2021

Lived Experiences of Newly Graduated Registered Nurses

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This is to certify that the doctoral dissertation by

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Abstract

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MSN, Walden University, 2012

BS, Rio Grande University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing-Interdisciplinary Health

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Abstract

Attrition rates for first year newly graduated registered nurses (NGRNs) are between 30% to 60%; high level of attrition negatively affects hospital organizations, other nurses, and patient outcomes. Transitioning from student nurse to clinical nurse poses challenges for NGRNs which includes assuming responsibilities for a full patient load, communicating with physicians, and adjusting to shift work. The purpose of this phenomenological study, guided by Kramer's reality shock theory and Duffy's quality caring model, was to examine the lived experiences of a first-year cohort of NGRNs working in the acute care setting of a Florida hospital. Thirteen NGRNs were interviewed using open-ended, semistructured interviews about their transitional experiences and their perceptions of the caring behaviors exhibited by nursing leadership and other nursing staff. Emerging themes from the data verified by Raven's Eye software included transitioning from student nurse to the role of clinical nurse, caring behaviors experienced, applying previous knowledge to clinical practice, and cultural differences and transitioning. Both caring behaviors and incivility were reported among all participants. Furthermore, experiencing caring behaviors from others during this transition was a crucial element for job satisfaction. The results from this study may be useful for nursing educators, nursing leadership, and healthcare organizations who wish to focus on the retention of NGRNs to increase positive patient outcomes which will, in turn, effect positive social change. Future studies related to tailored orientation programs for the NGRN could prove beneficial for the organization, the learning institution, the patient, and the NGRN.

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Dedication

I dedicate this paper to my parents who taught me to never give up, and that any job worth doing, is worth doing well. They instilled in me the importance of following through on commitments to myself and others. I am forever grateful for these life lessons.

Acknowledgments

I acknowledge God, who gave me the courage and strength to complete this dissertation. Dr. Leslie Hussey and her unending support, patience, and thoughtful guidance. Dr. Kathleen Brewer my content expert, who supported and guided me through my data analysis. I am grateful to my Husband Randy, who has been my biggest cheerleader. He never stopped believing and supporting me during this journey. To my friend Robert, who was instrumental in keeping me focused on my dissertation, when I did not want to be focused. I am grateful for the love and patience of my children, Lyndsay, Lauren, Clay, and Lexie. I am blessed beyond belief, by friends and family that supported me with love, understanding, and patience, during this journey.

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Chapter 1: Introduction to the Study

Currently, a need for 1.2 million new nurses is estimated (Geriatric Nursing, 2018). The 10 states with the top nursing shortage include California, Florida, New York, Ohio, Pennsylvania, Illinois, Texas, New Jersey, Michigan, and Massachusetts. Each year newly registered nurses' transition from nursing school to the acute care setting of the hospital. Transitioning nurses enter nursing practice with varying ages, genders, as well as previous educational, work, and life experiences (Casey et al., 2011; Kovner et al., 2007).

In the state of Florida, 6,023 registered nurses separated from their employer during 2014-2015.Those separations included all full time and part time nurses. Agency, temporary, or per-diem nurses were not included in this number (Florida Center for Nursing, 2016). Successful transitioning of newly graduated registered nurses requires active participation from nursing programs, nursing managers, and hospital administrators (Kumaran & Carney, 2014; McCalla-Graham & De Gagne, 2015).

Implementing strategies which contribute to the retention of nurses beyond their first year of practice (Allen et al., 2009; O'Reilly & Pfeffer, 2000; St-Martin et al., 2015) may serve to address cognitive, emotional, and behavioral challenges known to impede professional role attainment of newly graduated registered nurses (NGRNs). Focusing on the lived experiences contributing to nursing retention (Henderson & Eaton, 2013; Henderson et al., 2015; Kosmoski & Calkin, 1986; McCalla-Graham & De Gagne, 2015; Price et al., 1986) combined with Kramer's reality shock theory (1974) and Duffy's (2009) quality caring model, was the focus of this study. The lived experiences of

NGRNs during their first year of working as a new nurse was examined. This study fills the gap in the literature by describing what perceptions NGRNs had regarding the level of quality caring they experienced during their transition to clinical staff nurse.

This chapter contains a description of the background of the study and the relevant factors associated with the transitioning of NGRNs into practice. Included are statistical data regarding attrition among NGRNs supporting this study and the significance of the problem which prompted this study. Research has not included NGRNs' perceptions of experiencing quality caring during their transition to staff nurse. This gap in the literature prompted an inquiry into the study of NGRNs and their quality of caring experiences (Duffy, 2009).

