of preceptors and mentors, and patient load or productivity standards for the NLRN.

My final recommendation is that hospital administrators develop organizational policies for a formal transition to practice program. Employers can access Phase II findings from the 2014 "NCSBN's Transition to Practice Study" and garner support from the NCSBN. The NCSBN (2015) has developed a Transition to Practice Model which can be implemented in live and online venues for organizations that do not have the resources to implement a full transition to practice program. Greene (2010) recommends schools of nursing collaborate with local

hospitals to institute a 6- to 9-month practicum either before or after the licensure exam. The AACN National Post-Baccalaureate Graduate Nurse Residency Program curriculum is also available to staff development and nursing educators (AACN, 2008).

Strengths and Limitations of This Study

There are a number of strengths that enhance this study's value within the nursing discipline. Since there were significant design flaws with several qualitative research studies pertaining to NLRNs, one strength was the use of and adherence to Merleau-Ponty's existential phenomenology as applied to nursing research by Thomas and Pollio (2002). Personal reflections relating to the early years of clinical practice from NLRNs provided valuable insight regarding factors that contribute to nursing retention. Their perceptions provided a clearer understanding of the enduring nurse and helps to direct future research.

Another strength of the study was the various strategies used to ensure study rigor. A bracketing interview prior to conducting participant interviews and continual bracketing process throughout the course of study minimized researcher bias. Participant interviews continued to the point of suspected data saturation then two more interviews were conducted to confirm data saturation. Collaboration with an interdisciplinary research group aided in identifying themes within and across all nine participants. The final thematic analysis was presented and agreed upon by the research group and the study participants who responded to my request for feedback. Chandler and Rose both replied, "Looks great to me!" There were no suggestions for revision.

The purpose of phenomenological research is neither to describe the characteristics of the sample (age, gender, race, etc.) nor to generalize to a population. The purpose of interviewing multiple participants was to produce variations related to their *experiences* as a NLRN. Good qualitative phenomenological research seeks to elicit new insight and deeper meaning of topics

that may have already been investigated (Sandelowski, 2008). Qualitative findings are not intended to be generalized to a population, but rather validated by the reader. Individuals reading this study will determine relevance or validity in the context of their own practice. Because of the diversity of hospitals and types of units represented by the participants, the thematic structure is representative of NLRNs experiences across various patient care settings.

There are some limitations related to this study. First, participants were from the same undergraduate nursing program and all worked in the Tennessee; therefore participant's clinical practice and bedside nursing experiences may be different from those working in other geographic locations. Interviews were limited to new nurses who did not have prior healthcare experience other than working as a student nurse. Several new nurses were excluded because they were Certified Nursing Assistants prior to becoming RNs. Findings were also limited to the perception of NLRNs; no interviews were conducted with coworkers, preceptors, managers, or physicians who are influential in NLRNs decision to stay in or leave their jobs. Although I do not believe the study findings were biased by my past relationship with the participants, I was aware of a single incident with one participant (Jacob) wherein I perceived the student-teacher relationship may have hindered full disclosure about his transition experience from school to practice.

Recommendations for Future Research

There are several recommendations for nursing research. Based on the findings of this study, there continues to be a gap between nursing education and clinical practice; therefore a qualitative inquiry with NLRNs, nurse managers, clinical preceptors, and nursing faculty may help to describe "ready for practice" and identify opportunities for nursing faculty to better prepare student nurses for the realities of nursing practice. This data can also be used by nursing

faculty to assess nursing school curricula for outdated or missing content. In addition, quantitative studies to assess readiness on a larger scale may evolve from findings of the qualitative research.

Next, emotional maturity and emotional intelligence (EI) have been identified as better predictors of turnover and retention than chronological age. Emotional intelligence and personal resilience have been credited to those who were able to move beyond the negative influences and make the most of the situation. Therefore, a longitudinal study assessing EI scores over three time periods (T_1 upon acceptance into nursing school, T_2 end of the final semester, and T_3 one year post- graduation) along with turnover and retention data with T_3, to determine if EI scores change over time or if the nursing school experiences affect individual EI scores, and to determine if there is a correlation between EI scores and retention.

Finally, since physician interactions are such an intimidating factor for NLRNs. It would be interesting to hear the physicians perceptions of their role in socializing the NLRN into the practice setting, and to understand the perceived trust issue between physicians and newly licensed nurses.

