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Perceptions of Nurses after the First Year of Practice: Expectations and Reality

Susan R. Lesser

PERCEPTIONS OF NURSES AFTER THE FIRST YEAR OF PRACTICE: EXPECTATIONS AND REALITY

A DISSERTATION

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SUSAN R. LESSER, MSN, RN-BC

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To the Dean for the School of Nursing:

I am submitting a dissertation written by Susan R. Lesser and entitled "Perceptions of Nurses in the First Year of Practice: Expectations and Reality." I have examined the final 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 in Nursing.

Joan Engebretson, DrPH, RN
Committee Chair

We have read this dissertation
and recommend its acceptance:

Accepted

Dean for the School of Nursing

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Nursing has been an integral part of my life story. It has been more than a profession, it has been my life's calling. I sincerely hope that by sharing the information obtained in this study we will be able to improve the transition into

practice for the next generation of nurses. The future of the nursing profession is in their hands.

Abstract

Susan Lesser, MSN, RN-BC

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Background: The nursing profession is facing a critical shortage stemming from retirement of experienced nurses, increasing healthcare needs of an older population, and more inclusive healthcare coverage. Newly licensed nurses (NLNs) have been the long-term plan to fill the gap. Despite the support from nurse residency programs (NRPs), many of these graduate nurses are leaving their first position. This turnover of nurses is detrimental to the nursing shortage, and financially burdensome for health care systems.

Purpose: Two aims were explored: 1) to better understand the perceptions of newly licensed nurses after the first year of practice about their expectations and the actual reality of working as a nurse; and 2) to describe the perceived influences in the transition of newly licensed nurses into practice within an acute care setting.

Methods: Using a medically focused, ethnographic approach semi-structured interviews were conducted with purposive sampling of 15 NLNs who had just completed a NRP. Transcribed interviews were coded using Atlas ti. V8. Data content was analyzed and once redundancy was reached relevant themes were identified through content analysis from exemplars.

Findings: Perceptions of the NLN experience of being a nurse was that it was overwhelming and hard. Interpretive descriptive analysis of their perception of transition showed that nursing school provided them with a foundation but clinical experiences were not realistic to their real life practice. Four concepts to the reality of being a nurse emerged from the data; *"Unexpected patient care experiences"; "More responsibility than expected"; "Difficulty with patient coordination and time management"; "Living the nursing lifestyle".* Success depended on NLNs receiving additional education and sufficient support.

Conclusion: NLNs enter practice not prepared for the role of the real nurse. Strong academic preparation, an NRP, and time with support from experienced nurses is necessary for NLNs to become confident in navigating the physical, mental, and emotional requirements of caring for acutely ill patients.

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Summary of the Study

The nursing profession is facing a critical shortage of nurses in the next ten years as baby boomers age and health care reform implementation creates a demand for nurses at the same time a million nurses plan to retire. Newly licensed nurses (NLNs) are expected to fill this gap. Consequently, hospitals have established nurse residency programs (NRPs) to assist NLNs through their first year to ease the transition from the academic setting to the clinical setting. Surveys given to NLNs in their first year of practice have demonstrated that even with the support of a NRP, many NLNs feel decreased confidence, job satisfaction, and competence. Despite NRPs, overall retention rates of these new nurses at one year is only 83%. The aims of this study were to better understand the perceptions of newly licensed nurses after the first year of practice about their expectations and the actual reality of working as a nurse and to describe the perceived behaviors, influences and barriers in the transition of newly licensed nurses into practice within an acute care setting. This study incorporated a medically focused ethnographic descriptive qualitative design to explore the experience and perceptions of NLNs transition into practice in the subculture of a 1082 bed metropolitan hospital. The dissertation is comprised of two sections 1) the research proposal and 2) a first manuscript of key findings. The project received IRB and hospital approval in January 2019. However when participant recruitment was initiated the hospital had concerns about their employee involvement in the study and it took an additional three months for the hospital's legal counsel to grant approval. Participants were easily obtained and

interviews were conducted between June 2019 and September 2019 with analysis and peer debriefing occurring simultaneously. (Appendices A-E).

The manuscript includes findings for both aims of the study accomplished through content analysis of the coded data. Codes used for analysis are included in Appendix F. Themes reflecting the stated aims were described and supported by NLN quotations and observations. These findings led to the development of a model depicting the perceptions of nursing school, the reality of being a real nurse and behaviors/influencers to transitioning into practice. These findings are clinically relevant for nursing schools and hospital nursing leaders in developing strategies for increasing student nurse exposure to the role of the real nurse before they enter into practice. Future research ideas are also included in the manuscript.

Proposal

Specific Aims

The nursing profession will be greatly impacted when more than half of the nurses currently working retire by 2020 (Windey, Guthrie, Weeks, Sullo, & Chapa, 2015). Anticipating the shortage, universities have responded by graduating students in mass numbers (American Association of Colleges of Nursing [AACN], 2015).These large volumes of students have created competition for clinical placement in acute care settings, and that, in conjunction with the increased acuity and complexity of today's patient population, have left new graduate nurses feeling unprepared for the patient care requirements expected of them when they enter the workforce (Cochran, 2017). Consequently, the responsibility of preparing new graduate nurses to safely practice now lies with the hospital industry.

It is known that transitioning from nursing student to practicing nurse can be challenging as the new nurse learns to function independently. Following the Institute of Medicine (2010) recommendation for transition programs for new graduate nurses, there was an increase in the number of nurse residency programs (NRPs) around the country. The NRP is designed to assist newly licensed nurses through their first year by offering educational programs, preceptors, and support to deal with issues that arise and to ease the transition from the academic setting to the clinical setting (Parker, Giles, Langtry, & McMillan, 2014; Goode, Lynn, Krsek, Bednash, 2009). However, these programs can be expensive, with the estimated cost between $62,100 - $67,000 to recruit

and train one new nurse (Cochran, 2017). Despite NRPs, overall retention rates of these new nurses at one year is only 83% (Blegen, Spector, Lynn, Barnsteiner, & Ulrich, 2017).

Surveys given to newly licensed nurses at various time intervals in their first year of practice have demonstrated that even with the support of a NRP, many newly licensed nurses feel decreased confidence, job satisfaction, and competence (Missen, McKenna, & Beauchamp, 2014; Van Camp, & Chappy, 2017). However, limited research has been done in order to explore the underlying perceptions and expectations of these new nurses and their reality of being a professional nurse.

The long-term goal of this study is to describe the perceptions of new nurses in their first few years of practice. While NRPs have surveyed many parameters of the newly licensed nurses, none of them have probed deeper to discover the underlying reasons behind job satisfaction or why newly licensed nurses are leaving their positions or the profession. The rationale for the proposed research is that understanding their perceptions could lead to possible recommendations for ways to better prepare and support newly licensed nurses in their practice.

Aim 1: To better understand the perceptions of newly licensed nurses in the first two years of practice about their expectations and the actual reality of working as a nurse.

Aim 2: To describe the perceived behaviors, influences and barriers in the transition of newly licensed nurses into practice within an acute care setting.

The knowledge gained from this study is expected to have an impact on how we prepare and support new nurses through the continuum of entering the nursing profession. The study will describe to how newly licensed nurses believe they can best be transitioned into practice.

Research Strategy

Significance

A literature review was conducted and it was established that most acute care settings utilize a NRP. NRPs were developed to assist in the transition of newly licensed nurses by teaching the essential skills and knowledge required to achieve competence in practice as well as providing support and socialization into the role of the professional nurse. NRPs are often an inducement for hiring newly licensed nurses and in one study, when newly licensed nurses were asked if they preferred a higher salary or a NRP, 73% responded that they preferred a NRP (Rosenfeld, Glassman, & Capobianco, 2015). Additionally, not only are these newly licensed nurses' novices in their new role, they also have been described as a vulnerable population, requiring the protective support of preceptors and mentors within a NRP to assist their transition into practice (D'Ambria & Andrews, 2014; Rush, Adamack, Gordon, & Janke, 2014). Outcomes for those completing a NRP should be increased job satisfaction and organizational commitment, ultimately resulting in increased retention (Kramer et al., 2012; Kowalski & Cross, 2010; Olson-Sitki, Wendler, & Forbes, 2012).

Based on a review of literature in this area some studies support that newly licensed nurses need at least a year to feel comfortable in their role (Casey, Fink, Krugman, & Propst, 2004; Kramer et al., 2012), but may benefit from being followed and supported for a longer period of time (Goode et al., 2009; Van Camp & Chappy, 2017). Providing a supportive transition program will assist with increased confidence and competence, positive job satisfaction levels, and higher retention rates (Chappell & Richards, 2015; D'Ambra & Andrews, 2014; Edwards, Hawker, Carrier, & Rees, 2015; Missen et al., 2014; Van Camp & Chappy, 2017). Research also shows that there is a decline in job satisfaction scores when newly licensed nurses are evaluated at six months, halfway through their first year of practice (Goode et al., 2009; Medas et al., 2008; Williams, Goode, Krsek, Bednash, & Lynn, 2006). This timeframe where satisfaction decreases has been described as the "reality shock" period, and has been well defined in literature for the last 40 years, as that time in the first year of practice, when the reality of what denotes being a nursing professional is conceptualized (Goode et al., 2009; Kramer, 1974; Medas, Amato, Grimm, Radziewicz, Rhodes, VanHorn, & McNett, 2008; Williams et al., 2006). During this time, they become disillusioned about the professional nurse's role and with their preconceived notions of nursing, and they no longer want to stay in their new profession. With awareness of this phenomenon, a NRP puts supportive strategies in place to assist newly licensed nurses through this challenging time.

Even though it has been demonstrated that NRPs play a vital role in transitioning newly licensed nurses from school to a professional career, the

retention rate of newly licensed nurses (including those who have participated in a NRP) at one year is only 83% (Blegen et al., 2017). With replacement costs of around $62,100 - $67,000 to recruit and train one new nurse, there is a business case to support a positive return on investment, by decreasing the turnover of newly licensed nurses (Cochran, 2017; Halfer, Graf, & Sullivan, 2008; Silvestre, Ulrich, Johnson, Spector, & Blegen, 2017; Trepanier, Early, Ulrich, & Cherry, 2012). The need to increase retention rates is a necessity in a budget-driven health care economy. Additionally, the fiscal costs associated with recruitment and onboarding do not measure the emotional drain on the experienced staff whose time is spent orienting new nurses who are not retained.

Other factors have influenced transition into practice of newly licensed nurses. It is believed that there is decreased job satisfaction with nurses who were not working in specialties of their choice and that specialty choice influences retention (Beecroft, Kunzman, & Krozek, 2001). Incivility and bullying were experienced by 39% of the newly licensed nurses, regardless of being in a NRP (Rush et al., 2014). It appears that there are contributing factors that influence transition into practice that extend beyond the influence of a NRP (Chappell et al., 2015; Letourneau & Fater, 2015; Edwards et al., 2015; Rosenfeld et al., 2015; Van Camp et al., 2017).

A number of studies have evaluated newly licensed nurses in NRPs with validated job satisfaction and organizational commitment scales, with answers using a Likert scale template. While these numbers show that NRPs are endorsed by newly licensed nurses, they are not capturing those nurses who

leave or plan to leave their practice. Retention rates are collected by Human Resources, and seldom reveal why the nurse is leaving the organization. Adding to the inaccuracy of job satisfaction and retention are those hospitals that require employment commitment contracts to their organizations, which only postpones some resignations.

There have been over 140 studies done that have used scales to gauge aspects of the newly licensed nurse's experience, but none have been done looking at their perceptions and expectations. Contributions from this study will provide, in greater depth, newly licensed nurse's perspectives of the nursing profession by using qualitative research methodology. Contributions are expected to be grounded in a deeper understanding of how new nurses' transition into the nursing profession and their perceptions of their expectations and reality of practice. In order to adequately support newly licensed nurses, it is important to know their experiences and perceptions and how they can be best supported.

Innovation

It is broadly documented in surveys that there is disparity between what these novice newly licensed nurses expected and reality, but no research has been done to determine the perceptions and verities' that exist with these newly licensed nurses in the first two years of practice. It was hoped that NRPs would bridge the gap between academia and practice but newly licensed nurses are still changing employment or leaving the profession. With acute care settings facing financial constraints, the cost of this ambivalence and discontent is creating a

burden for health care at a time when they are trying to preemptively fill nursing vacancies. This study will use a qualitative design to explore perceptions of newly licensed nurses about their transition into practice, work experience, their job satisfaction, and NRP experience. Obtaining this information will provide insight into the newly licensed nurse and may support a paradigm shift into how these nurses are supported in their transition into practice.

Conceptual Framework

Duchscher's stages of transition theory (Duchscher, 2008) will serve as the conceptual framework for this study (Appendix A). Duchscher's theory is derived from Benner's adaptation of skills (Benner, 1984; Benner, 2001) and Kramer's process of transition to professional practice among nursing graduates (Kramer, 1974). Boychuk Duchscher incorporated ten years of qualitative methods, including a grounded theory research program, to develop the aspects of a newly licensed nurse's transition experience in the first year into acute care (Boychuk Duchscher, 2008).

This model is not a linear but more of a transformational process as the newly licensed nurse embarks on their professional journey (Duchscher, 2008). All newly licensed nurses begin with an overview of the hospital in orientation. The newly licensed nurse will focus initially on completing tasks and routines, managing competing demands, prioritizing and managing emerging situations. Duchscher refers to this three-month period as the "doing" stage and notes that "transition shock" occurs at this time. In transition shock they feel stressed about everything and realize the reality of being a nurse. At approximately four to

seven months into their experience they are in the "being" stage, where they are building on their foundational knowledge, taking on a full patient assignment, and are challenged by complex clinical scenarios. Duchscher's model incorporates at this time, a period that she calls "transition crisis." This phenomenon was first documented by Kramer (1974) and has been validated in many other studies. At this point in time, the newly licensed nurse doubts their clinical competence, and if not fully supported will lose all confidence in their abilities. Eventually from eight to twelve months they reach the "knowing" stage, where they still face challenges but are able to recover and cope with their responsibilities. The bulk of their frustration at this point is in dealing with their institution or the health care system at large. By the twelve-month period the newly licensed nurse is relatively stable and confidently capable of managing their professional nurse role.