Background of the Problem

National and international concern exists regarding the attrition rate for NGRNs. According to the Nursing Solutions Incorporated report (2016), there was an 8.8% to 37.0% turnover rate for bedside registered nurses. The reported turnover rate for the first-year registered nurses was 29.2%. An average of 91% of hospitals reported they did not closely monitor the costs for nursing turnover. The report further estimated that the cost of replacing a direct care nurse ranges from $37,700.00 to $58,400.00 per nurse. The average hospital would lose approximately $6.6 million per year. This same turnover can cost a hospital $5.2 million to $8.1 million a year. Each percent change in registered nurse turnover will cost the average hospital an additional $373,200.00 (Nursing Solutions, 2016). Internationally, similar patterns were evident in hospital settings of Canada (Young, 2009), Norway (Wangensteen et al., 2008), Ireland (O'Shea & Kelly,

2007), Japan (Takase et al., 2008), Kuwait (Al-Enezi et al., 2009), and Pakistan (Khowaja et al., 2005).

Makary and Daniel listed hospital errors as the third leading cause of death (2016). Many hospital errors are directly attributed to inadequate nurse staffing and poorly trained nurses (Agency for Healthcare Research Quality, 2017). Inadequate staffing levels are a common issue faced by hospitals, forced to make cutbacks due to decreased reimbursements from the Centers for Medicare and Medicaid Services (CMS, 2016). Hospitals are experiencing a reduction in reimbursements based on a reported increase in patient injuries and infection rates (Rau, 2014). Patient injuries and infections are directly correlated to nursing services provided within these hospitals (Agency for Healthcare Research Quality, 2017).

Although hospitals continue to try to recruit a talented nursing workforce, many NGRNs continue to leave their employer within the first 1 to 2 years following graduation from nursing school programs (Kumaran & Carney, 2014). It is postulated this attrition is due in part to reality shock (Kramer, 1974). Reality shock is a phenomenon experienced by nursing graduates as they transition from nursing school to work in the acute care setting such as a hospital. During this transition, new nurses begin to realize that nursing education did not adequately prepare them for the reality of working as a new nurse.

Casey et al. (2011) indicated that a new nurse needs a minimum of 1 year to develop confidence within their nursing role. Current research related to NGRNs' attrition addresses readiness for nursing practice (Casey et al., 2011; Hickerson et al., 2016;

Theisen & Sandau, 2013), bullying and incivility (Ibrahim & Qalawa, 2016; Johnson & Rea, 2009; Luparell, 2011; McNamara, 2012; Smith et al., 2016), unclear role expectations (Duchscher, 2008; Pennbrant et al., 2013), inadequate skill sets (St-Martin et al., 2015), poorly designed orientations (Henderson & Eaton, 2013; Henderson et al., 2015), and a lack of support from nursing leadership (Spence, Laschinger et al., 2012; Pan et al., 2015). Despite nursing shortages being a global phenomenon, research is limited as to whether a working environment which promotes caring behaviors directed towards NGRNs could decrease attrition rates among these same NGRNs (Dyess et al., 2010; Khademian & Vizeshfar, 2008; Purnell, 2009). Due to limited research on the impact caring behaviors have on NGRN retention, the timeliness and importance of this study is clear.

Problem Statement

Registered nurses coordinate care for groups of patients and are responsible for delegating appropriate tasks to other licensed and unlicensed personnel (American Nurses Association, 2021). Due to their scope of practice, registered nurses are needed to legally provide ongoing patient assessments, care for critically ill patients, administer intravenous and oral medications, and manage laboring patients (American Nurses Association, 2021). There is a direct correlation between medical errors and decreased registered nurse staffing ratios (Godshall & Riehl, 2018). Medication errors cost over $30 billion yearly (Watson, 2016) and result in 7,000 deaths annually (Walsh, 2015).

NGRNs are leaving their employment with the hospital or the profession within the first year following graduation at high rates (Pellico et al., 2010). Attrition rates for

first year NGRNs are between 30% to 60% (Smith, 2008). This increased attrition impacts hospital organizations, other nurses, and ultimately patient outcomes (Aiken et al., 2002). The hospital work environment influences job commitment, job satisfaction, and the intention to stay (Brewer et al., 2011; Dingley & Yoder, 2013). Incivility displayed by other nurses towards NGRNs is a significant factor contributing to attrition (D'Ambra & Andrews, 2014).