Summary

Newly licensed registered nurses enter a complex healthcare environment where they experience staffing shortages, high nurse-patient ratios, and unprofessional behaviors. The difficulties associated with the entry into practice and the resulting high turnover rates have been well documented; however, little was known about why nurses stay in their first RN jobs. The purpose of this study was to described the lived experiences of nurses who have stayed in their first hospital nursing job for 18-36 months. The philosophical lens of Merleau-Ponty provided the framework for this phenomenological study. Using the four existential grounds of body,

time, world, and others to view NLRNs experiences helped provide a more accurate understanding of the participants' who had endured the early years of clinical practice. Five figural themes emerged from participant interviews: 1) *I found the perfect fit*, 2) *we're a pretty cohesive group,* 3) *it's about caring for the patients,* 4) *I've learned a lot,* and 5) *I make a difference.* This research offers a rich understanding and awareness of what it is like to be a newly licensed registered nurse working in an acute care hospital setting.

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Appendices

Appendix A

Invitation to Participant in a Research Study

My name is Lisa Kirkland, and I am a doctoral candidate in the College of Nursing at the University of Tennessee, Knoxville. As part of my degree requirements, I am conducting a research study on the experiences of newly licensed registered nurses who have stayed in their first nursing job as a bedside nurse in an acute care hospital for at least 18 months. Registered nurses who graduated from a state-approved pre-licensure nursing program between May 2012 and May 2013 are invited to participate in this research study.

If you would like to volunteer to participate in this study or have any questions or comments, please contact me at 865-777-5113. You may leave a message stating your desire to participate and a telephone number to set up a meeting. Details about the study and maintaining your privacy are outlined in the enclosed *Information About the Research Study* and will be discussed during the initial phone call. The names of individual participants will only be shared with my faculty advisor, Dr. Sandra Thomas. Your employer will not know of your participation in this research study. The interview will be voice recorded and will take about an hour to complete. The interview will be conducted at a mutually agreed upon location. No interviews will be conducted at your place of employment. You will receive a $20 VISA gift card as a token of appreciation for participating in the interview. No other compensation will be provided.

Thank you in advance for your interest in this research project.

Sincerely,

Lisa Kirkland, MS, BSN, RN
Doctoral Candidate, UTK-CON

Appendix B

Information About the Research Study

Please note that if you received this letter from another person, that person has NOT provided your personal information to the researcher and details regarding your participation will NOT be released to this person at any time.

Title of Research Study
Perceptions of Newly Licensed Registered Nurses Who Remain in Bedside Nursing in an Acute Care Hospital

Principal Investigator: Lisa Kirkland, MS, BSN, RN, PhD Candidate

Background
Many new nurses leave their first nursing job within 12 to 18 months after graduation. Even though hospital administrators agree retention is a problem, few organizations have formal retention strategies in place for new or experienced staff. Most of the current research focuses on high nurse-patient ratios, workplace violence, and nurses intent to leave. What is lacking in nursing science is the perspective of the new nurses who endured the early years of bedside nursing and continue working in their first nursing job. I want to learn more about what it means to endure the early years of clinical practice from the perspective of the new nurse in order to help the nursing discipline develop effective organizational retention plans.

Purpose
You are being invited to participate in a research study to talk about your personal experiences during the first one to three years of clinical practice.

Procedure
If you decide to take part in this research study, contact the researcher, Lisa Kirkland, to verify your eligibility and to schedule a date, time, and place for the interview. After eligibility is determined, you will be assigned an alias name to protect your identity. On the day of the interview, you will be asked to sign an informed consent stating your willingness to participate in the study. During the interview, you will be asked to tell the researcher about your experience as a newly licensed registered nurse working in an acute care hospital. You will be asked to think about what stands out to you from the early years of clinical practice. We can meet for the interview wherever is most convenient for you, such as your home, my office, or a private meeting room that can be reserved by the researcher. The interview will not be conducted at your place of employment. The interview will last approximately one hour. What you say will be digitally recorded (audio only, no video) and transcribed by a professional transcriptionist. Upon completion of the interview, you will be asked to complete a short demographic survey. You will receive a $20 VISA gift card as a token of appreciation for participating in the interview. During the data analysis phase, your transcript may be read and reviewed by an interdisciplinary research group at the University of

Tennessee. After all the data have been reviewed, you will have the opportunity to provide feedback to the researcher on the overall findings. This entire research study will be completed by December 2015.

Possible Benefits

There are potential but no guaranteed benefits for you as an individual participant. Participants in other studies have found it helpful to discuss personal experiences with a nurse researcher. However, there is a societal benefit. Participation in this research study may help raise awareness in the healthcare environment of nurses who endure the early years of nursing practice, which may assist the nursing discipline in recommending and implementing more effective retention strategies.