If the newly licensed nurse has participated in a NRP, it is expected that the concept of providing support throughout the transitional phases seen in Duchscher's model has occurred and assistance has been provided during the important time junctures.

Approach

A medical ethnographic descriptive qualitative *approach* of newly licensed nurses will be conducted in the subculture of a hospital setting (Green & Thorogood, 2004). The aims for this project are:

Aim 1: To better understand the perceptions of newly licensed nurses in the first two years of practice about their expectations and the actual reality of working as a nurse.

Aim 2: To describe the perceived behaviors, influences and barriers to newly licensed nurses transitioning into practice within an acute care setting.

It is the *expectation* that results from this study will provide insight into in how we prepare and support new nurses through the continuum of entering the nursing profession. Research will determine how newly licensed nurses believe they can best be transitioned into practice in a manner that promotes job satisfaction and retention.

Methods for Aims 1 and 2.

Research Design. A medically focused ethnographic descriptive qualitative design will be used for this study because it is a method whose "primary goal is to describe a situation or phenomenon vividly and in detail, to give a clear picture of what is going on" (Richards & Morse, 2013, p. 50). An ethnographic method allows the exploration of newly licensed nurses in the subculture of a hospital setting (Green & Thorogood, 2004).

Sample and Setting. Purposive sampling will be used in order to get variation in demographics, such as ethnicity, education level, age, gender, previous experience in health care, and specialty areas where they are working. The variety of demographics will provide perspectives among the newly licensed

nurses across the transitioning experience, thereby increasing the credibility of the findings (Kuzel, 1999). Educators and managers might also be engaged, if needed, to refer possible participants, in order to encompass breadth and depth of professional experiences. The researcher is a former education specialist in the NRP and is familiar with the program and has a relationship with the NRP coordinators. Participants will be interviewed until redundancy is reached in thematic content, and saturation in the depth and breadth of the topics discussed (Green & Thorogood, 2004). Based on other qualitative studies with in-depth interviews, it is estimated that redundancy may occur in 20 - 30 participants (Moser & Korstjens, 2018). The setting will be a large metropolitan hospital in Southeast Texas that routinely accepts approximately 150 newly licensed nurses into their NRP annually.

Participant Recruitment. Participants will be recruited from the rosters of newly licensed nurses who have participated in the NRP in a large metropolitan hospital. Eligibility criteria will be that they have been employed as a nurse for less than two years after passing the NCLEX exam. Potential study participants will be recruited at the mandatory monthly NRP seminar with a verbal presentation on the study. A flyer also will be created and distributed to nursing units throughout the hospital. Follow-up and interview appointments will occur at the seminars and via email correspondence. It will be explained during recruitment that interviews will be confidential and that only auditory portions of the interview will be recorded.

Data Collection. A medically focused ethnographic qualitative interview approach is needed to identify the perspectives of the newly licensed nurses in the subculture of a hospital setting (Green & Thorogood, 2004). Participants will provide informed consent prior to enrollment into the study and before any face to face interviews. Self-report demographic data will be obtained, including age, gender, ethnicity, marital status, experience in healthcare education level and specialty area where they are working (Appendix B). Data responses will be coded and blinded to everyone but the study researcher.

Participants will be asked to share their experiences in semi-structured individual interviews. Semi-structured interviews will be used to address themes and topics of interest in an informal or conversation-style dialogue with the newly licensed nurses. The flexibility of a semi-structured interview allows the researcher to uncover and explore themes that might be unexpected but prove to be important in understanding the newly licensed nurse's experiences (Kvale & Brinkman, 2009). The interviewer will guide the participant to share perceptions of their nursing experience through a series of open-ended questions (Appendix C). The semi-structured interview guide will initially be reviewed for relevance of questions and credibility will be established by the nurse researcher and two independent nurse educators who are experts in new graduate nurses and transition to practice (Polit & Beck, 2017). Triangulation will occur by interviewing different types of individuals in order to obtain multiple perspectives (Polit & Beck, 2017). Additional questions and probes may be added throughout the interviewing process in order to explore unexpected or emerging themes

(Brinkman & Kvale, 2015). Interview order will be based on participant availability.

One-on-one interviews will be a conducted over the phone with the option of FaceTime (if available and agreed upon by the participant) or in person in a small conference room located away from patient care areas. The justification for FaceTime is to try to mimic as close as possible a face-to-face interview and not miss facial expressions and other nonverbal communication. Interviews will only be audio recorded and transcribed verbatim. Data analysis will be started immediately after the first interview. Field notes and observations of the informant's responses during the interviews will be documented to reflect inflections, tones and nonverbal cues (Kvale & Brinkman, 2009). At the end of the interview dependability will be established by the interviewer by confirming that the participant's responses were complete and accurate (Polit & Beck, 2017). Participants will be informed that all names mentioned in the interview will be removed in the transcription of the interview. The interviewer is also the researcher and is not employed by the institution to eliminate any bias.

Data Management. Audio recordings will be downloaded onto a password-protected server. Every audio file will be identified with a study identification number and uploaded onto the server. The transcriptionist will be given access to a guest account in order to retrieve the file for transcription. Once the transcription is complete it will be loaded onto the server, with study identification, and the researcher will be notified by email. The transcript will then be verified for accuracy and authenticity by the researcher by listening to the

audio recording and comparing it to the transcript (Polit & Beck, 2017). All references to names or places will be removed from the transcription. Audio recordings will be kept on the secure server until all study interviews and transcripts are finished. At that time, all recordings will be deleted, and the transcripts will be stored by study number on the password-protected server.

Despite security measures and the use of study ID numbers, there could be a breakdown in protecting the identity of interview participants. If a breach in participant confidentiality were to occur, we will notify the participant and IRB as soon as the incident was discovered. We would create an action plan to prevent future breaches. Violations in the conduct of the study will also be reported to the IRB as soon as they are identified.

Data Analysis. Transcriptions will be imported into ATLAS.ti version 8 for Windows (Scientific Software Development GmbH, 2017) for data coding and analysis leading to preliminary themes. By content analysis, codes will be derived directly from the text data (Hsieh & Shannon, 2005). Codes will be identified and developed iteratively from the data and a codebook will be developed (Saldana, 2009). Codes will be established and categorized for themes, constructs, models, etc. (relating to the research questions) by the nurse researcher. Transcriptions will be analyzed recursively validating the emerging themes and patterns. Lastly, peer debriefing will be done with other researchers who are familiar with the research approach, to substantiate the themes, eliminate bias and make the findings resonate with the providers, thereby establishing trustworthiness (Saldana, 2009). In ethnographic research the researcher is

seen as the instrument of data collection (Richards & Morse, 2013). Therefore, to further enhance the rigor of the data, reflexivity will occur by ongoing dialectical analysis, with the researcher keeping a journal with analytic notes, to avoid bias (Korstjens & Moser, 2018). Sampling will continue until good depth and repetition or "saturation" of themes is reached, and little new information emerges (Green & Thorogood, 2004).

Expected Outcomes

This study will use a medical ethnography approach to explore perceptions of newly licensed nurses about their transition into practice, work experience, their job satisfaction, and NRP experience. The objective in obtaining this information is to provide insight into the newly licensed nurse's experiences and provide recommendations on how to best transition them into practice.

Potential Problems and Alternative Strategies

When executing semi-structured interviews, the quality of the data collected is imperative to the study. With that in mind, data could be lost if the audio recordings fail to capture the participant's responses. To safeguard this from happening, during the interviews two devices will be used simultaneously to capture the audio recording. Field notes will be both audio recorded and written in journal. Transcriptions will be verified for accuracy immediately upon receipt so that the researcher can remember the interview and enhance the audio with the nonverbal communication that might not be captured.

Another potential problem could be the recruitment of participants. It will be important to stress to them the confidentiality of their identity and their responses. It will also be imperative that the interviews are held in areas that have limited access. Should sample size become an issue, another hospital, with similar demographics, in the same hospital corporation, might need to be added to the study.

Risks to Human Subjects / Ethics

The Committee for the Protection of Human Subjects will be the IRB of record. All persons involved with collecting, managing or analyzing data for this project will have completed Human subjects' training and be included in the IRB application. All persons who are involved as participants in the project will be informed verbally of the purpose, risks/benefits and the voluntariness of their role by the researcher. Information sheets will be provided about the study for all participants. Written consents will be obtained from subjects before interviewing is initiated. If a subject does not want to participate they can withdraw at any time during the interview. There is low risk associated with the proposed interviews and adverse events are not expected. All ethnicities and genders will be included.

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10/31/2019

Susan R. Lesser, PhD, RN-BC
[redacted]
Sugar Land, TX 77470

Kathleen Burke, PhD, RN-BC, CENP, FAAN
JNPD Editor-in-Chief
Kathleen.Burke@wolterskluwer.com

Dear Dr. Burke,

Attached you will find a manuscript for consideration to the Journal for Nurses in Professional Development entitled, *Perspectives of Nurses after the First Year: Expectations and Reality.* Congruent with ANPDs objectives to provide innovative information to Professional Development Specialists, this manuscript provides current perspectives of newly licensed nurses about their transition into nursing practice. Using a medical ethnography approach, we interviewed 15 nurses after they completed their residency program and had been working for a year in a large tertiary hospital. Through analysis we describe how they feel nursing school prepared them for nursing, their perspectives of being a real nurse and the influences/barriers that impacted their transition into practice.

This manuscript provides a conceptual model of the newly licensed nurse's journey into becoming a professional nurse. Information learned could possibly provide insight into the newly licensed nurse, and may provide a paradigm shift into how these nurses are supported in their transition into practice.

This paper has not been previously published and is not currently under consideration by another journal and all authors have approved of and have agreed to submit the manuscript to this journal.

Thank you in advance for your consideration.

Sincerely,

Susan R. Lesser, PhD, RN-BC
University of Texas health Science Center at Houston Cizik School of Nursing
Susan.lesser@uth.tmc.edu

Perceptions of Nurses after the First Year: Expectations and Reality

Susan R. Lesser, PhD, RN-BC[1]
[1]University of Texas Health Science Center Houston
Cizik School of Nursing
Houston, Texas

Cathy L. Rozmus, PhD
[1]University of Texas Health Science Center Houston
Cizik School of Nursing
Houston, Texas

Joan Engebretson, DrPH, AHN-BC, RN, FAAN[1]
[1]University of Texas Health Science Center Houston
Cizik School of Nursing- Department of Family Health Nursing
Houston, Texas

Corresponding Author:

Susan R. Lesser, PhD, RN-BC[1]
[1]University of Texas Health Science Center Houston
Cizik School of Nursing
Houston, Texas 77059
Susan.lesser@uth.tmc.edu

Introduction

The nursing profession will be greatly impacted when a predicted one million registered nurses retire by 2030 (Buerhaus, Skinner, Auerbach, & Staiger, 2017). The Bureau of Labor Statistics (2019) projects a need for at least 210,400 new nurses each year through 2028 to fill newly created positions and replace retiring nurses. Anticipating the shortage, universities have responded by graduating students in mass numbers. An American Association of Colleges of Nursing (AACN) survey in 2014 found that nearly 112,000 students graduated from baccalaureate programs alone (American Association of Colleges of Nursing [AACN], 2015) and by 2018 there was a 3.7% enrollment increase in entry-level baccalaureate nursing programs (AACN, 2019). These large volumes of students have created competition for clinical placement in acute care settings, and that, in conjunction with the increased acuity and complexity of today's patient population, have left new graduate nurses feeling unprepared for the patient care requirements expected of them when they enter the workforce (MacIntyre, Murray, Teel, & Karshmer, 2009; Soto, 2015). Undergraduate nursing curriculum places a major emphasis of the student's education on knowledge and the basic fundamentals needed to start clinical practice (Goode, Lynn, Krsek, & Bednash, 2009). Consequently, new graduate nurses are entering the workforce unprepared for the patient care requirements that is expected of them, and the responsibility of preparing them to safely practice, lies with the hospital industry.

Background

It is known that transitioning from nursing student to practicing nurse can be challenging as the new nurse learns to function independently. Due to the increased acuity and complexity of the patient population, it is impossible for nursing schools to adequately prepare new graduate nurses to practice in the hospital environment (Goode, et al., 2009). Suggestions that newly licensed nurses were not capable of caring for high-acuity patients, in the practice setting, prompted the Institute of Medicine's (2010) recommendation for transition programs for new graduate nurses. With that recommendation there has been an increase in the number of nurse residency programs (NRPs) around the country. It is now an expectation that newly licensed nurses will transition into their new role with the assistance from a NRP.

The NRP is designed to assist newly licensed nurses through their first year by offering educational programs, preceptors, and support to deal with issues that arise and to ease the transition from the academic setting to the clinical setting (Parker, Giles, Lantry, & McMillan, 2014). Though they vary in length, format and funding, they are all designed to support and educate newly licensed nurses during their first year of nursing to encourage retention (Goode, et al., 2009; Parker et al., 2014). Formalized NRPs have been reported to reduce anxiety and provide a support system for novice nurses (D'Ambra & Andrews, 2014; Kramer et al., 2012; Rush, Adamack, Gordon, & Janke, 2014). They have also been shown to positively impact critical thinking and leadership skills (AL-Dossary, Kitsantas, & Maddox, 2014; Chappell, Richards, & Barnett, 2014). With

the estimated cost of over $90,000 to recruit and educate one newly licensed nurse (Advisory Board Company, 2017), there is a business case to support a positive return on investment, by decreasing the turnover of newly licensed nurses (Silvestre, Ulrich, Johnson, Spector, & Blegen, 2017; Trepanier, Early, Ulrich, & Cherry, 2012). The need to increase retention rates is a necessity in a budget-driven health care economy. Additionally, the fiscal costs associated with recruitment and onboarding do not measure the emotional drain on the experienced staff whose time is spent orienting new nurses who are not retained. Despite NRPs, overall retention rates of these new nurses at one year is only 83% (Blegen, Spector, Lynn, Barnsteiner, & Ulrich, 2017).