Reviewing the literature related to attrition rates among nurses revealed extensive research studies have been conducted nationally (Beecroft et al., 2008; Kemeny et al., 2012; MacKusick & Minick, 2010; Pellico et al., 2010; Robert Wood Johnson Foundation, 2014). International studies have been completed suggesting similar findings as those of the national studies (Al-Enezi et al., 2009; Brewer et al., 2011; Khowaja et al., 2005; O'Shea & Kelly, 2007; Takase et al., 2008; Wangensteen et al., 2008). The results of these studies demonstrate that nursing attrition is a global problem requiring an immediate solution. Despite nursing shortages being a global phenomenon, research was limited as to what lived experiences contribute to NGRNs' retention (Blevins, 2018; McCalla-Graham & De Gagne, 2015; Martin & Wilson, 2011; Parker et al., 2014; Phillips et al., 2013; Tapping et al., 2013; Zinsmeister & Schafer, 2009). Many NGRNs leave the organization and their profession with the first year following graduation (Kovner et al., 2016). Hospitals and nursing leadership could decrease nursing attrition rates by being cognizant of the perceptions of NGRNs and their lived experiences contributing to first year turnover (Kutney-Lee et al., 2013). Implementing relationship

centered care practices such as those found within the quality caring model (Duffy, 2009) could improve retention rates for first year nurses.

The quality caring model (QCM©; Duffy, 2009) is a mid-range, progressive theory originally developed for measuring the relationship between the quality caring of nurses and patient outcomes. The QCM© requires caring relationships be the center of practice for the hospital, leadership, and the nurse's practice (Duffy, 2009). Duffy (2013) expanded the QCM© to include "caring for self, patients, families, each other and communities" (p. vii). Research conducted by Duffy (2009, 2013) demonstrated the act of engaging in caring relationships with others produces positive outcomes. Applying the QCM© to clinical practice and leadership (Duffy, 2009) and within health care systems (Duffy, 2013), has demonstrated a decrease in the attrition rates for registered nurses.

Research completed by Duffy (2013) did not include NGRNs within their first year of practice, however. There was a lack of knowledge about NGRNs experiencing quality caring behaviors from hospital personnel. Duffy (2013) suggested using the QCM© could improve outcomes for patients' families and others by focusing on individual centered care. When individuals experienced the caring behaviors of attentive reassurance, human respect, mutual problem solving, and affiliation needs, both recovery times improved, and complication risks decreased. Employees who report feeling valued are more productive and utilize less sick time benefits.

A lack of knowledge about the lived experiences of caring behaviors experienced by NGRNs from other professional registered nurses and healthcare professionals in their work environment is the problem. This study was unique in that it explored the lived

experiences of NGRNs, and their perceptions and experiences of caring behaviors demonstrated by preceptors, other nurses, and administration. These observations may either encourage the NGRN to remain in the acute care setting or leave the acute care setting. Nursing administrators and CEOs who have the authority to make changes will be provided study results to support any necessary changes.

Purpose of the Study

The purpose of this phenomenological study was to examine the lived experiences of a first-year cohort of Florida NGRNs working in the acute care setting of the hospital, and their perceptions of the caring behaviors exhibited by nursing leadership and other nursing staff during their first year of transition. The definition of NGRN is a newly graduated registered nurse employed in their first position within the hospital. Caring behaviors include providing attentive reassurance, demonstrating human respect, exhibiting an encouraging manner, and participating in mutual problem solving. A gap in the literature existed for exploring the perceptions of NGRNs and their experiences of receiving caring behaviors. Through study, I sought to understand the experiences of NGRNs and their experiences of receiving caring behaviors as they transition to the acute care setting of the hospital.

Research Questions

The primary research questions for this phenomenological study were:

Research Question 1 (RQ1): What are the lived experiences of a first-year cohort of Florida NGRNs' working in the acute care setting of the hospital?

Research Question 2 (RQ2): What are the perceptions and experiences of NGRNs' working in a Florida Hospital related to experiencing caring behaviors?

Theoretical Framework

A theoretical framework provides a connection between the research problem and the research question(s; Smyth, 2004). Working with a theoretical framework provides boundaries for the researcher (Smyth, 2004). This study used a constructivist approach by developing a professional rapport with the participants and engaging each participant in a private, semistructured interview regarding their lived experiences as an NGRN. The frameworks of reality shock (Kramer, 1974), and the QCM© (Duffy, 2009, 2013) were used to examine the lived experiences of NGRNs.