Possible Risks

The risks associated with this study are no more than those associated with everyday life. There is almost no risk for breeching confidentiality and little risk that you will become emotionally upset while reliving past experiences. Participation in this research study is voluntary. You have the right to end the interview at any time. If you become visibly upset, e.g., tearful, saddened, or anxious, the PI will stop the interview and ask if you want to continue or to terminate the interview. If you wish to terminate the interview all records of your participation will be destroyed. If you want to continue, the PI will offer time, with the recorder turned off, for you to regain your composure. The interview will continue when you are ready. If you are unable to regain your composure, the PI will stay with you until you are calm and will offer to contact someone (family member, friend, or counselor) on your behalf. If you express an interest in seeking counseling due to participation in this study, the PI will provide information about accessing counseling services in your community. The PI will not be responsible for any fees related to doctor appointments or counseling sessions.

Confidentiality

Your confidentiality will be maintained during and after this research study. Information will be made available to persons directly involved in the research study, including the researcher (Lisa Kirkland), four members of the dissertation committee, and members of the Interpretive Research Group at the University of Tennessee, Knoxville after they have signed a pledge of confidentiality. No form of written messages, e.g., texting or email, will be used to communicate with you during the study. All telephonic communication will occur in a private area. Your privacy will be protected by removing all identifiable personal details, e.g., names of people and organizations, on all documents related to the research study. Only the researcher and her advisor, Dr. Sandra Thomas, will have access to the participant names, pseudonym roster, and consent forms. All data sources will be stored in locked cabinets and on a password protected, single-user computers located at the researcher's personal residence and Dr. Sandra Thomas' university office. The University of Tennessee IRB is responsible for oversight of this research study and may be reviewed by federal regulatory agencies.

The results of this research study may be included as part of a dissertation or published in a journal article. Your name will not be mentioned in any of these documents. No participant in this research study will be identified by name in either a presentation or publication. The

information you provide could be used in future studies with appropriate ethics committee approval.

Voluntary Participation

Taking part in this research study is completely voluntary, and you may withdraw from the study at any time without penalty. If you withdraw before the interview is completed, all recorded data will be destroyed. You will receive a $20 VISA gift card as a token of appreciation for participating in the interview. No other compensation will be provided.

Contact Names and Telephone Numbers

If you have any questions or concerns about your rights as a study participant, please contact the Research Compliance Officer-University of Tennessee at (865) 974-7697.

If you wish to participate in this study, please contact Lisa Kirkland at (865) 777-5113.

Appendix C

Eligibility Verification Questions

Primary Investigator (PI): *Thank you for expressing interest in my research study. Before we go any further, I am going to ask you a series of questions to determine if you meet the criteria to participate in the research study. Please answer "yes" or "no" to each question. Do you understand these instructions?*

Caller: [no] PI will restate the above instructions.
[yes] PI will proceed with the questions below.

Caller must answer "yes" to the following questions:

If Caller answers "yes", the PI will continue to the next question. If the Caller answers "no", the PI will thank the Caller for his/her time and explain that he/she does not meet inclusion criteria and will be unable to participate in the research study.

- Is English your primary language? YES NO
- Are you at least 21 years of age? YES NO
- Did you graduate from a state-approved pre-licensure nursing program? YES NO
- Did you graduate between May 2012 and May 2013? YES NO
- Are you still working in your first RN position? YES NO
- Do you work in an acute care hospital? YES NO
- Does your nursing role involve direct patient care at the bedside? YES NO
- Have you worked at least 18 months in your first RN job? YES NO

Caller must answer "no" to the following questions:

If Caller answers "no", the PI will continue to the next question. If the Caller answers "yes", the PI will thank the Caller for his/her time and explain that he/she does not meet inclusion criteria and will be unable to participate in the research study.

- Have you worked more than 36 months in your first RN job? YES NO
- Were you a licensed or certified healthcare provider, e.g., CNA, LPN, therapist, social worker, or counselor prior to RN licensure? YES NO

****

Status: (check one)

_____ Caller does not meet inclusion criteria. Unable to participate in the research study.

_____ Caller meets inclusion criteria but does not desire to participate in the research study.

_____ Caller meets inclusion criteria and verbally expressed desire to participate in the research study. Assigned pseudonym and scheduled interview.