Other factors have influenced transition into practice of newly licensed nurses. It is believed that there is decreased job satisfaction with nurses who were not working in specialties of their choice and that specialty choice influences retention (Beecroft, Kunzman, & Krozek, 2001). Incivility and bullying were experienced by 39% of newly licensed nurses, regardless of being in a NRP (Rush et al., 2014). It appears that there are contributing factors that influence transition into practice that extend beyond the influence of a NRP (Chappell & Richards, 2015; Letourneau & Fater, 2015; Edwards, Hawker, Carrier, & Rees, 2015; Rosenfeld, Glassman, Capobianco, 2015; Van Camp & Chappy, 2017).

Surveys given to newly licensed nurses at various time intervals in their first year of practice have demonstrated that even with the support of a NRP, many newly licensed nurses feel decreased confidence, job satisfaction, and

competence (Missen, McKenna, & Beauchamp, 2014; Van Camp & Chappy, 2017). The purpose of this study was to better understand the perceptions of newly licensed nurses after the first year of practice about their expectations and the actual reality of working as a nurse and to describe the perceived behaviors, influences and barriers in the transition of newly licensed nurses into practice within an acute care setting.

Theoretical Framework

Duchscher's stages of transition theory (Duchscher, 2008) served as the conceptual framework for this study (Figure 1). Duchscher's theory is derived from Benner's adaptation of skills (Benner, 1984; Benner, 2001) and Kramer's process of transition to professional practice among nursing graduates (Kramer, 1974). Duchscher incorporated ten years of qualitative methods, including a grounded theory research program, to develop the aspects of a newly licensed nurse's transition experience in the first year into acute care (Duchscher, 2008).

This model is not a linear but more of a transformational process as the newly licensed nurse embarks on their professional journey (Duchscher, 2008). All newly licensed nurses begin with an overview of the hospital in orientation. The newly licensed nurse will focus initially on completing tasks and routines, managing competing demands, prioritizing and managing emerging situations. Duchscher refers to this three-month period as the "doing" stage and notes that "transition shock" occurs at this time. In transition shock they feel stressed about everything and realize the reality of being a nurse. At approximately four to seven months into their experience they are in the "being" stage, where they are

building on their foundational knowledge, taking on a full patient assignment, and are challenged by complex clinical scenarios. Duchscher's model incorporates at this time, a period that she calls "transition crisis." At this point in time, the newly licensed nurse doubts their clinical competence, and if not fully supported will lose all confidence in their abilities. Eventually from eight to twelve months they reach the "knowing" stage, where they still face challenges but are able to recover and cope with their responsibilities. The bulk of their frustration at this point is in dealing with their institution or the health care system at large. By the twelve-month period the newly licensed nurse is relatively stable and confidently capable of managing their professional nurse role.

If the newly licensed nurse has participated in a NRP, it is expected that the concept of providing support throughout the transitional phases seen in Duchscher's model has occurred and assistance has been provided during the important time junctures.

Methods

Study design

A medically focused ethnographic descriptive qualitative design was used for this study because it is a method whose "primary goal is to describe a situation or phenomenon vividly and in detail, to give a clear picture of what is going on" (Richards & Morse, 2013, p. 50). An ethnographic method allowed the exploration of newly licensed nurses in the subculture of a hospital setting (Green & Thorogood, 2004).

Setting

This study was undertaken at a 1082 bed metropolitan hospital in Southeast Texas that routinely accepts approximately 150 newly licensed nurses into their NRP annually. Their NRP program is in its tenth year, they participate in the Vizient/ ANCC program and they have been accredited with distinction by ANCC as a practice transition program.

Participants

Purposive sampling was used to gather newly licensed nurses who had been employed as a nurse for less than two years and had completed the first year of the NRP. Study participants were recruited at mandatory NRP seminars with a verbal presentation of the study. Follow-up and interview appointments occurred at the seminars and via email correspondence. Educators provided follow-up emails explaining the study to specific units to broaden the depth of the participants. Demographic data were collected for age, gender, ethnicity, marital status, education level, school of graduation, previous experience in health care and specialty areas where they worked (Figure 2).

Data Collection

Data were collected through in depth, semi-structured face-to-face or telephone interviews (one interview) to allow participants to fully explore and communicate their experience of transition. The interviews were conducted by an experienced researcher who did not have a prior relationship with the participants. Interviews were conducted in a conversation-style dialogue and initiated with a grand tour question: "Tell me about your transition into nursing

practice." Further mini tour and probing questions developed from those comments (Figure 3). Interviews were audio recorded, transcribed verbatim and coded and blinded to ensure confidentiality. Each interview lasted between 30 and 75 minutes. Field notes were kept to document informant's inflections, tones and nonverbal cues. The study was conducted between June 2019 and August 2019.

Ethical Considerations

The study was approved by the Committee for the Protection of Human Subjects of the health service and local university. Written consent was obtained at the time of participation.

Audio recordings were downloaded onto a password-protected server. Every audio file was identified with a study identification number and uploaded onto the server. The transcriptionist was given access to a guest account in order to retrieve the file for transcription. Once the transcription was complete it was loaded onto the server, with study identification, and the researcher was notified by email. The transcript was then verified for accuracy and authenticity by the researcher by listening to the audio recording and compared to the transcript (Polit & Beck, 2017). All references to names or places were removed from the transcription. Audio recordings were kept on the secure server until all study interviews and transcripts were finished. At that time, all recordings were deleted, and the transcripts were stored by study number on the password-protected server.

Data Analysis

Data analysis began immediately after the first interview. Transcriptions were imported into the data management system ATLAS.ti version 8 for Windows (Scientific Software Development GmbH, 2017) for data coding and analysis leading to preliminary themes. By content analysis, codes were derived directly from the text data (Hsieh & Shannon, 2005). Codes were identified and developed iteratively from the data and a codebook was developed (Saldana, 2009). Codes were established and categorized for themes, constructs, models, etc. (relating to the research questions) by the nurse researcher. Transcriptions were analyzed recursively validating the emerging themes and patterns. After analysis of codes was completed a coding schema was developed (Figure 4). Sampling continued until good depth and repetition or "saturation" of themes was reached, and little new information emerged (Green & Thorogood, 2004). Data saturation was achieved after interview 12 with no further themes emergent from analysis, with the 3 remaining interviews coded to confirm saturation.

Study rigor was provided using the four criteria of Lincoln and Guba (1985): credibility, transferability, dependability and confirmability. To provide credibility peer debriefing was done with other researchers who are familiar with the research approach, to substantiate the themes, eliminate bias and make the findings resonate with the providers, thereby establishing trustworthiness (Saldana, 2009). Transferability was obtained by the ethnographic approach of keeping field notes rich in data to supplement and support the content of the interviews (Cohen & Crabtree, 2006; Nowell, Norris, White, & Moules, 2017).

Dependability was established by an external audit done by an outside researcher (Cohen & Crabtree, 2006). An audit trail is available for confirmability (Lincoln & Guba, 1985). Lastly, in ethnographic research the researcher is seen as the instrument of data collection (Richards & Morse, 2013). Therefore, to further enhance the rigor of the data, reflexivity occurred by ongoing dialectical analysis, with the researcher keeping a journal with analytic notes, to avoid bias (Korstjens & Moser, 2018).

Findings

Analysis of the interview data showed that the reality of being a real nurse was not what NLNs had expected after completing nursing school. Words frequently used by NLNs to represent the reality of being a "real" nurse were "overwhelming", "hard", "terrifying" and "scary". So, it is not unexpected to find that the transition from nursing school to practice was not always smooth and easy. This study was an opportunity for NLNs to reflect on their first year of practice and share their experiences. The overarching premises of their perceptions of transition from nursing school to practice and influences to transition into practice can be seen in Figure 5.

Experiences in Nursing School

Provided a Foundation

Reflecting back over the last year the NLNs had positive regard for their nursing schools. They felt that nursing school had provided them with the basic knowledge and skills foundation they needed to start practice, but their clinical

experiences did not really expose them to total care of the patient because they often only shadowed practicing nurses.

> I think my school did a pretty good job. I don't think anything prepares you until you walk in on that first day, and you have a patient for real, and they are your own patient. I don't really know how they could prepare you better for that. I think you just have an idea in your head about what it's going to be before you come because I think when you're in nursing school, you get this semi-rose-tinted view because you're working with someone all the time. (1)

> I feel like (nursing school) was kind of like a toe in the water. I feel like it really prepared me for the learning. Like, it helped me be able to learn and critically think, because it forces you to practice that. I don't think clinically, like skill-wise, I don't think it really did anything. Like, it helped to see the things happen, but I didn't really learn that until I was actually here and doing it. (6)

> I didn't expect how much stress there was, because I don't know that that was talked or discussed about in school about what that transitional period is going to be. I mean, we learned about like the honeymoon phases and all that kind of stuff, but I don't think that ever really hit me of like it's going to be a huge jump from when you're in clinical to when you're an actual nurse. (7)

NLNs stated that in nursing school they "took care of pieces of patients", as in their diagnosis, but not "the whole patient."

> You can have as many simulations, as many whatever, and until you're actually in it yourself, I don't think you can be totally prepared. You really can't prepare someone until they're in it. I think your mindset is very different because in nursing school we write the care plans and your goal was not totally patient-centered. It was still focused on school. And like the patient was a means to the end to do the assignment lots of times. Whereas in real world, it's just about the patients. They're not an assignment, if that makes sense. (4)

Clinical Not Realistic

The NLNs worked shorter hours and therefore were not able to fully see the entire realm of the patient. They were not allowed to participate in all aspects of patient care, so they missed the complete role of the nurse in the patient care spectrum.

> I kind of, like I had this idea of what nursing was and what I was going to be, to do, everything based on clinicals, and school, and everything. And then, there's a lot of times that you're not directly in part of the team. Like you don't communicate with the doctors, you don't communicate with patients' families, you don't communicate with other nurses. So just that transition of learning how to be the person actually talking to everyone and not just like be in the background listening. (5)

> You're not taught how to transition between your patients super quickly, and you're not taught—like you're taught prioritization; but you're not taught prioritization within the hour. You're taught, do I pass meds first, or do I do a bath first, or do I do it altogether? And it's like, I don't know. (5)

Some NLNs felt that they were sheltered from the critical patients in nursing school. The patients they saw in clinical were not as acutely ill as they saw on a routine daily basis in their current practice.

> I realized that as a student, I must have been shown the easiest of the easy and I'm thinking that it represents the unit. I think that a very critical component is that students need to really see what it looks like, you know. I mean, even ECMO, like, I remember hearing about ECMO. I was like, "Oh, that sounds so hardcore, so intense. I want to be somebody that can take care of that because that's the worst of the worst and the sickest of the sick, and we can get them back." And, you look at photos of it, and they're all, like, drawn, you know, and it's cute and the baby is smiling, and it has two little teeth. And, you're like, "Oh, we can do that." I saw ECMO. I don't ever want to see ECMO for the rest of my life because it is horrible. The, you know, these kids are purple. They're—everything is hemolyzed, and everything is inflamed. And, tubes are leaking, and heart rate is zero, but it's alive. It is the worst, you know. (3)

> When you get into it, you're like, "Holy cow. This is hard." So, I have had days where it's like, "Man, is this really what I want to do? Like go through shifts and see really awful things?" (4)

Many had practiced patient's coding in simulation scenarios in nursing school, but few had experienced this in real life, nor had they witnessed patient's dying. Almost every NLN interviewed shared the trauma of their first patient coding and dying.

> Our school instructors actually tried to keep us away from any death during nursing school. Because they're like, you know what, you're going to see this for the rest of your lives, for the rest of your career. You don't need to have that grief right now on top of nursing school, on top of everything else. So, they tried to keep us away from it. I don't know if that helped or hurt. (5)

> My first code, I burst into tears after it was over and had to just step out and get away from the situation after I knew everything was okay. We were at a point, I just had to remove myself from that situation because it was just so much. It didn't happen because I did something wrong. It happened because the patient was sick, but it took me a while to get to that point. I was thinking this isn't my fault. This is just because they're unwell. This isn't something I've done. Because they kind of teach you, when you're in school, well, if you do things wrong, then the patient codes, that sort of thing. (1)

Reality of Being a Real Nurse

The perceptions of NLNs after their first year of practice was that nursing school had not provided them with a realistic view of caring for the patient. They had glimpses in clinical, but they were not immersed into the role of the nurse and therefore they had a lack of preparedness when they started working in acute care. The overall concepts that define nursing care and the profession were not illuminated for them until they entered their own practice. The data yielded four themes around the realities the NLNs experienced as they transitioned into being a real nurse: 1) unexpected patient care experiences, 2)

difficulty with patient coordination and time management, 3) more responsibility than expected and 4) living a nursing lifestyle.

Unexpected Patient Care Experiences

The NLNs found that patients had a higher acuity and were more critical than they had anticipated from nursing school. They acknowledged that their education had prepared them to work in a general medical/surgical environment and they were not prepared for specialty areas, particularly intensive care. They were ill prepared for patient's becoming critical, experiencing intractable pain, having mental illness, drug dependency and the stress brought on by patient's families.

> I feel like I struggle a lot mainly with dealing with the patient population, because we do have an odd bunch because, you know, our unit takes in like all kinds of patients, and whether they can pay or not, and the homeless and all that kind of stuff. We kind of get like a plethora of different personalities and things, on our unit. We tend to get a lot of psych patients; some of them are violent, some of them are not. We get a lot of them are gunshot wounds or car or things like that, so there's always a pain issue. And it's just trying to deal with pain and dealing with, you know, we're trying to help the patients with the pain. (2)

The psychosocial experience of patients and families was both challenging and satisfying. The NLNs were not anticipating that their patients and families might be abusive and ungrateful. Yet many felt rewarded by providing care to patients and families when they were compromised and vulnerable.