Reality Shock

Reality shock (Kramer, 1974) is a phenomenon experienced by nursing graduates as they transition from nursing school to working in the acute care setting such as a hospital and during it realize their nursing education did not adequately prepare them for the reality of working as a new nurse. Transitional phases of reality shock (Kramer, 1974) include the honeymoon phase, shock phase, recovery phase, and the resolution phase. The first stage is known as the honeymoon phase. In this phase, the new nurse is excited to be graduated from nursing school and feels euphoric to be gainfully employed. This period is considerably stressful as the new nurse must make many adjustments within an orientation period that typically averages 3 months (Kramer, 1974).Within these 3 months, new nurses must acclimate to a clinical environment in which they are expected

to use a limited skill set to effectively communicate with physicians, patients, ancillary departments, and other nurses, appropriately respond to emergent situations, and adjust to various shift rotations, while balancing home and personal obligations. Phase 2 is considered the shock phase (Kramer, 1974). Intense stress and conflict describe the shock phase resulting when an individual perceives that their educational preparation is lacking, and they are not adequately prepared for their nursing role. (Kramer, 1974). The individual contemplates leaving their employment during this phase. Phase 3 is the recovery phase. In this phase, the nurse begins to examine their work situation objectively and their stress level decreases (Kramer, 1974). Phase 4 is the resolution phase. Within the resolution phase, the nurse either accepts or rejects their new role due to the overwhelming stress experienced by (Kramer, 1974). Phases 1 and 4 are the most stressful phases. It is within these two phases that the nurse contemplates making a change, dealing with overwhelming stress responses.

Quality Caring Model

Duffy's QCM© (2009, 2013) is a mid-range, progressive theory which places human interaction or relationships at the heart of nursing and all nursing interactions. According to Duffy and Hoskins (2003), the primary purposes of the QCM© are to: guide professional nursing practice, reaffirm and expose the hidden work of nursing, describe the conceptual-theoretical-empirical linkages between quality of care and human caring, and propose a research agenda will provide evidence of the value of nursing. Duffy's research (2009, 2013) demonstrated that when individuals feel cared for, goals become more achievable and positive outcomes are more likely to occur. To accomplish

these outcomes, relationship centered caring places the specific needs of the individual as the primary goal. The NGRNs' perceptions of receiving caring behaviors from their nursing leadership and other nursing staff provided insight into the effectiveness of using the QCM© as a tool for decreasing nursing attrition rates among NGRNs'. An investigation of the literature in Chapter 2 further describes attrition and quality caring, as it relates to this study.

Nature of the Study

This study is qualitative using Husserl's phenomenological approach (Patton, 2015). This research method is designed to foster an understanding of the lived experiences of participants who have experienced a phenomenon (Creswell, 2009). A phenomenological study is appropriate for developing a deeper understanding of experienced phenomenon of a small number of participants (Creswell, 2009). Examining the lived experiences of NGRNs in their first year of practice within the hospital may assist with determining primary factors of NGRN attrition (MacKusick & Minick, 2010).

This study examined the lived experiences of NGRNs in their first year of practice in Florida Hospitals. Inquiries as to the caring behaviors experienced by NGRNs from nursing leadership, the hospital, and other nurses whom they work with, were conducted through semistructured, open-ended interview questions. A qualitative phenomenological design incorporating open-ended, semistructured interview questions, allows for the participant to expand upon the question if they feel the researcher can ensure privacy and confidentiality (Creswell, 2005; Neuman, 2006). Participant interviews were recorded.

Recording interviews decreases researcher bias which can occur when the researcher transcribes interviews during the interview session (Creswell, 2009). Each tape-recorded interview was transcribed and provided to the participant for an accuracy review, further decreasing researcher bias. It was necessary to compare the themes of each participant within the study and individually to determine hidden themes (Neuman, 2006). Examining the lived experiences provided the researcher with information regarding theories and themes to be expanded upon in future studies and provided a comparison with previous studies.

Definitions

Operational definitions define the constructs of an intended study (Patton, 2015). The following definitions are intended for this study:

Associate Degree Nursing Program Education: A 2-year nursing program which provides essential skills and knowledge necessary to pass the NCLEX (National Council of State Boards of Nursing, 2017).

Associate Degree Registered Nurse (RN): Someone who has completed a 2-year course of study from a nursing school and demonstrated that they were able to pass the minimum proficiency standards set forth within the National Council Licensing Examination (NCLEX; National Council of State Boards of Nursing, 2017).

Bullying: The act of exhibiting behaviors that are intended to cause distress in the recipient (McNamara, 2012).

Caring Behaviors: The act of providing attentive reassurance, human respect, displaying an encouraging manner, and participating in mutual problem solving (Duffy, 2013).

Hospital Acute Care Setting: A hospital acute care setting is a clinical environment which provides staff to diagnose, treat and provide care for individuals requiring acute care services (McCalla-Graham, & De Gagne, 2015). Nurses frequently start their nursing careers in the hospital environment. In this study hospital and acute care setting are used interchangeably.

Hospital Clinical Unit: A specialized medical unit within the hospital that provides care to persons residing within this unit (McCalla-Graham, & De Gagne, 2015).