Appendix D

Pseudonym Roster

Female Alias	Participant	Male Alias	Participant
Abigail		Alexander	
Ava		Daniel	
Elizabeth		Ethan	
Emily		Jacob	
Emma		Jayden	
Isabella		Liam	
Madison		Mason	
Mia		Michael	
Olivia		Noah	
Sophia		William	

Social Security Administration (2014). *Top 10 baby names for 2013*. Retrieved from http://www.ssa.gov/oact/babynames/

Appendix E

Informed Consent

TITLE OF PROJECT: Perceptions of Newly Licensed Registered Nurses Who Remain in Bedside Nursing in an Acute Care Hospital

INTRODUCTION
You are invited to participate in a research study to describe your personal experience of the first three years of clinical practice as a registered nurse in an acute care hospital setting. This study is being conducted by Mrs. Lisa Kirkland, MS, BSN, RN as her dissertation research for her PhD in Nursing at the University of Tennessee, Knoxville. The goal of this research study is to attempt to understand the experiences of newly licensed registered nurses who have endured the early years of bedside hospital nursing in order to help nurse managers and hospital administrators to develop effective organizational retention plans. The results will be presented as group data and no personal identifying information will be given for any individual data. Results will be published as part of the dissertation requirements for the University of Tennessee College of Nursing and may be published in journal articles and may be presented at professional meetings or conferences. The information you provide could be used in a future study with appropriate ethics committee approval.

INFORMATION
You will be one of 10 to 12 nurses asked to participate in a 60 to 90 minute interview with Mrs. Kirkland. A one-on-one interview will be conducted in a private location that was mutually agreed upon. During the interview you will be asked to think about being a newly licensed registered nurse and then describe your experiences from the early years of bedside nursing. The interviews will be digitally recorded and transcribed verbatim. At the conclusion of the interview, you will be asked to complete a short demographic form. Mrs. Kirkland and an interdisciplinary research group at the University of Tennessee will read transcripts to identify common themes. If you agree, Mrs. Kirkland may contact you regarding the findings of the study to obtain your feedback about the results. The research study is due for completion in December 2015.

CONFIDENTIALITY
Your confidentiality will be maintained during and after this research study. Information will be made available to persons directly involved in the research study, including the researcher (Lisa Kirkland), four members of the dissertation committee, and members of the Interpretive Research Group at the University of Tennessee, Knoxville after they have signed a pledge of confidentiality. No form of written messages, e.g., texting or email, will be used to communicate with you during the study. All telephonic communication will occur in a private area. Your privacy will be protected by removing all identifiable personal details, e.g., names of people and organizations, on all documents related to the research study. Only the researcher and her advisor, Dr. Sandra Thomas, will have access to the participant names, pseudonym roster, and

IRB NUMBER: UTK IRB-14-01957 XP
IRB APPROVAL DATE: 02/04/2015
IRB EXPIRATION DATE: 02/03/2016 rev. 012415

consent forms. All data sources will be stored in locked cabinets and on a password protected, single-user computers located at the researcher's personal residence and Dr. Sandra Thomas' university office. The University of Tennessee IRB is responsible for oversight of this research study and may be reviewed by federal regulatory agencies.

RISKS

The risks associated with this study are no more than those associated with everyday life. There is almost no risk for breeching confidentiality and little risk that you will become emotionally upset while reliving past experiences. Participation in this research study is voluntary. You have the right to end the interview at any time. If you become visibly upset, e.g., tearful, saddened, or anxious, the PI will stop the interview and ask if you want to continue or to terminate the interview. If you wish to terminate the interview all records of your participation will be destroyed. If you want to continue, the PI will offer time, with the recorder turned off, for you to regain your composure. The interview will continue when you are ready. If you are unable to regain your composure, the PI will stay with you until you are calm and will offer to contact someone (family member, friend, or counselor) on your behalf. If you express an interest in seeking counseling due to participation in this study, the PI will provide information about accessing counseling services in your community. The PI will not be responsible for any fees related to doctor appointments or counseling sessions.

BENEFITS

There are potential but no guaranteed benefits for you as an individual participant. Participants in other studies have found it helpful to discuss personal experiences with a nurse researcher. However, there is a societal benefit. Participation in this research study may help raise awareness in the healthcare environment of nurses who endure the early years of nursing practice, which may assist the nursing discipline in recommending and implementing more effective retention strategies.

CONTACT INFORMATION

If you have any questions about the research study, you may contact Mrs. Lisa Kirkland, MS, BSN, RN at any time at (865) 777-5113. You may also contact the faculty research advisor, Dr. Sandra Thomas, at (865) 974-7581 or by mail at 1200 Volunteer Boulevard, University of Tennessee College of Nursing, Knoxville, TN 37996. If you have questions about your rights as a study participant, please contact the Research Compliance Officer at the University of Tennessee at (865) 974-7697.