> I thought the patients would be nicer, I really did. I didn't expect them to be over the top gracious, but I did not expect to be yelled and cursed at as much as I am on a daily basis. Not even thankful, just not rude. I just expected them to be neutral, or a little bit thankful and/or neutral. But it's fine. The neutral patients are the ones I'm happy with. I'm like, "Oh, my God, my patient was so great today." And I'm like, "They never actually said, 'Thank you once today, but they didn't yell at me, so it was a great day.'" (5)

> ...any family that I'm able to change their perspective, or just make them feel a little bit better. Especially because I do speak Spanish, I very often get those Spanish speaking patients, and so the moment that they know that they have that, they feel a hundred times better. And if I'm able to make them feel good enough to where they're able to just go home and just rest, which is something that our parents typically don't like to do, because they just want to be there. I get it. It's very scary. And so, if I'm able to allow them to have that moment to feel so secure in the care that they're about to receive that they're able to go home and get a good night's sleep, then that just makes it so worth it. (14)

> I really enjoy taking care of them and just doing, just being the bedside nurse. And being an advocate. And what's been cool about primarying is I know a lot about his care and so you know, I can be a better advocate for him. So, that's been really cool. That's definitely been a highlight. (9)

Difficulty with Patient Coordination and Time Management

The NLNs had been drilled in nursing school the need to be critically thinking. They found it more difficult than expected when they had to care for a full patient assignment, especially if they received a new admission or patient's status changed. Although they had expected to be slower until they became proficient at new skills, they had not anticipated the amount of time it took to coordinate patient's care. Many commented that they spent more time on the phone and less time in the patient's rooms as they made sure their patients had their medications, equipment and consults. Documentation was time consuming and new to them. They struggled with learning to delegate tasks to techs or assistants, and when they were short staffed with those roles, they were overwhelmed in assuming those tasks. Non-nursing tasks such as finding equipment and performing housekeeping duties also strained their time and stressed their organization. Although they expected it to get easier with more experience it was stressful while they were still in the learning process.

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Nursing, it's been a lot different than I expected. The nurse's role is really far more reaching than what I thought it was and what it was portrayed to be in nursing school. I think it's almost overly simplified in nursing school. So, when you come into the real world and start working on a unit, you really learn that the bed changes, the medication administration, really like nursing tasks, is actually a very small part of your day. You know, the largest part of my day, unless I have a critically ill patient, is really in coordinating care and making sure everyone's on the same page, that there's a plan in place and that it's appropriate, that really all the teams involved are aware of what all is going on with the patient, because a lot of little things fall off or get missed or are overlooked with so many different, you know, hands kind of in the jar with that. And so, it's really a lot of phone time. It's a lot of trying to track down people and social work and get them on board. Yeah. So that I definitely was not prepared for heading into the profession. You kind of just have to learn as you go and learn very quickly. Yeah. (8)

As far as what I have had that's been really terrible days was where there was too much for me to do in one shift. Like, there's been patient loads, usually associated with an admission. Where I am so overwhelmed that I cannot... Like, I could cry. Like, that happened to me my first week on night shift. I got an admission and I already had two other babies. And one of them was going into crazy cardiac rhythms. And I was really busy. And I had a really busy admission, so I didn't have time to devote to her. And that was extremely stressful. So, that was one of the more recent bad days with just no time to chart, no time to eat. I have help, but it didn't feel like I had that much help. It, kind of, felt like every time somebody would help me, well then, they would have to go back to whatever they were doing. So, that was not a good day. So, I would say, a lot of times, some of the bad days can be associated with admissions because you don't know what's coming, and you don't know, like, it may not be a great time with your other patients.(9)

If we're feeling overwhelmed, of course, somebody's going to help, but it's more of tasks, I guess. I think it's just too much to do sometimes. I think it will get easier with more experience. Just stuff like I still question should I contact this person or if this lab is needed. You know, I still question some of my actions. And I think with experience, you kind of are like you've seen this multiple times. You've seen what doctors do. You might not need to call them for this lab value or this bleeding or, you know, things like that. So, I do think it will get easier, but I think every nurse still gets overwhelmed if multiple things are happening at one time. (10)

We have three patients and they are always really sick. You're drowning. Just so busy that you can't—it's like there's like a good

> busy and then there's a messy busy, I think. And the messy busy is like, you're just trying to, like, catch up with yourself the whole time. You don't have time to sit down and like plan out your day and be like, "Oh, it will be busy from this time to this time. And then I'll have a break and I can catch up on something." It's like you haven't had time to do that. It's just one thing after the other constantly happening. And then like, it's like just chasing things. You try and organize things so you can be a good busy, not a messy busy. (6)

Coordinating care and speaking with physicians was also challenging. The NLNs noted that they had to learn how to talk to physicians and they worried about bothering them, not being correct or having all the answers. There was a learning curve before they felt confident in their communication.

> I think just learning about physician communication was a big one. I didn't have a lot of experience with that in nursing school and so I think, you know, learning when a doctor calls and asks about certain things, what are the important things that I want to tell them. Certain doctors are a little snippier than others and kind of learning their mannerisms and learning their temperament, just as they're learning yours. I think that was another big one too that I was so nervous about, especially certain ones, you know, that are known to be a little bit more snippy than others. Just getting the confidence to be like, its fine, just brushing it off, I guess. You know, I would take that home and be like nervous about that all the time, and be like, oh my gosh, what if I get one of her patients tomorrow or whenever, then just being like, it will all work out, it will be fine even if she's like kind of cranky to me on the phone once, it doesn't ruin my day, like it's fine. (12)

More Responsibility than Expected

There was a consistent dialogue among the NLNs that they had not expected the responsibility that assuming total care of patients entailed. They were especially afraid of making mistakes. These included everything from overlooking an order, poor judgement, to missing assessment cues that could ultimately harm the patient. They worried that they "didn't know what they didn't know" and that they would be called upon to make a decision or do a procedure

that they weren't prepared to undertake. They especially feared making mistakes when they were physically, emotionally and mentally drained from working 12-hour shifts and night shifts.

> And so, it was rough to realize how little you know when you first start, like how very little, and how much you're actually responsible for. Really, everything that touches the patient at the end of the day is on you and on your license, and that was a lot to take at first. And that still is, if we're being perfectly honest, yeah. (8)

> I feel like, as a new nurse, sometimes you get to where you doubt yourself. Because one of the things that I was always kind of scared about being a nurse is like, like I could—I need to do my job very well or I could kill somebody. Like, this is a serious thing. (2)

> Being a nurse is stressful. But, you know, you can't anticipate until you're in the moment feeling the pressure of that. And I think, you know, sometimes the stress of not wanting to make an error or harm a patient, things like that. That's, you know, that pressure is more than you can imagine. But, times two. (9)

> One time, I literally was like, just [screams]. I can't do it. I can't go to work, and I'm like on my way to work. I was like, I can't do it. Oh, yeah. It gets—because in the ICU, it's not just oh, you make a mistake. Oh, it's okay. We'll fix it. You make a mistake, you can kill that patient, and it's just downhill from there. And then not only can you almost kill that patient, but they resuscitate them, and then you have to take care of them for the rest of the shift knowing that that was your fault. (15)

> Just to feel like I'm 25 years old, but I am completely responsible for all of these super sick patients. And that's both really humbling and an honor, but also really scary sometimes, because like all of us new grads. I feel like if I was a patient, I would look at a really young person and be like, are you really qualified to be doing this? It's kind of crazy... (13)

> I was terrified that something I did might, like, cause damage to the kid or something that I missed. I think it's recognizing the consequences that all your actions truly have, like even far out you, you recognize those consequences, not just, like, immediate next hour consequences. (3)

The NLNs recognized that they were not as capable to function under duress as their experienced colleagues. They worried about their licenses and patient safety when they worked short staffed.

> And I had literally just gotten off orientation, and I had a pair assignment that was, I would say, pretty unsafe. I felt very unsafe. And I felt like it was not the right choice, but they just threw me out there, and I was like, okay, I'm just going to handle it. (15)
>
> Right now, our unit is kind of understaffed and so it can be really stressful some nights because we're super tight. And so, I think that sometimes at shift change, day shift will come on and kind of have an attitude a little bit towards us if little things didn't get done and it's like, you don't know the night we've just had. (12)

Living a Nursing Lifestyle

Working the lifestyle of a nurse proved to be more challenging than they had expected. They knew they were going to start out with no seniority and probably work night shifts. Many were not prepared for how physically taxing night shift was to their bodies; however, some still liked working night shift more than days because the units moved slower and the experienced nurses had more time to teach them.

> I think I always knew that it was going to be pretty grueling. I mean, the fact that I think it's just like a rite of passage, you know, going onto nightshift immediately after. That has definitely been a really tough adjustment just for my life, and I do feel like it drains your body, and drains your mind, and you're just not used to being awake at these hours. I've already been on it for six months, and I definitely can tell the changes in my body and stuff like that. (13)
>
> For nightshift I thought it would be really difficult, but after like kind of figuring out how I need to be sleeping, I actually enjoyed it a lot, because on nightshift, things are a little bit slower, so, especially as a new grad starting off on my own taking my own patients, it was a good pace for me. And then on nightshift, since there's not so much going on as dayshift, the floor is not busy. People have time to teach you or help you, so I feel like I got to learn a lot more skills on nightshift. (11)

> I think night shift does take a toll. Well, it can be difficult being married just because, you know, he gets home and I leave. Or, sometimes we don't even see each other if I work three days in a row. At first, I was like, I can't wait to go back to days. I hate this. And now I've really grown to like it. And I like the people on nights. And it's a good environment. But then, there's, kind of, the messed-up sleep cycle and how long you can do that. (9)
>
> We never had to do any night clinicals in school or anything and so that was kind of a slap in the face. Some people respond really well to it and then some people kind of struggle with it more and so I found that I've kind of struggled with night shift a little bit more. Just like my sleep cycles and stuff kind of getting off. ...But yeah, that was definitely a little bit of a struggle, especially when I wasn't sleeping more than three hours at a time. I was like losing my mind a little bit. (12)

NLNs knew that nurses work 12-hour shifts, weekends and holidays. But they had not anticipated that they would have to schedule their shifts three months in advance and possibly not get vacation time when it was requested. Some struggled with balancing their work and personal life and felt that personal life was sacrificed. Significant others wouldn't see them on the days they worked, and they didn't always understand how overburdened they were from taking their troubles home from work.

> You're so tired after your shifts. Your shifts are over 12 hours long. It's always closer to 13 by the time you do handoff and the interactions with staff at work. That's hard. I remember coming home from that first day, and I looked at my mom, and I was like, "I'm not sure I can do this." Because it just felt like so much and trying to take in all the information, I was just mentally exhausted and physically exhausted and tired from being up early. Yeah, it was just a lot to take in. (1)
>
> Transition has been hard. A lot different than I expected. A lot more sacrifice. How can I describe it? It's a lot more sacrifice than I expected from my personal life. I think especially being in the acuity setting. And my husband's not in healthcare whatsoever. And then just the 12-hour shifts, working weekends, working holidays. And in my first year, I worked every single holiday but Christmas Day but

> all the holiday days and touching days. And so it was like, oh, my goodness. That's really hard. And so now working nights, we don't see each other, other when passing, so I think it's just impacted my personal life a lot more than I expected. (4)

> It's been a struggle, like needing to do like weekend things and needing time off for things. We have to work seven weekend shifts in a six-week period. And that's Friday, Saturday, and Sunday, so I think just trying to figure out how to balance it all. It was worse on nights. But I think now that I'm on days, it's a little bit better for sure. I mean, I knew, you know, as a nursing student, I definitely knew about working every other holiday and things like that. But I never kind of thought about weekends and being off when no one else is off and being on when everyone's off. That's not a nurse. I've just kind of my whole family's had to get on the board of planning your schedule three months out. Because, you know, people plan maybe that month...(10)

> I remember, I was on my way home, and I would call him, [her boyfriend] and I'm trying to vent to him about something that happened or whatever. And he'd just be like, oh, okay. Not knowing what to say. Not knowing what to do. I was like, you know what, this is a pointless conversation. I'll talk to you later. And it just caused strain on my relationships. Not just with him, but with anybody else that I tried to talk to about it, because I would just get so frustrated, that I'm just like, you're not helping me in any way, shape, or form. Just go away. (15)

Influences to Transitioning into Practice

The NLNs had perceptions of behaviors, influences and barriers they witnessed transitioning into practice. Successful transition into practice for an NLN was largely impacted by the healthcare organization providing education to fill the knowledge gaps between nursing school and practice and offering a culture with sufficient levels of support.

Additional Education: Knowledge and Skills

The NLNs acknowledged that the knowledge they gained in nursing school was at a fundamental level and that they needed a higher level of education and attainment of more technical skills, especially in association with their new clinical specialty. It was important to them that this education was given to them in a timely manner and not given in large doses immediately upon hire. However, they also stressed that they wanted enough education so that they did not "sink or swim."

> I just wasn't getting delivered the education the way that I needed it, and the residency program itself, played out in a different way than I thought it was. I thought it was going to have, a lot of frontloaded education, and it wasn't. There's education in the first three weeks and it's a lot of, feel-good happy stuff, you know, like, heart, head, heart and all the other things that we go through that nobody does. Right? Like, none of that is going to help me in a code, right? So, I thought it was going to be a lot more unit-specific stuff up front. (3)

> I think the residency program was really good. It helped me a ton. I learned so much. I liked the classroom setting paired with the real-life hands-on. Every week or two weeks we would have a lesson that went over what stage we were in. And so, we were able to correlate what we're seeing and doing with our hands-on learning and getting more information about it in a classroom setting. And with each phase there were different goals to accomplish during that phase. And so that grew with acuity—and then the classes we took were aligned with that. (4)

> With the way orientation is set up, it does ease you in. And, you know, you kind of go from taking like a walkie-talkie patient, we call them, to, you know, your sicker patients. But with the nature of our floor and just the acuity of the unit, you're kind of like in a sink or swim, regardless. But definitely, the orientation helped quite a bit, yeah. I couldn't have done it just starting off without that. (8)

> They had classes, kind of to bridge that gap between what we learned in nursing school, and what we were going to see. And the problem is though, it was right at the beginning. They were like these hour-long lectures, where we were just like bombarded with all of this information, and all of it was good, and useful, and very

> helpful information. It was way too much, too fast. We were not prepared for that, and so, three months down the road, when we're finally starting to connect things, or six months later, we finally have a patient that drowned. We finally have a patient that went through this ABC that we can connect with. They're like, well, don't you remember us saying that? I'm like, no, I don't remember you saying that one time, six months ago, of course I don't remember that. You know, it's like all this monitoring, and how to do this, and how to do that. And at the time, I've never seen that patient. I've never had to deal with that patient. It doesn't make sense to me. I can't connect the dots. Now that I've seen the patient, now that I've taken care of the patient myself, now I'm able to connect the dots. (14)

Culture of Support

Support NLNs received from other nurses was instrumental to a successful transition into practice. They defined support as experienced nurses being present and aware of their needs, providing guidance, sharing knowledge, "offering a hand" and showing they cared. Experienced nurses took the form of charge nurses, staff nurses, managers, educators and preceptors. They also expressed gratitude for support from the NRP and in particular the contacts they made with fellow NLNs who offered the opportunity for peer support.