Incivility: A form of rude and discourteous actions, of gossiping and spreading rumors, and of refusing to assist a coworker. Actions may include name-calling, using a condescending tone, and expressing public criticism (Andersson & Pearson, 1999; Laschinger, 2013).

Job Satisfaction: Refers to nurses who are content with employment as a nurse in a specific area of nursing or with a specific employer (Dall'Ora et al., 2015).

Mentor: An expert who assists a novice with developing confidence, skills, for handling situations and emotions (Pasila, et al., 2017.)

Newly Graduated Registered Nurse (NGRN): A newly graduated registered nurse is a newly registered nurse within their first year of practice. This nurse has successfully graduated from a nursing program and passed the NCLEX (National Council of State Boards of Nursing, 2017).

Nursing Attrition: Refers to the turnover of nurses (Currie et al., 2014).

Nursing Leadership: An individual working within the healthcare setting who manages, leads, and encourages the fulfillment of the healthcare organization's mission and vision (Sfantou, et al., 2017)

Nursing Orientation: A nursing orientation is an introduction of the nurse to the expectations of the organization. This introduction involves providing information related to human resources, policies, procedures, and other information required by state entities (Parker et al., 2014; UC Davis Health, 2017).

Nursing Retention: Refers to those nurses who have remained employed (Fontaine, 2014).

Nursing Shortage: Refers to the existing nursing deficit in the United States. (Buchan et al., 2015).

Preceptor: The responsibility of the preceptor is to guide the new, inexperienced nurse regarding unit procedures. A preceptor assists with the orientation of the new nurse by orienting them to policies, and the social milieu of the unit (Ingwerson, 2014; Richards & Bowles, 2012; Smith, 2015).

Perception of caring behavior: Receiving attentive reassurance, human respect, an encouraging manner and participating in mutual problem solving with a mentor or other professional (Duffy, 2013).

Readiness for Practice: A state of having appropriate skill acquisition to complete the tasks associated with the role of a registered nurse (Wolff et al., 2010).

Transitioning to Practice: The movement from student to clinical nursing practice as an RN (Schoessler & Waldo, 2006).

Assumptions

The primary assumption of this study was that NGRNs desire a smooth transition into practice and want to be valued and not experience incivility. I assumed that the participants would openly and honestly share their transition experiences in the host environment, during the data collection process. I assumed participants would answer the interview questions based on their understanding and knowledge of the terms presented. I assumed participants would desire to review their transcribed interviews for accuracy.

Scope and Delimitations of Qualitative Research

I explored the transition experiences of NGRNs during their first year, as they began working in the hospital environment. I recruited 13 NGRN study participants using a convenience sample of available participants. Only Associate Degree Registered Nurses who have recently graduated (less than 1 years' experience), were asked to participate in this study. I did not recruit RNs with more than 1 year experience because nurses who have been working for more than 1 year have experienced all stages of culture shock according to Kramer (1974).

A phenomenological approach was chosen for this study to examine experiences from more than one participant. Neither a case study nor a narrative study would provide the comparison of experiences among research participants which was the intention of this study. Kramer's reality shock theory (1974) combined with Duffy's QCM© (2013) was a better choice than Benner's novice to expert theory (1984) and Bandura's social

cognitive theory (1986). Transitional phases (Kramer, 1974) and personal experiences aligned more closely with Duffy's QCM© (2013) in determining if the experience of feeling cared for during a professional transition positively impacted an NGRN's intent to remain beyond the first year of practice.

Limitations

A phenomenological study is designed to allow for an understanding of the phenomenon through information that is reported by the participants (Creswell, 2013). Researcher bias poses potential limitations. Selecting a small group of NGRNs who were working in their first year of nursing within rural hospitals was the major limitation of this study because it narrows the research findings to a specific type of hospital and the culture of those hospitals. Working directly with participants through interviewing created a relationship. Each relationship has the potential to change the direction of a study based on potential researcher bias (Creswell, 2013). It was my responsibility to allow participant responses to stand on their own merit and not to assign meaning to these experiences.

Significance

Conducting a study on the attrition rate of NGRNs in the hospital setting was significant because of the U.S. nursing shortage. A global problem without a solution, the U.S. nursing shortage has far-reaching consequences for all citizens and their families across the lifespan, from infants to the elderly. These consequences include increased patient injuries, post-operative complications, and mortality rates. Increased medical errors result in increased financial costs to the patient and the hospital. Increased nurse

burnout, absenteeism, and work-related stress further impact nursing attrition rates (Boamah & Laschinger, 2016; Enns et al., 2015; Guadine et al., 2013; Kovner et al., 2014; Unruh & Zhang, 2013).