PARTICIPATION

Taking part in this research study is completely voluntary, and you may withdraw from the study at any time without penalty. If you withdraw before the interview is completed, all recorded data will be destroyed. You will receive a $20 VISA gift card as a token of appreciation for participating in the interview. No other compensation will be provided.

IRB NUMBER: UTK IRB-14-01957 XP
IRB APPROVAL DATE: 02/04/2015
IRB EXPIRATION DATE: 02/03/2016 rev. 012415

CONSENT

I have read the above information and received a copy of this form. I have had all questions and concerns about participating in this research study answered. I agree to participate in this research study.

Assigned Pseudonym: _____

Participant's Name (Print): _____

Participant's Signature: _____ Date: _____

Researcher's Name (Print): _____

Researcher's Signature: _____ Date: _____

Mrs. Kirkland has my permission to contact me for feedback regarding the validity of the proposed findings toward the end of the study. My phone # is: _____ Participant's Initials _____

Mrs. Kirkland has my permission to use this interview data in future research studies granted approval by an ethics review board.

Participant's Initials _____

IRB NUMBER: UTK IRB-14-01957 XP
IRB APPROVAL DATE: 02/04/2015
IRB EXPIRATION DATE: 02/03/2016

Appendix F

Demographic Data

Pseudonym of Participant: _____

Age: _____ **Gender:** _____Female _____Male

Ethnicity/Racial Background: (check one)

_____Asian-American _____Black/African-American

_____Hispanic/Latino _____Mixed race/ethnicity

_____Native American _____White/Caucasian

Other (please specify): _____

Nursing Education: _____Associate Degree _____Baccalaureate Degree

Graduation date: _____May 2012 _____December 2012 _____May 2013

Employment status: _____Full-time _____Part-time

Clinical Specialty: _____Adult _____Pediatrics

check one: _____Emergency dept. _____Intensive Care

_____Medical-surgical _____OB/GYN

Other: _____

Usual Shift: 8 Hours: _____7a-3p _____3p-11p _____11p-7a

12 Hours: _____7a-7p _____7p-7a

Do you work rotating shifts? (e.g. days, evenings, nights) _____Yes _____No

Did you work in healthcare as a student nurse before you became an RN?

_____No _____Yes

Appendix G

Gift Card Receipt

I received a $20 VISA gift card for participating in the research projected titled: *"Perceptions of Newly Licensed Registered Nurses Who Remain in Bedside Nursing in an Acute Care Hospital"*.

Alias Signature	**Date**

Appendix H

Transcriptionist Confidentiality Agreement

I, _____, as a transcriptionist for the study entitled "Perceptions of Newly Licensed Registered Nurses Who Remain in Bedside Nursing in an Acute Care Hospital" pledge to maintain confidentiality of this digitally recorded research interview during and following transcription. I will not discuss the transcript with anyone other than the Primary Investigator, Lisa Kirkland.

Date: _____

Appendix I

Interpretative Research Group Confidentiality Agreement

As a member of the Interpretive Research Group at the University of Tennessee, I pledge to maintain confidentiality of this recorded and transcribed interview for the research study entitled: "Perceptions of Newly Licensed Registered Nurses Remain in Bedside Nursing in an Acute Care Hospital". I will not share any information from these transcripts with anyone other than the primary investigator, Lisa Kirkland, MS, BSN, RN, or other members of this phenomenology research group.

Signatures: Date:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VITA

Lisa D. Kirkland is married to Randall W. Kirkland. She has two children, Marc Webb, Jr., and Ashley M. Webb. She obtained a diploma in nursing from the Fort Sanders School of Nursing in 1986. Lisa worked as a bedside nurse in the neuroscience unit at Fort Sanders Regional Medical Center and Patricia Neal Rehabilitation Center. While working at the rehabilitation center, she became a Certified Rehabilitation Registered Nurse, helped develop case management and nurse liaison programs. While serving as manager in the outpatient rehabilitation clinic, she developed a Rehabilitation Day Hospital program for clients who no longer required 24 hour nursing care, but needed three or more hours of physical rehabilitation services throughout the day. Lisa also served as Education Coordinator for Covenant HomeCare prior to obtaining her Bachelor of Science degree from Tennessee Wesleyan College in 2002, and Master of Science in Health Promotion & Health Education from the University of Tennessee, Knoxville in 2003. At that time, Lisa accepted a nursing faculty position with Tennessee Wesleyan College where she continues to teach in the traditional undergraduate and RN-BSN online nursing programs. She enjoys working with the student government and leading student nurses on medical mission trips. Lisa is active in her local church and has participated in numerous medical missions to various Central and South American countries. Lisa's philosophy in life, faith, and nursing is: *lead by example*.