Preceptors

The personal relationship NLNs had with their preceptor was crucial to their learning process and they made key points about the importance of their preceptor in their overall success. Good preceptors were described as patient, not negative and not critical. Consistency, as in having the same one or two preceptors, was very important and seemed to lead to overall satisfaction and increased confidence.

> I had a really consistent preceptor. And that was nice because I could see myself growing, because I could see myself based on where I was at the beginning with her, and what I could do. (5)

> It's hard if you're at a level and then you have a new preceptor, and they kind of start doing everything again. You're like, "Wait, I want to do that. I'm learning." But it's understandable. They don't know you. And comfortability of just knowing how to ask questions and communicate their style of teaching. (4)

> So, each day, I would show up for the day that I was assigned thinking that I would be with that nurse, and, then, I would be paired with somebody else. And so, this carried on for, like, the first six weeks every single day, I was given a new nurse. There wasn't two or three nurses that I had consistently. So—Because, I counted it, and it was, like, you know, 18 or 19 different nurses. So, that was during the very, like, foundational period where you're learning just the ultra-basics. And, it was little things. Like I saw four different ways to give IV Lasix, and each time I would learn it, then, the next time I would try to give Lasix that way. That nurse would be like, "What are you doing? Don't do it that way. That's ridiculous." And so, when you keep getting shot down while you're trying to develop a routine, trying to develop confidence in yourself and it keeps getting shot down, it just, destroyed any ability and any, like, movement that I had. (3)

Learning styles and personality matches between NLNs and preceptors were significant. Having preceptors that recognized the NLNs disposition so that they were progressing forward without being overwhelmed, held back or micromanaged was instrumental. The key was trusting the NLN and allowing independence while providing support.

> The best analogy that I have is that training under this woman is equivalent to learning how to drive a car for the first time in a Ferrari. (3)

> I think we were just different learning styles, and then on top of that, it was like some of the goals that she had for me, some of them were kind of unrealistic, as far as, like, I just started. Like, you have to give me time. And so, you know, it would be like, "Oh, you know, if you see, this, this, this, this, and this." And I'm like, "Oh, my gosh. It's too much information at once." Like, I can't—because I have to write things down. I keep a notebook in my pocket with all the numbers and stuff that I need, like little tidbits of information that I may forget. So, in the beginning it was just too much information. (2)

> They said they match based us on what they can tell with personality. We filled a little questionnaire of what we were looking for and like our best style of learning. And so, they tried to match us, if I'm more so a direct person or if I'm a hands-on person, if I'm a verbal person. Yeah. I feel like they matched me really well. (4)

> My preceptor was super awesome. And she was very patient with me. She understood my learning style, so it made me very comfortable when I came onto this unit. And I think she made a huge difference in how everything has begun. I'm one of those people who learn by like watching, doing. And sometimes I think it might take me longer, compared to others. And she was very patient with me, always willing to help me and just would always give good tips. And because I felt comfortable with her, it made a difference, like a huge difference. (11)

> At times, it seemed like she was overly critical about things. And then, I'll say I'm like very independent. Once you kind of guide me where I need to go, I want to try to do things on my own, because that's how I learn. I learn better doing things on my own, better than, you know, somebody basically just having me watch them over and over and over again. If I watch it a few times and I get it, let me just try to do it myself and you can kind of just watch me. She wouldn't let me do things on my own. And so, that got frustrating. (2)

Receiving feedback on their progress was on their minds. Although some said that feedback was at times difficult to hear, they felt that it was vital to their progression, and often the preceptors did not provide enough. They also appreciated preceptors who liked to teach and sought out learning experiences for them. Many NLNs were grateful that they maintained a supportive relationship with their preceptor after orientation ended.

> So, once I had been there for a few weeks, she would really more so watch for—like if a situation or a task came up that needed to be addressed, see kind of where my thought process was first or how I would approach it first before she said anything or kind of, you know, exchanged ideas there, and then would give me feedback, most certainly almost every shift, if we weren't there incredibly late. So, it was a really good relationship there, yeah. (8)

> She was very very good about feedback, and it was never, I never felt like I was attacked, or she was thinking I wasn't a good nurse or whatever, it was always very constructive. Very like, okay, now that we have this nailed, we're going to add this layer and now that you have this layer added, we're going to move on to the next thing. She was very good about introducing me to things in a really good and strategic way where I feel like it, I was able to grasp it and so yes, I felt overwhelmed with things, but I never was just like okay, sink or swim here... And then once I was off orientation, I mean I could text my preceptor right now and she would probably text me back if I ever needed anything. Like anything, I still talk through clinical situations with her all the time. (12)

> And my preceptor, in particular, he said to me when—on our last day of buddies, like, "I know I'm not going to be in the same pod as you anymore, but you can always call me. Here's my text. Here's my number. You can text me. If I'm not at work, text me, and I can find someone who's at work, and they can come and help you." Stuff like that. And I know not all of my friends in the residency program have had that experience, but it was something that made me feel there were people there to help me, help me get through my shift. (1)

Unit Support

After orientation ended NLNs still felt the ongoing need to have large amounts of support from experienced nurses, charge nurses, managers/educators and ancillary support. They needed someone to answer their questions, lend a second eye or ear and overall boost their confidence and morale. They feared being caught in unfamiliar situations and it was important for them to know that someone "had their back."

> After my code was over and the patient was stabilized and everything, that was when I just broke down and I needed to take a break. And one of the charge nurses just went, "Come on. We're going for a walk" and took my hand, and she just talked to me about everything. That what was going on in that room at that time, she was like, "Don't even think about it. There are six nurses, five doctors, RTs. You don't need to think about it. Just come for a walk,

and let's just talk about"—she told me about her wedding plans, her holiday—I can't even remember. We just talked, and I just took 10, 15 minutes away. And then, when I went back, the practitioners told me the things I did right. We had to do that debrief. Like "What happened?" But it wasn't a pointed, like, "What did you do?" Then, throughout the day, my preceptor, he came in and found me and pulled me aside and was like, "You did the right things, and I heard that you coped with it really well," and just gave me that confidence. A couple of the other nurses came up to me and they were like, "Do you need a hug right now because I'm here?" That sort of thing, which was something I needed because that day was really tough. (1)

I had this patient and—he was rowdy. He was very rowdy. He misbehaved all the time. And anytime the monitor would beep, and it was a real reason, like a real alarm, somebody would be there. I would look out my door, and I would see them already there. And I didn't have to call for anybody. I didn't have to do anything. They just showed up, because they were watching me the entire time. There's such a comfort in knowing like, okay, no matter what assignment—I can get an assignment from this impossible place in hell. It doesn't matter, but I know that I have like, I'm so supported by my charge nurse, and my rapid nurse, and whoever is resourcing, and whoever is my neighbor, and whoever—whatever. (15)

... I won't say all—most of the senior nurses are really, really good about checking in with us younger nurses and just making sure everyone's okay. We've had a lot of new nurses that have had some really, really big emotional struggles with this job and the acuity and the stress. And everyone just kind of bands together and says, "Okay, we'll get through today. What can we do for you? How can we help? Or maybe if you just need a break for a moment, let us do that task." Yeah, I work with some really, really good people. That's kind of been the saving grace of this last year. (8)

It's all the experienced nurses that are helping you and that you have just such positive support. Because I think if you have support, it goes so much further. You feel so much more confident. You feel like you can take care of all these patients, because everyone's going to need help at some point. (10)

I feel a little stressed, overwhelmed. But then I feel comfortable asking others for help here. I feel comfortable asking my charge nurse here. And, on this unit specifically, a lot of the nurses will walk by, ask if you're doing okay. So I know I'm never alone and I'm not drowning. (11)

Support from Peers

The NLNs all seemed to value sharing the transitional experience with each other. The phrase they repeated was that it was nice to know "they weren't alone" and that others were living their same experiences.

> We started as four new grads together, so we would always discuss things. And like if someone learned something from their preceptor, we would share it with each other because we're all at the same level. So, you know, if you have concerns or something, you feel more comfortable sharing it with your peers versus your superiors. (11)

> I have a couple of friends from nursing school. I call them all the time and we all talk about our different floors and everything and I think it's just good that even though they don't work in the same unit, they still understand just everyday stresses of like, oh man, my patient was so challenging yesterday or whatever, they still understand that, so yeah, support system I think is key. That has been like a huge stress relief just being able to vent sometimes. (12)

> I went to Reddit and like looked up their nursing forums, and it was right—like it was right when all the new grads are like getting off orientation stuff and being like, "I'm so nervous. I cry every day before I go to work. Like I throw up and stuff." And be like, "Okay, other people are dealing with this." Because I was the only one in my unit who was new, so I didn't have anyone to be like, "Hey, are you also like going crazy?" (7)

Support from Nurse Residency Program (NRP)

There were mixed feelings about the NRP. Some of the NLNs appreciated the classes while others felt that they did not need the extra time taken away from their unit. The NLNs in specialty areas felt that the general education often did not apply to them. The support group portion of the monthly seminars offered some the opportunity to share and vent while others felt that they received emotional support from other arenas.

> I actually liked that towards the end it was more like a debriefing and people could—felt like they could express, like, things that had happened and their concerns about their unit, like, patient, like, scenarios that had, like, affected them. And so, it was interesting to see all the different units and have like a safe space to talk about that. I really liked it. I think it was helpful. And it's like if you think sometimes maybe you're learning slowly, and when you're like around all these experienced people, you can get, like, kind of like—like, "Man, I wish I knew all of this right now." And it's, like, bums you out. But then hearing all the other people and coming together who are like on the same level, it's nice because you realize, like, you're not alone. Everyone's going through the exact same thing, you know. (6)

> I didn't really talk about it till the very end, about how much the new grad program did help provide support. Just because of the fact that no other way would I have met other new grads in this hospital without that new grad program. So, I mean, my friends are all different ages, but we've all just graduated nursing school. This is our first nursing job. We're all new to a hospital, all new to an area. That's, I mean, otherwise, there is no other way I would have met these people. And so, now I get to know people throughout the hospital because they're all on different floors than I am. And just having that support system is a lot better. (5)

> The residency program that was something I looked for knowing that that would help with the transition. And so, that's been really great. Starting with a group of people, you know, I have a group of peers who are all doing the exact same thing. So, that's been a really great experience. A lot of support in the residency program. (9)

Outcomes

Successful Transition

NLNs that were given supplemental education to fill their knowledge and skills gaps and were provided with proper support were able to successfully transition into practice. These NLNs showed increased confidence and satisfaction in nursing at one year. These NLNs spoke of wanting more difficult assignments, wanting to become clinical coaches, make quality improvement changes and work with nursing students. Several were thinking of transferring to

a unit with a higher level of care to be more challenged. Some wanted to go back to school in order to gain knowledge to be better providers.

> I feel like even things that I've never done before; I've never seen before, I feel confident that I'll be able to do it, yeah. I don't think there's really much that I wouldn't want to try to tackle. (6)
>
> I feel super confident and competent in my skills now because of my super long orientation, and because I've just seen so much. I feel like now, when something scary happens, I feel a lot more calm about it. (13)
>
> You're just like, it's part of your habit, it's part of your routine and even just thinking ahead and thinking okay, I might need to grab this because this could happen, or I need to have this ready in case this happens. And then like a year ago, I would have never been able to come up with that and now that's almost like second nature. It's like learning another language almost and now you're immersed in it and so now you're picking it up. (12)

Unsuccessful Transition

NLNs that did not receive adequate education and support were unsuccessful or had difficult transitions into practice. Although all NLNs noted levels of stress, anxiety and forms of self-acclaimed "PTSD (Post-traumatic stress disorder)" in some it was extreme. They described that their PTSD-like symptoms manifested in them replaying work situations at home, sleep disturbances and counting down and dreading coming to work. Some NLNs described obsessively rechecking all their tasks and reliving events. Those who were the most stressed verbalized that they wanted to leave their unit or leave bedside nursing.

> You know, like I would go home and think about it. I would like try to go on walks and like listen to a podcast and like go out with people. I remember one weekend I went to a wedding with some of my college friends, and the whole time like I was—I had thought that I was going to be able to get away from it. I was like, finally, like I can go like see some old friends and we'll have a good weekend. And

> the whole time, it was just counting down like I have 72 hours until I have to be back at work kind of deal, you know. (7)
>
> But I would go home, and there was just like, even if I didn't talk about that, in the very beginning stages, I would hear things all the time. So, I'd hear like alarms. I still hear alarms sometimes. But I would hear alarms, or like the first big code that I went to, the parents were right behind me, and they were crying in my ear. And so, I kept hearing them. I'd be washing my hands at home or brushing my teeth, and I would just like, hear it over and over again. (15)
>
> I've gotten better about crying. I'm actually very impressed with myself. I used to cry like once a month in college, and then it turned into once a week in work. Probably like two weeks after stopping orientation, yeah. Like as soon as that stress went away, everything got a lot better. And then, I kind of hit an anxiety period about a month and a half ago when I started feeling anxiety about just the verbal abuse by patients and my reactions to it, and just not being as compassionate as I want to be because I just am annoyed with everyone.(5)

Several NLNs were so distressed they required antianxiety medication and others spoke of colleagues who were on medication in order to come to work. They struggled with decisions on whether they should continue working in their present units or if they needed to completely leave bedside nursing.