Negative outcomes decrease hospital reimbursement rates and profit margins (Herbert, 2012). Retention of NGRNs is a crucial step in addressing the current nursing shortage presented from a population of aging nurses (Pellico et al., 2010) and the increasing health disparities observed among an aging population (Gandhi et al., 2017). Contributions of this study include the identification of needed practice changes that support the transitioning NGRN related to nursing education and clinical nursing. Some of the participants related an absence of experiencing caring behaviors from other coworkers. This information can be utilized to modify existing orientation programs and perceptions of future NGRNs. Other information provided by the participants regarding their lived experiences was provided to develop programs addressing first-year attrition rates among NGRNs.

Significance of the Study for Nursing Leadership

Authentic leadership consisting of transparency, openness, and trustworthiness, promotes employee engagement and increases job satisfaction (Carsten et al., 2008). Nursing leadership plays a significant role in creating healthy working environments for NGRNs (Germain & Cummings, 2010). Unhealthy working environments contribute to depression, anxiety, and other physical disorders experienced by nurses (Peterson et al., 2008). A study conducted by the Canadian Nurses Association (2006) revealed nurses'

rate of illness-related absenteeism was 58% higher than the overall labor workforce (7.9% vs. 5.0%).

Nurses who leave their job within the first year may leave the hospital or the profession (Henderson et al., 2015; Martin & Wilson, 2011). Those nurses who remain in the nursing profession frequently change to different units within the hospital, change to another hospital setting, pursue employment in ambulatory care, and/or return to school for more education (Clipper & Cherry, 2015). Implications for social change include addressing a global social problem of nursing attrition among first-year registered nurses. Decreasing nursing attrition rates among this population could preserve a labor force that already exists, having a direct effect on global nursing shortages. Efforts to improve the nursing shortage impact the health of patients and communities, while at the same time decreasing the existing stress levels among working nurses employed within hospitals.

Summary

Attrition rates among NGRNs is a global phenomenon (Al-Enezi et al., 2009; Brewer et al., 2011; Khowaja et al., 2005; Robert Wood Johnson Foundation, 2014). Nursing shortages affect the health of patients and communities (Benner, 1984; Kutney-Lee et al., 2013; Smith & Crawford, 2003). Incorporating the QCM© into orientation programs and the hospital culture serve to retain an existing workforce of NGRNs. The purpose of this study was to examine the lived experiences of NGRNs during their first year of working in a hospital setting. Part of this examination included the NGRNs' perception of experiencing caring behaviors by nursing leadership, hospital administration, and other hospital staff members. The implications for social change

included identifying methods for addressing the global nursing shortage, retaining NGRNs beyond their first year, and improving outcomes for patients, communities, individuals, and organizations are topics of discussion in Chapter 2.

Chapter 2: Literature Review

Nursing care may be provided to patients by either a Licensed Practical Nurse (LPN), a Registered Nurse (RN), an Advanced Registered Nurse Practitioner (ARNP), or a combination of these three (American Nurses Association, 2021). The scope of practice for these nurses varies depending on their education level, degree, and licensure. RNs coordinate the care for groups of patients, and delegate appropriate tasks to LPNs and unlicensed personnel (Nursing Assistants; American Nurses Association, 2021). This study will focus on the Associate Degree RN.

An RN's scope of practice dictates they be responsible for coordinating care among groups of patients and delegating tasks to LPNs and unlicensed personnel (nursing assistants and unit secretaries). Additional responsibilities of the RN include providing ongoing patient assessments, caring for critically ill patients, administering intravenous medications, caring for trauma patients, and managing laboring patients (American Nurses Association, 2021). Recruitment, development, and the retention of RNs is necessary to staff hospital units and provide competent patient care is prevalent within the literature. Health Resources and Service Administration (Biviano et al., 2002) forecasted a massive shortage of RNs within the United States by 2020 if changes did not occur. This prediction has come to fruition. According to the Bureau of Labor Statistics (2017), the existing RN shortage, combined with the regular turnover rates of NGRNs serves as a reminder that a shortage of RNs persists (Kovner et al., 2016).

Research indicates that NGRNs are leaving their nursing employment with the hospital and the profession within the first year following graduation (Pellico et al.,

2010). Attrition rates for NGRNs is between 30% - 60% (Smith, 2008). This increased attrition effects hospital organizations, other nurses, and ultimately patient outcomes (Aiken et al., 2002). The research indicates that the nature of the working environment influences employee commitment, job satisfaction, and the intention to stay (Brewer et al., 2011; Dingley & Yoder, 2013). Attitudes of hospital personnel towards NGRNs is a significant factor contributing to attrition (Flateau-Lux & Gravel, 2014). Recruiting RNs to the workforce has not been as problematic over this past decade (National Council State Boards of Nursing, n.d.). What is problematic are the issues which focus on the development and retention of RNs within the workplace (Budden, Moulton, Harper, Brunell & Smiley, 2016; Goodare, 2015; Unruh, & Zhang, 2013). Multi-level transitional influences such as work attitudes/values, prior work experiences, social skills, job readiness, and educational preparation are suggested by Dwyer and Revell (2016) as reasons for nursing attrition among new NGRNs.

Nursing shortages continue to be presented in the literature as a global issue requiring an immediate solution (Al-Enezi et al., 2009; Beecroft et al., 2008; Brewer et al., 2011; Khowaja et al., 2005; MacKusick & Minick, 2010; O'Shea & Kelly, 2007; Pellico et al., 2010; Takase et al., 2008; Robert Wood Johnson Foundation, 2014; Wangensteen et al., 2008). Research is needed as to why NGRNs leave the organization and their profession with the first year following graduation. Most studies examine RN attrition in general and do not differentiate attrition between RNs and NGRNs. Reasons cited for leaving include bullying and incivility (Flateau-Lux & Gravel, 2013; MacKusick & Minick, 2010; McNamara, 2012), unclear role expectations (Bisholt, 2012a; Bisholt,

2012b; Duchscher, 2008; Kumaran & Carney, 2014; Pennbrant et al., 2013; Teoh et al., 2013), inadequate skill sets (Hickerson et al., 2016; Sportsman, 2010; Theisen & Sandau, 2013; Thomas et al., 2011; Wolff et al., 2010), poorly designed orientations (Benner, 1984; Bisholt, 2012a; Henderson & Eaton, 2013; Henderson, et al., 2015; St-Martin et al., 2015), and a lack of support from nursing leadership (Carsten, et al., 2008; Johnson & Rea, 2009; Spence Laschinger et al., 2012).

Nursing attrition rates could be decreased by hospitals and nursing leadership being cognizant of the perceptions of newly graduated registered nurses and their lived experiences contributing to first-year turnover (Kutney-Lee et al., 2013). Implementing relationship-centered care practices, such as those found within the QCM© (Duffy, 2003, 2009, 2013), could improve retention rates for first-year nurses. Applying the QCM© to clinical practice and leadership (Duffy, 2009) and within health care systems (Duffy, 2013) has demonstrated a decrease in the attrition rates for RNs. Research completed by Duffy (2013) did not include NGRNs within their first year of practice, however. There is a lack of knowledge about NGRNs experiencing quality caring behaviors from hospital personnel. Duffy (2013) suggests the QCM© can improve outcomes for patients' families and others. These outcomes include improved health outcomes for patients', education, and peace of mind for families and foster commitment from employees.

Employing and keeping NGRNs in the hospital setting is a crucial step in addressing the nursing shortage. These RNs can revive an aging workforce and decrease the workload of nurses who are stressed out, tired, and overworked (American Association of Colleges of Nursing, 2009; Peterson et al., 2008; Schaufeli & Salanova,

2014). Jones (2008) suggests that developing and maintaining an NGRN is more cost-effective than cycling NGRNs from the local college each year. Cycling a new nurse refers to the process of educating, graduating, testing, onboarding, orienting, and offboarding this same nurse from the organization when they leave their employment.

A change in the current culture of thinking among hospital organizations and nursing leaders needs to transpire. These changes need to include implementing Evidenced Based Practice (EBP) guidelines for implementing change (Fleiszer et al., 2016). Employing and maintaining NGRNs requires a commitment to staff development (St-Martin et al., 2015). The literature demonstrates that organizations who treat their employees as assets are the most successful of organizations (Henderson et al., 2015; O'Reilly & Pfeffer, 2000).

Remaining to be explored is the process of examining what, if any, lived experiences may contribute to the NGRN remaining in the work environment. This study is unique in that it explored the possibilities that experiencing caring behaviors by preceptors, other nurses, and administration, may either encourage the NGRN to remain in the acute care setting or leave the acute care setting. Study outcomes will be made available to administrators and CEOs who have the authority to make changes. Significant sections of this chapter include the literature search strategy, the theoretical framework framing this study, a discussion of the theories and their appropriateness for this study, and a review of the literature related to the study variables.