> I think I was in, like, that classic, like, panic state where you're not even learning anymore. You're just responding. It got so bad that I had to start taking Xanax at home and before coming to work, and I'm an open book. And, I would talk to all the people that I was with, and I came to realize that a lot of the nurses there went through similar things, where they were having to medicate to come to work. Some of them grew out of it. Several of them still needed it, and, then, whenever I would talk to my educators, that's when I learned that, like, 75 percent of ICU nurses have some form of PTSD. I would go home after shifts and still hear screaming while I'm in the shower or laying in bed trying to go to sleep and I would still hear the alarms beeping. And, I still didn't know what the alarm was. Is that my food pump? Is that my, is that the ventilator? I would still hear them going off while I'm trying to go to sleep, and that is very common with a lot of us. (3)
>
> I guess like six months, seven months in, it was the day after Thanksgiving, because I had been with the family and, you know, it

> was all very happy and stuff. Like I felt like I had finally escaped. And then the second like the food and the meal was over and I needed to go to bed to wake up the next day, I cracked. I just like broke down, was crying. My sister was there, and I was like, "I can't do this. I am going to quit my job." Nursing was not the right deal for me, like this is too much. So, we ended up going to an urgent care, and I got some like anti-anxiety, like some buspirone, and I texted my educator. I was like, "I'm not in a good place right now, and I'm not going to be able to come to work today, because I'm having like a mental breakdown right now." (7)
>
> So, I used to be on medication. I stopped it, because I didn't like the side effects. I will say I thought about restarting it, because at some point, a couple of weeks ago actually, I've just been very nauseous. And to the point where I just started randomly having panic attacks. I literally was doing nothing, and I'll just have a panic attack. And honestly, I have no other stressors in my life, I will say. So, it's just like, I definitely think that it has to be work related. I've looked into some non-pharmacological medications, just to see if that would help. It definitely does help. I work out, and that definitely helps with anxiety, but for the most part, I think one other person, or maybe two, I've talked to said, that they wanted to start medication just because starting in the unit was very, very rough. (15)

Discussion

This study provides examples of NLNs and their experiences as they transitioned into the life of a practicing nurse. Many found the expectations of nursing they had developed in nursing school was not synonymous to their actual real-life experience. Discrepancy between preparation and the realities of practice was first identified and named "reality shock" by Kramer (1974) and further studied and labeled "transition shock" by Duchscher (2009). The NLNs in this study experienced these "shocks" throughout their first year of practice. They were overwhelmed by the acuity of their patients, especially those hired into critical care areas where they had very little exposure clinically in nursing school. This disparity of their perceived experience from their nursing school education was displayed in technical skills, roles and responsibilities and critical thinking

and decision making of the professional nurse. These findings were also consistent with other studies (Cantrell & Browne, 2005; Casey, Fink, Krugman, & Propst, 2004; Duchscher, 2009; Zinmeister & Schafer, 2009).

Time management and care coordination was challenging and unexpected because in nursing school they cared for pieces of patients but not the whole patient. Probably the biggest shock for the NLNs was that they had not expected the overwhelming responsibility of the real nurse and they were terrified of making mistakes that could harm a patient or cost them their license (Fink, Krugman, Casey, & Goode, 2008). Fear of making mistakes was especially amplified when they were forced to work short staffed and in compromising situations. Other studies have noted that NLNs were unable to balance unreasonable work demands, short staffing and their concern for patient safety (Fink, et al., 2008; Maddalena, Kearney, & Adams, 2012).

Communication with physicians was noted to be a new skill and more difficult than expected. Having never spoken to physicians in nursing school they did not anticipate the hierarchy and in some cases incivility they experienced. Physician communication and incivility was also noted by Casey et al. (2004) and Medas et al. (2015).

Many NLNs did not realize that patient care was so intense. Emotionally few were prepared to care for mentally ill or addicted patients who verbally abused them (Parker, et al., 2012). They did not expect to witness the criticality and pain observed in their patients. Every NLN in the study shared their first experience with a patient coding or dying. They expressed that they could never

have been ready for the feelings those situations invoked. Mellor and Gregoric (2016) suggest that clinical skills are not an obstacle for NLNs but rather it is the ability to cope with the socioemotional skills that is the culture of nursing.

The nursing lifestyle was often not easily adopted. Even those who had some clinical experience in their specialty noted that caring for complex patients for entire twelve-hour shifts was exhausting. Night shift was draining, even to those who chose the shift because they liked the environment and "night-shift family" it was still acknowledged to be hard on their bodies. Strain was placed on their personal lives by working off-shifts, weekends, holidays and planning their schedules months in advance. Even though they were aware that nurses worked 24/7, the reality was more than they expected. Shiftwork was noted by Casey et al. (2004), Halfer & Graf (2006) and Medas et al. (2015) in their studies also to be an area of dissatisfaction by NLNs.

The NLNs acknowledged that nursing school provided medical/surgical nursing fundamentals and they were not prepared to do more the more advanced skills required for specialties such as critical care, pediatrics, obstetrics and trauma. They relied on the education provided by the NRP. Casey et al. (2004) and Duchscher (2008) also found that they appreciated learning the complex didactic and technical skills of their specialty, but they did not want the education pre-loaded at the beginning of their orientation. Rather they wanted it given to them in pieces, in a timely, incremental manner.

It is not surprising that preceptors played a role in the success of the NLN. In this study NLNs viewed consistent preceptors as critical to their transition from

nursing school to a clinical setting. Findings of having consistent preceptors has been observed in other studies (Casey et al., 2004; Glynn & Silva, 2013; Spiva et al., 2013; Young, Stuenkel, & Bowel-Brinkley, 2008). Several studies have found that NLNs required preceptor support, feedback and to be challenged to progress in their competence (Watkins, Hart, & Mareno, 2016; Clipper & Cherry, 2015). In this study it was found that if these characteristics did not exist the NLN was more stressed and progress was delayed. NLNs that were matched with their preceptor using learning style and personality seemed to be the most satisfied—a finding supported by other researchers (Lalonde & Hall, 2017; Poradzisz, Kostovich, O'Connell, & Lefaiver, 2012).

Support was a consistent theme across this study. All NLNs experienced stress, anxiety and feelings of being overwhelmed. Some to the point of needing medication and wanting to leave their unit or the bedside. Support from peers, preceptors and experienced nurses helped many to cope and become more confident in their ability to provide care.

After orientation ended it was still vital that they had ongoing support from experienced nurses, charge nurses and ancillary providers to assist in their decision making and patient care. Many were still stressed by new experiences and overloaded assignments with too many tasks to handle. Nurse-to-nurse relationships made them feel more capable to fulfill their assignments safely (Zinsmeister & Schafer, 2009). Unlike some studies, these NLNs did not feel a lack of acceptance or respect from experienced nurses (Casey et al., 2004) or feel they could not seek help from busy senior counterparts (Duchscher, 2009).

Peer support and support from support groups within the NRP seminars helped NLNs to realize that "they were not alone." This was a theme also identified by Olson-Sitki, Wendler, and Forbes, (2012). Overall, they took comfort in knowing that they would improve and gain confidence with exposure and time.

Although many NLNs have reported in studies that they experienced horizontal violence or bullying (D'Ambra & Andrews, 2014; Parker et al. 2014; Rush, et al., 2014) none of the NLNs in this study mentioned it as an issue. Although some NLNs stated that they specifically knew nurses not to question or initiate help from, none of them stated that they had been singled out or picked on.

The NLNs in this study were all finishing their first year of practice. They all felt more confident in their capabilities and were proud of their accomplishments. Their perception was that they were resilient and successful. Other studies have also shown that it took at least twelve months for NLNs to feel comfortable and confident to practice in an acute care setting (Casey et al., 2004; Missen et al., 2014) and to achieve integration into the professional nurse role (Kramer, Brewer, & Maguire, 2014).

Implications for Practice

It has been well established that NRPs guide transition into practice and studies have shown that they increase competency, job satisfaction and retention (Chappell & Richards, 2015; Letourneau & Fater, 2015; Edwards, Hawker,

Carrier, & Rees, 2015; Rosenfeld, Glassman, & Capobianco, 2015; Van Camp & Chappy, 2017). They provide additional advanced education and ongoing support and have become the accepted norm for NLNs. However, NRPs are not enough. Duchscher (2008) noted that "the limited scope of knowledge about the professional role transition in undergraduate nursing theory may be contributing to students' unfamiliarity with and lack of preparedness for what awaits them after graduation" (p.1110). NLNs are overwhelmed and stressed because they are not prepared mentally, emotionally and physically, for the acuity and complexity of patient care in the acute care setting. More exposure to the role of the nurse, especially with critical patients, needs to occur in nursing school. When hospitals hire NLNs into critical care areas they need to be aware that not every NLN has the ability and fortitude to thrive without substantial education and emotional support. In fact, some advise that NLNs should not be placed into highly acute clinical areas that require complex decision making until after a year of practice (Phillips, Kenny, Esterman, & Smith, 2013). However, this could lead to job dissatisfaction since many NLNs desire specific specialties (Beecroft, et al., 2001), often without complete understanding of that clinical area, and hospitals have positions available in those areas that they are eager to fill. Academia and hospitals need to collaborate and think about ways to expose student nurses to more real-life situations so that NLNs are not so overwhelmed when they start caring for real patients, especially those who choose to practice in critical care areas.

NLNs are still leaving their first place of employment at around a year either to change units, specialties or to leave the bedside (Windey et al., 2015 and Halfer, Graf, & Sullivan, 2008). Many saw themselves going back to school after a few years of practice, some to get more knowledge in order to advance but some as a means to leave the bedside. The NLNs stated it was because of the physical intensity of nursing, emotional drain, shift work and strain on their personal lives. If these new nurses only stay at the bedside for a few years and older nurses continue to retire, the nursing profession will still be experiencing a deficit.

Implications for Research

NLNs have been studied as they transition into practice and their association with NRPs. However, further research needs to be done with these NLNs as they complete their second year of practice. Duchscher's Stages of Transition Theory (2008) ends at 12 months. What happens to these NLNs as they continue to practice? As part of the NRP agreement, many hospitals place NLNs under contract for two years so they can't be mobile. It would be interesting to see at the two-year mark if NLNs stay in their current employment or if they change units, specialties or hospitals. Additional qualitative research should be done to see how they feel about their practice, the nursing profession in general and what motivates them to stay at the bedside.

It has been observed that resiliency is a trait of a successful nurse (Concilio, Lockhart, Oermann, Kronk, & Schreiber, 2019). Studies should be

done to gauge resiliency in nursing students and NLNs to see if it is a predicting factor in their success as they transition and in their future as a nurse.

Finally, many NLNs enter practice with nursing as their second degree. These NLNs who have had previous careers provide a different perspective to the work force and their perceptions of the professional nurse. They are a demographic that should be studied further to see if their experience differs from those who enter nursing as their first employment.

Conclusion

Considering the current nursing shortage and need for fiscal responsibility, as well as an obligation to the nursing profession, we owe it to our nursing novices to empathetically guide them into the profession. The transition into nursing practice is hard and becoming a competent and confident nurse takes a village. This research supports the need for strong academic preparation, an NRP, but also time and support from experienced nurses to be willing to nurture new nurses as they are faced with situations unlike any they had ever experienced. Successful nurses are resilient and all these NLNs showed that with help and guidance they could succeed.

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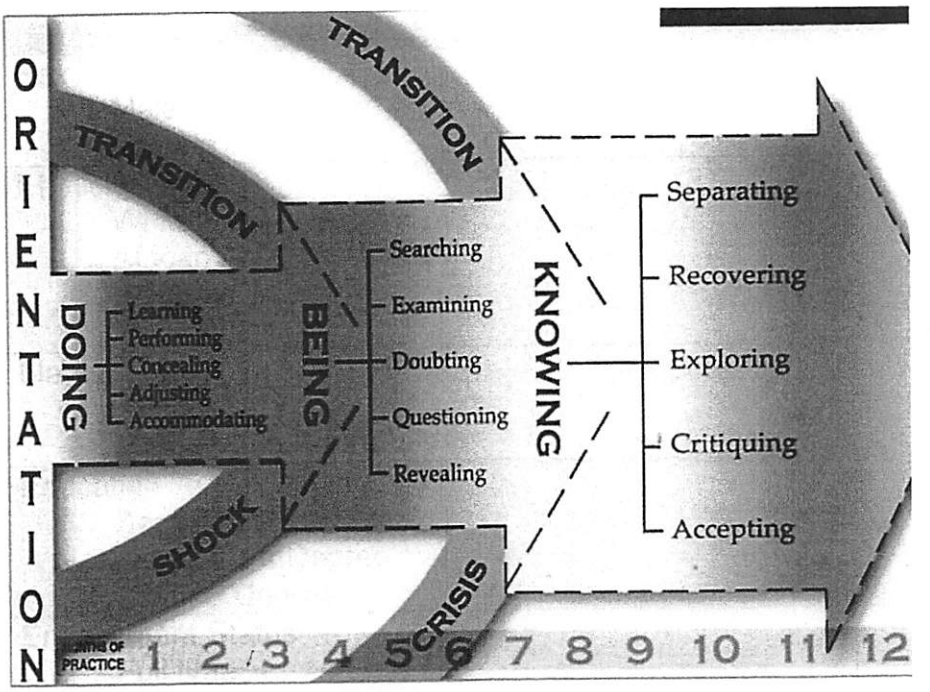

Figure 1. Conceptual Framework: The Stages of Transition Theory by Duchscher (2008)

Characteristics	n	%
Sex		
Male	2	13
Female	13	87
Ethnicity		
White	11	73
African American/Black	1	7
Hispanic	2	13
Asian	1	7
Marital Status		
Single	12	80
Married/Life Partner	3	20
Education		
Baccalaureate	14	93
Associate's Degree	1	7
Second Degree	5	33
Employment Status		
Full time	15	100
Specialty Area		
Adult Medical/Surgical	1	7
Adult Cardiac ICU	1	7
Adult Cardiac IMU	1	7
Emergency Room	1	7
Neonatal Intensive Care	3	20
Pediatric Intensive Care	2	13
Pediatric IMU	2	13
Labor and Delivery	1	7
High Risk Antepartum	1	7
Postpartum	2	13
Previous Health Care Experience		
Worked in a healthcare environment but not healthcare worker	4	26
Worked as a Nurse's Aide (CNA, PCA, etc.)	3	20
Volunteered in a healthcare environment	1	7
Only Clinical Experience in Nursing School	7	47
Mean age in years	25.7	
Mean months practice	12.4	

Figure 2. Demographics (N=15)

Grand Tour Question: Tell me about your transition into nursing practice.
Mini tour 1. What have you heard about the experience of a new graduate nurse? Probe: What was the experience like for you? Probe: How was your work environment?
Mini tour 2. What aspects did you most enjoy? What aspects did you least enjoy?
Mini tour 3. Tell me about your work life balance? Probe: Were you able to leave work on time?
Mini tour 4. How did you feel about your coworkers? Probe: Was there anyone in particular who made you feel supported?
Mini tour 5. How much feedback did you receive? Probe: Did your preceptor, educator, managers tell you how you were progressing?
Mini tour 6. Do you feel that your nursing school adequately prepared you for practicing in the Hospital? Probe: Were your clinical experiences beneficial?
Mini tour 7. How do you feel that being in a NRP transitioned you into practice? Probe: What parts were the most beneficial? Least beneficial?
Mini tour 8. Since graduation, have you ever considered leaving the nursing profession? Probe: Have you heard of someone who has quit the program? Probe: Have you considered another specialty?
Mini tour 9. How do you feel about yourself as a professional nurse?
Mini tour 10. Where do you see yourself in the next couple of years? Probe: What are your plans for the future?

Figure 3. Interview Guide

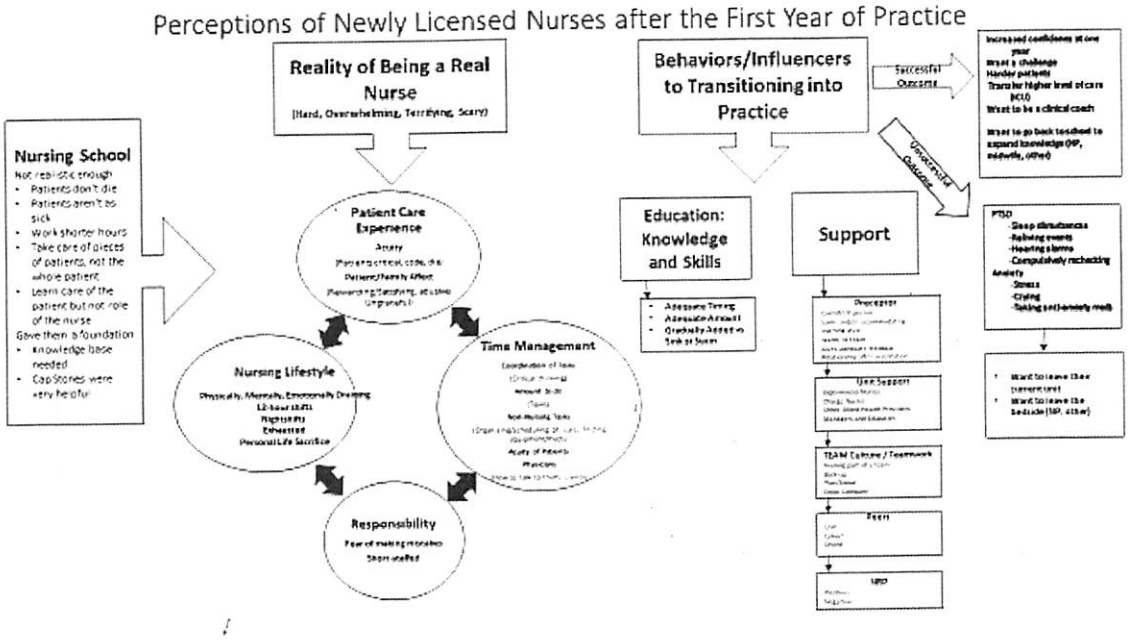

Figure 4. Final Coding Schema

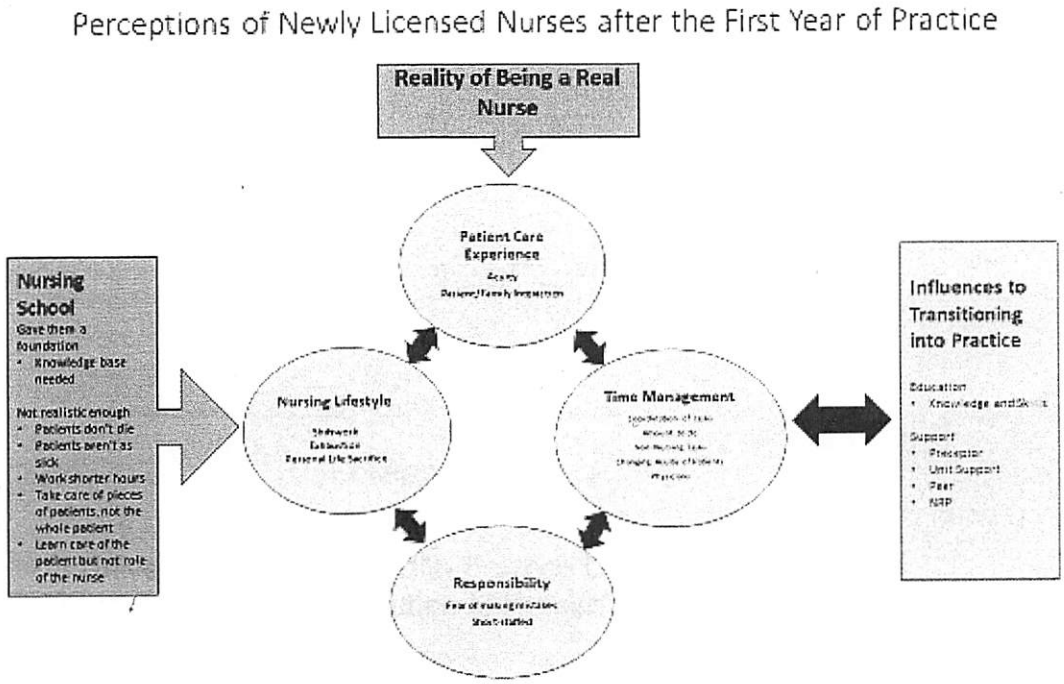

Figure 5. Perceptions of Newly Licensed Nurses after the First Year of Practice Model

Appendix A

University of Texas Health Science Center at Houston
Committee for the Protection of Human Subjects Approval

UTHealth
The University of Texas
Health Science Center at Houston

Committee for the Protection of Human Subjects

Susan Lesser
UT-H - MS - Dept of Pediatric Surgery

NOTICE OF APPROVAL TO BEGIN RESEARCH **January 16, 2019**

HSC-SN-18-1041 - Perceptions of Newly Licensed Nurses One Year after Practice

Number of Subjects Approved: Target: 30 /Screen: 30

PROVISIONS: This approval relates to the research to be conducted under the above referenced title and/or to any associated materials considered by the Committee for the Protection of Human Subjects, e.g. study documents, informed consent, etc.

APPROVED: By Expedited Review and Approval

REVIEW DATE: 12/06/2019

APPROVAL DATE: 01/16/2019

CHAIRPERSON: L. Maximilian Buja, MD L. Maximilian Buja

Subject to any provisions noted above, you may now begin this research.

PLEASE NOTE: Due to revisions to the common rule that went into effect July 19, 2018, this study that was approved under expedited approval no longer needs to submit for continuing review. Changes to the study, adverse events, protocol deviations, personnel changes, and all other types of reporting must still be submitted to CPHS for review and approval. When this study is complete, the PI must submit a study closure report to CPHS.

CHANGES: The principal investigator (PI) must receive approval from the CPHS before initiating any changes, including those required by the sponsor, which would affect human subjects, e.g. changes in methods or procedures, numbers or kinds of human subjects, or revisions to the informed consent document or procedures. The addition of co-investigators must also receive approval from the CPHS. **ALL PROTOCOL REVISIONS MUST BE SUBMITTED TO THE SPONSOR OF THE RESEARCH.**

INFORMED CONSENT DETERMINATION:

Signed Informed Consent Required

INFORMED CONSENT: When Informed consent is required, it must be obtained by the PI or designee(s), using the format and procedures approved by the CPHS. The PI is responsible to instruct the designee in the methods approved by the CPHS for the consent process. The individual obtaining informed consent must also sign the consent document. Please note that only copies of the stamped approved informed consent form can be used when obtaining consent.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA):

Exempt from HIPAA

UNANTICIPATED RISK OR HARM, OR ADVERSE DRUG REACTIONS: The PI will immediately inform the CPHS of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects, and of any adverse drug reactions.

RECORDS: The PI will maintain adequate records, including signed consent and HIPAA documents if required, in a manner that ensures subject confidentiality.

Appendix B

Memorial Hermann Health System Approval

MEMORIAL HERMANN
Clinical Innovation & Research Institute

January 17, 2019

MEMORIAL HERMANN HEALTH SYSTEM APPROVAL FOR MEMORIAL HERMANN – TEXAS MEDICAL CENTER

Thank you for choosing Memorial Hermann as your service provider for this research study.

IRB ID: HSC-SN-18-1041 **PRINCIPAL INVESTIGATOR: Susan Lesser, PhD(c), MSN, RN-BC**

STUDY TITLE: Perceptions of Newly Licensed Nurses One Year after Practice

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Approval is hereby granted by Memorial Hermann Health System to initiate this research study at the Memorial Hermann – Texas Medical Center location. This approval is subject to the Principal Investigator's acceptance of the following stipulations:

STUDY-SPECIFIC STIPULATIONS:

Data Security and HIPAA:

1. All data security computer devices used in this study must be password protected and/or data encrypted.

2. The Principal Investigator will please note to use a separate linking log to connect study data to the identifiable subject information. The linking log should be stored and secured in a separate location form the data collection tool.

Other Stipulations:

3. Please remember to acknowledge the Memorial Hermann Health System in any publications resulting from this study, and provide a copy of the publication to the Director of Clinical Research Operations for Memorial Hermann Clinical Innovation & Research Institute (Sheila.Ryan@memorialhermann.org). The methods of acknowledgement may include:
    a. Memorial Hermann – Texas Medical Center as an author's affiliation;
    b. mention in an "acknowledgement" section; or
    c. as a footnote.

Please sign and return a copy of this letter to the Memorial Hermann Clinical Innovation & Research Institute, c/o Memorial Hermann Hospital, scanned .pdf file to Eleonora.Balibalita@MemorialHermann.org to indicate your acceptance of our terms and policies (guidelines attached).

This study may not be initiated until the letter is signed and returned to the Memorial Hermann Clinical Innovation & Research Institute.

If you have questions or need additional information, please contact the Memorial Hermann Clinical Innovation & Research Institute at (713) 704-3430.

APPRQVED:

Sheila L. Ryan — 01/17/2019

Sheila Ryan, JD, MPH, CCRP — Date
Director, Clinical Research Operations
Clinical Innovation and Research Institute
Memorial Hermann Health System

ACCEPTANCE:

Susan Lesser — 1/24/19

Susan Lesser, PhD(c), MSN, RN-BC — Date
Principal Investigator

Appendix C

Participant Informed Consent Form

UTHealth Cizik
The University of Texas School of Nursing

INFORMED CONSENT TO JOIN A RESEARCH STUDY

Perceptions of Newly Licensed Nurses in the First Two Years of Practice:
Expectations and Reality
HSC-SN-18-1041

INVITATION TO TAKE PART

You are invited to take part in a research project called, Perceptions of Newly Licensed Nurses in the First Two Years of Practice: Expectations and Reality, conducted by Susan Lesser, PhD(c), RN-BC of The University of Texas Health Science Center School of Nursing at Houston. For this research project, Susan Lesser will be called the Principal Investigator or PI.

Your decision to take part is voluntary. You may refuse to take part or choose to stop from taking part, at any time. A decision not to take part or to stop being a part of the research project will not change the any part of your future practice at Memorial Hermann TMC, or Children's Memorial Hermann Hospital.

You may refuse to answer any questions asked or written on any forms. This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of The University of Texas Health Science Center at Houston as HSC-SN-18-1041

PURPOSE

The purpose of this research study is to better understand the perceptions of newly licensed nurses in the first two years of practice about their expectations and the actual reality of working as a nurse. The knowledge gained from this study is expected to have an impact in how we prepare and support new nurses through the continuum of entering the nursing profession. Research will contribute to how newly licensed nurses believe they can best be transitioned into practice.

The study will enroll up to 30 newly licensed nurses who have participated in a NRP at Memorial Hermann TMC, or Children's Memorial Herman Hospital.

PROCEDURES

What to expect as a participant in this study:

- If you decide to take part in the study you will be asked to attend 1 interview appointment. The interview will be done in person in a private room within the healthcare facility or on the phone (using FaceTime if available and acceptable). The time of the interview will be scheduled at your convenience.

- The interview will discuss your experience of being a newly licensed nurse having completed the NRP and practicing as a nurse. Your thoughts about the things that affected your transition into practice will help with future newly licensed nurses. I will have some questions prepared to help guide us through the interview. As a newly licensed nurse, telling me your thoughts, I might come across an important question that was not asked when you were interviewed or need to clarify something you told me. If this happens, I would like your permission to contact you over the phone at a later time.

  ____ Yes, you may contact me again if needed about this study.
  ____ No, I prefer that you not contact me again about this study.

- An audio recording of the interview will be made from the information you tell me. Your name or identity will not be associated with the recording. A written copy of the audio recording will be made to help me review and analyze the responses. I will not be use the recoding for any other reason. It will be destroyed at the end of the study.

I will generate a report of the combined information shared by you and the other participants from NRP cohorts. I will not use any names.

TIME COMMITMENT

The total amount of time you will take part in this research study is about an hour and half.

BENEFITS

You may find sharing your experiences helpful. Your help in the study may benefit future new nurses.

RISKS AND/OR DISCOMFORTS

Some people may find talking about their experience of being a newly licensed nurse in the NRP emotionally stressful. You are free to skip any question or stop the interview at any time. There is always the risks associated with possible breach of confidentiality.

ALTERNATIVES

As has been stated, this study is completely voluntary so you can choose to not to take part in this study. 83

STUDY WITHDRAWAL

Your decision to take part is voluntary. You may decide to stop taking part in the study at any time. A decision not to take part or to stop being a part of the research project will not change any aspect of your employment. If you choose to withdraw from the study at any time during the interview, I will stop the recording and will ask you if you want me to erase the recording. I will comply with your wishes.

CONFIDENTIALITY

I will keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people may become aware of your participation in this study. For example, federal government regulatory agencies, and the Committee for the Protection of Human Subjects (CPHS) of The University of Texas Health Science Center (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you. To help protect your confidentiality, the audio recording and all study related documents will be de-identified. All study related material will be stored in locked offices. Electronic information will be stored on firewall protected UT servers utilizing passwords and data encryption. If I write a report or article about this study or share the study data set with others, I will do so in such a way that you cannot be directly identified.

NEW INFORMATION

Once this study is complete, I will publish the results and will provide you a copy of the article via the mail. If you do not want me to mail you anything, please inform me below,

_____ I prefer that you do not send me anything about this study.

QUESTIONS

If you have questions at any time about this research study, please feel free to contact Susan Lesser, PhD(c), MSN, RN-BC, the Principle Investigator at 713-500-7481. I will be glad to answer your questions, discuss any problems, listen to your concerns, and provide you with information about the research.

SIGNATURES

Sign below only if you understand the information given to you about the research and choose to take part. Make sure that any questions have been answered and that you understand the study. If you have any questions or concerns about your rights as a research subject, call the Committee for the Protection of Human Subjects at (713) 500-7943. You may also call the Committee if you wish to discuss problems, concerns, and questions; obtain information about the research; and offer input about current or past participation in a research study. If you decide to take part in this research study, a copy of this signed consent form will be given to you.

_____

Printed Name of Subject or Legally Authorized Representative

_____ _____ _____

Signature of Subject or Legally Authorized Representative Date Time

_____

Printed Name of Person Obtaining Informed Consent

_____ _____ _____

Signature of Person Obtaining Informed Consent Date Time

CPHS STATEMENT: This study (HSC-SN-18-1041) has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston. For any questions about research subject's rights, or to report a research-related injury, call the CPHS at (713) 500-7943.

Appendix D

Interview Guide

Grand Tour Question: Tell me about your transition into nursing practice.
Mini tour 1. What have you heard about the experience of a new graduate nurse? Probe: What was the experience like for you? Probe: How was your work environment?
Mini tour 2. What aspects did you most enjoy? What aspects did you least enjoy?
Mini tour 3. Tell me about your work life balance? Probe: Were you able to leave work on time?
Mini tour 4. How did you feel about your coworkers? Probe: Was there anyone in particular who made you feel supported?
Mini tour 5. How much feedback did you receive? Probe: Did your preceptor, educator, managers tell you how you were progressing?
Mini tour 6. Do you feel that your nursing school adequately prepared you for practicing in the Hospital? Probe: Were your clinical experiences beneficial?
Mini tour 7. How do you feel that being in a NRP transitioned you into practice? Probe: What parts were the most beneficial? Least beneficial?
Mini tour 8. Since graduation, have you ever considered leaving the nursing profession? Probe: Have you heard of someone who has quit the program? Probe: Have you considered another specialty?
Mini tour 9. How do you feel about yourself as a professional nurse?
Mini tour 10. Where do you see yourself in the next couple of years? Probe: What are your plans for the future?

Appendix E

Demographic Data Collection Form

Demographic Survey
(Please complete each question with one answer)

UTHealth The University of Texas Health Science Center at Houston Cizik School of Nursing

1. When did you pass NCLEX? _____

2. How long have you been a nurse?_____

3. What is your age?
   - ☐ 18 - 24 years old
   - ☐ 25 – 34 years old
   - ☐ 35 – 44 years old
   - ☐ 45 – 54 years old
   - ☐ Over 55

4. How would you describe yourself?
   - ☐ Hispanic, Latino or of Spanish origin
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White

5. Gender
   - ☐ Male
   - ☐ Female

6. What is your marital status?
   - ☐ Single (never married)
   - ☐ Married, or in a domestic partnership
   - ☐ Widowed
   - ☐ Divorced
   - ☐ Separated

7. What is the highest level of school you have completed?
   - ☐ Associate Degree School attended: _____
   - ☐ Bachelor's Degree School attended: _____

8. Experience in health care?
   - ☐ Worked as a Nurse's Aide (CNA, PCA, etc.)
   - ☐ Clinical experience in nursing school
   - ☐ Worked in a healthcare environment but not as a healthcare worker
   - ☐ Worked as a MA
   - ☐ Other_____

Area of Specialty Perioperative

☐ Emergency Room	☐ NICU	☐ Perioperative
☐ Medical/Surgical	☐ Labor & Delivery	
☐ Mother/Baby	☐ Critical Care	☐ Other_____

Appendix F

Qualitative Codebook

Code (7/19/19)	Definition
Acuity / Critical patients	any reference to intense patient load or very sick patients
Anxiety / medication	any reference to feeling anxious before or during work, might refer to need to take medication to deal with anxiety
Challenge	referring to after they have full confidence and are ready to accept more challenging or critical patients/higher acuity, more complicated
Changing shifts shift to night shift	when nurses switch from working day
Clinical Coach Class	taking the class that enables them to guide/mentor nursing students or new employees
Clinical hours nursing school	reference to hours at the bedside in
Communication with physicians	opportunities to share information with physicians, either feeling confident and respected or insecure
Confidence	feeling or believing they can rely on themselves. Having faith in themselves
Debriefing	reviewing and examining actions that occurred after an event transpires. Usually designed to help participants reach consensus and understanding.
Detached	Feeling unengaged and disassociated with a person or situation
Documentation	Reference to recording or reviewing patient events in the eMR
Ethics	moral principles that govern or impact how a nurse feels about a patient situation or caring for a patient

Exhaustion Mental fatigued or weary	references made to feeling mentally
Exhaustion Physical	references made to feeling physically fatigued or tired/drained
Feedback	Comments either positive or negative provided to the nurse about a performance or behavior
Frustration	references to feeling upset or annoyed because of the inability to perform or achieve something i.e. non-nursing tasks
Hard	references made to something being difficult or requiring excessive effort to perform or unpleasant to deal with
Implement Change	referring to the desire to make a change on the unit that would benefit other nurses or patients from insight they have gained or observed
Juicy quote	statement that describes a concept or experience clearly, can be double coded with the concept it describes
Knowledge seeking	references made to not understanding and/or requesting clarification or more information to broaden comprehension
Lack of support	references to situations where they were not emotionally provided with reassurance, encouragement or having the "persons back"
Managers/Leadership authority	referring to nurse leaders in positions of
Mentor	references made to an experience nurse who would provide counsel, advising and coaching to nurses newer in the profession
Mistake(s)	references made to an action, omission or error made in patient care

Nurse Practitioner	Advanced practice nurses, at a master's level of education, who treat medical conditions in patients without the direct supervision of a physician
Nursing school	referring to past experiences in nursing school where they received education and training to prepare for NCLEX
Overwhelmed	referring to the word overwhelmed and implying not able to keep up with tasks that need to be accomplished
Pain in Patients	references made to dealing with patient's pain or coping with witnessing patient's pain
Past experience	referring to experience gained in a healthcare setting prior to becoming a registered nurse
Patient's Coding/ Dying	references made to a situation where a patient required resuscitation and/or died
Personal life sacrifice	descriptions of how working as a nurse is having a negative impact on personal life
Positive Experience	references or positive descriptors related to actions/words/attributes of patients/families
Preceptor consistency/inconsistency	references made to having or not having Preceptor/Clinical Coach regularly assigned with them for the nurse's working shifts during orientation
Preceptor different learning styles	references to when the preceptor doesn't approach a learning situation in the same manner as the new nurse and does not accommodate in a manner that allows the new nurse to learn or accomplish an activity/skill
Preceptor not trusting/micromanaging	references made to the preceptor worrying or not trusting the new nurse to

	do a task independently when the new nurse feels ready/competent
PTSD	references to a condition of persistent mental and emotional stress occurring as the result of being a new nurse. This can also refer to the replaying of events that occurred at work, vivid recall of events, sleep disturbances and not wanting to return to work.
Role familiarity	references made to feeling comfortable, at ease or familiar with what constitutes a nurse or how nurses should perform their jobs
Rude/Difficult patients/family	references to patients/family that act rude, obnoxious to the nurse i.e. yell at them, say inappropriate things, don't do as they are asked, don't appreciate care they receive
Satisfaction	references to the nurse feeling fulfilled or deriving a sense of achievement from being a nurse
Scared/ terrified	descriptions of being scared, fearful, afraid, feelings of panic e.g. of making a mistake or harming a patient
Second degree	referring to those nurses who have returned to school after receiving a prior degree to pursue a nursing career
Self-Awareness/ Burn-out	references made to knowing when they are feeling over taxed by work or exhausted from overwork
Self-motivated	referring to actively seeking out learning situations in order to personally advance or improve
Shiftwork	References made to having to work 12 hour shifts of work, night shift, day shift, week-ends
Short staffed	comments about when there is not enough nursing staff to safely care for

	the amount or acuity level of the patients assigned to them
Specialty	references made to the particular branch or specific type of patient population/unit where the nurse is working
Stress personal life	comments about stain or tension in the nurse's personal life as a result of working as a nurse
Stress work occurring on the job	comments about strain or tension
Support Experienced Nurse	references made by the new nurse to feeling assisted, comforted, reinforced by nurses who are experienced or seen as nursing veterans and/or charge nurses
Support NRP	references made by the new nurse to feeling assisted, comforted, reinforced by attending the NRP seminars or interacting with nurse educators
Support Peer	references made by the new nurse to feeling assisted, comforted, reinforced by another new nurse
Support Preceptor	references made by the new nurse to feeling assisted, comforted, reinforced by the preceptor/clinical coach assigned to orient them to their job
Support Unit	references made by the new nurse to feeling assisted, comforted, reinforced by the all people working in the unit, including PCAs and physicians i.e. Positive unit culture.
Teamwork	use of the word teamwork to describe the health care professionals on the unit working efficiently and effectively together
Time Management	the ability or lack of ability of the new nurse to efficiently and effectively

	perform tasks needed to complete patient care in the required time
Volunteer work	comments made about volunteer work in the healthcare profession prior to employment as a new nurse
Wanting to quit	references made to feeling discouraged and overwhelmed, resulting in the desire to want to leave their current job or the nursing profession
Why nursing?	Statements made about why they chose nursing as a profession
Work/life balance	references made to how the nurse is able to accommodate their new job/profession into their personal life.

CURRICULUM VITAE

Susan Roehler Lesser, PhD, MSN, RN-BC

EDUCATION:

University of Texas Health Science Center Nursing Houston, TX	2019	PhD
University of Hartford Nursing Hartford, CT	2006	MSN
University of Colorado Health Science Center Nursing Denver, CO	1982	BSN

PROFESSIONAL POSITIONS:

Quality Improvement Specialist present UTHSC-H McGovern School of Medicine Houston, TX	2017 –
Education Manager Memorial Hermann Pearland and Southeast Hospitals Houston, TX	2016 – 2017
Education Specialist III Memorial Hermann System Education Houston, TX	2015 – 2016
Education Specialist III / Pediatric Quality and Safety Children's Memorial Hermann Hospital Houston, TX	2012 – 2015
Clinical Training & Development Specialist Texas Children's Hospital Houston, TX	2011 – 2012
Professional Development Director Cooley Dickinson Hospital Northampton, MA	2010 – 2010

Professional Development Manager — 2007 – 2010
Cooley Dickinson Hospital
Northampton, MA

Patient/Family/Community Educator and Nurse Educator — 1998 – 2007
Cooley Dickinson Hospital
Northampton, MA

Staff Nurse — 1994 – 1998
Childbirth Center
Cooley Dickinson Hospital
Northampton, MA

Perinatal / GYN / Pediatric Homehealth Nurse — 1996 – 1998
Kaiser Permanente / CHP of Massachusetts
Amherst, MA

Staff Nurse — 1993 – 1994
NICU
Memorial Hermann Southwest
Houston, TX

Staff Nurse — 1989 – 1993
Women's Services
Fort Bend Hospital
Sugar Land, TX

Staff Nurse — 1988 – 1990
NICU
St. Joseph's Hospital
Houston, TX

Advanced Clinical Nurse — 1983 – 1988
NICU
Rainbow Babies & Children's Hospital
Cleveland, OH

Childbirth Educator — 1984 – 1988
Euclid General Hospital
Euclid, OH

Staff Nurse — 1982 – 1983
NICU
St. Joseph's Hospital
Denver, CO

PROFESSIONAL MEMBERSHIPS & COMMITTEES

American Nurses in Professional Development (ANPD)	1998 – present
Texas Gulf Coast Nurses in Staff Development Organization	2011 – present
Sigma Theta Tau International Honor Society of Nursing	2006 – present
American Women's Health, Obstetrics and Neonatal Nursing	2014 – present

CERTIFICATIONS:

Graduate of University of Texas Clinical Safety and Effectiveness Course	2014
ANCC Board Certified in Nursing Professional Development	2002 – present
AHA BLS Instructor	2008 – 2014
ACLS Provider	2011 – 2013
Lamaze Certified Childbirth Educator	1986 – 2009
CPI Instructor	2006 – 2011

PUBLICATIONS:

Lesser, S. R., & Wooten, S. H. (2015), Increasing pertussis and influenza vaccination rates among postpartum women. *Newborn & Infant Nursing Reviews.*

Lesser, S. R. (July/2006). Conquering the diabetes education dilemma consistent lessons for a safe discharge. *Patient Management.*

LECTURE PRESENTATIONS:

February 2013	Horizontal Violence, Perinatal Kaleidoscope Conference, Galveston, TX
October 2010	Teaching to Low Literacy, Nursing Grand Rounds, Cooley Dickinson Hospital, Northampton, MA

POSTER PRESENTATION:

Lesser, S. R., & Wooten, S. H. *Vaccinating One to Protect Two.* Poster presented at Shared Visions Conference, October, 2014, San Antonio, TX.

Lesser, S. R. *Preceptor Rejuvenation.* Poster presented at ANPD Annual Conference, July, 2009, Philadelphia, PA. (Awarded third place)

Lesser, S. R. *Teach on Peach: Promoting Interdisciplinary Patient Education in the Acute Care Setting.* Poster presented at ANPD Annual Conference, July, 2004, San Diego, CA.

AWARDS AND RECOGNITION:

Sigma Theta Tau Induction	2006
Recipient of MNA Advanced Education Scholarship	2005
Recipient of the Dartmouth Hitchcock Nursing Scholarship	2005
Awarded "Program Volunteer of the Year" by the American Heart Assoc.	2002
Awarded "Local Hero" by the American Lung Association	2002
Recognition by the AHA for Exceptional Community Programs	2000