Literature Search Strategy

Databases chosen for this study provided insight into this topic and assisted with examining current research perspectives. These databases accessed through Walden University library included nursing, general psychology, organizational psychology, healthcare administration, medicine, and education. Accessed library databases include CINAHL with Full Text, ProQuest Nursing & Allied Health Source, Medline with Full Text, and ProQuest Health & Medical Collection. I also used Google Scholar to identify pertinent literature. Other databases included published dissertations as well. Key search terms and combinations were in all databases and included*: nursing shortages, lived experiences of the new nurse, newly registered nurse, graduate nurse, newly registered nurse, transitioning to nursing, readiness for practice, learning gaps, role expectations for new nurses, bullying, incivility, nursing attrition, nursing retention, mentoring, preceptor, orientation, orientation programs, employee satisfaction, engaged employees, caring behaviors, caring for new nurses, caring behaviors experienced by nursing graduates, caring,* and *Quality Caring Model©.* These terms were chosen to describe the NGRN who is within their first year of employment. Other terms provided information related to perceptions of nursing leadership as to an NGRNs readiness for practice and challenges perceived for keeping NGRNs in their role as a staff nurse. Terms included those that described the NGRNs' perceptions of satisfaction with their nursing role and reasons cited for leaving their employer and the nursing profession.

Theoretical Framework

The theoretical frameworks chosen for this study are Kramer's reality shock (1974) and Duffy's QCM© (2003). The final choice for a theoretical framework was decided based on the intent to study the lived experiences of Associate Degree NGRNs as they transitioned from nursing school to their first clinical practice within the acute care hospital setting and their personal experience of caring behaviors.

Reality Shock Theory

Reality shock theory (1974) is the seminal work of Marlene Kramer which she developed from her 1970s research of 400 nurses from across the nation. While attempting to understand what constituted successful transition of nursing students to the acute care working environment of the hospital, specific phases occurred during the socialization of these NGRNs within the first 8 months of their employment. These phases included the (a) honeymoon phase, (b) Shock phase, (c) recovery phase, and the (d) resolution phase (Kramer, 1974).

The first stage of reality shock is known as the honeymoon phase. In this phase, the NGRN is excited to be graduated from nursing school and feels euphoric to be gainfully employed. Kramer (1974) suggests that the NGRN experiences fascination with their new-found employment because they choose the parts of their environment that they find appealing. Friends, colleagues, and the orientation process serve as buffers between situational reality and the NGRN's perception of their actual employment situation. This period is considerably stressful as the new nurse must make many adjustments within an orientation period that typically averages 1 to 3 months, depending on the orientation

program, the orientee, and the organization (Kramer, 1974). Within the length of the orientation program, the NGRN must acclimate to a clinical environment in which they are expected to use a limited skill set to effectively communicate with physicians, patients, ancillary departments, and other nurses. The NGRN is expected to respond to emergent situations appropriately and adjust to various shift rotations, while balancing home and personal obligations (Kramer, 1974).

Phase 2 is considered the shock phase in which the NGRN experiences reality shock and rejection of either the working environment or of the familiarity of their previous nursing education (Kramer, 1974). An NGRN may engage in self-blame and exhibit self-defeatist behaviors while withdrawing into protective isolation and identifying with individuals who share their personal views, characterized by stress, conflict, and the individual's perceptions that their educational preparation did not prepare them adequately for their nursing role (Kramer, 1974). During the shock phase, the NGRN experiences conflicting values and processes related to their skill sets and their perception of how things are to be done, based on what they learned in their nursing education program. These same NGRNs often lack interpersonal skills such as the ability to interpret interpersonal cues and the ability to respond to these cues appropriately. Conflict resolution skills may be maladaptive. The shock phase is a period of intense stress, typically lasting about 3 months. During this phase, the NGRN often regresses, while engaging in vocal criticism, hostility, aggression, moral outrage, and excessive fatigue. Retreating to their bed is frequently reported as the dominant mechanism for the NGRN. Seasoned nurses report that NGRNs are unable to proficiently manage their

assigned patient load for the first 6 months (Kramer, 1974). It is during this phase that the individual contemplates leaving their nursing position. According to Kramer (1974), the shock phase occurs following the honeymoon phase but varies with each individual.

Phase 3 is the recovery phase. In this phase, the NGRN begins to examine their work situation objectively and their stress level decreases (Kramer, 1974). The length of this phase also varies depending on the individual and averages 1 to 2 months (Kramer, 1974). During this phase, the nurse lets go of idealistic nursing school values and accepts the reality of the existing bureaucracy of the nursing unit and the organization (Kramer, 1974).

Phase 4 is the resolution phase. During this phase, the NGRN decides to remain within their employment setting and accept the pros and cons of their current working environment or make the decision to leave their work environment and obtain employment in a work setting which is more aligned with their ideals (Kramer, 1974). Kramer (1974) recommended that additional research is needed in Phases 3 and 4. Research completed by Casey et al. (2011) indicated that a new nurse needs a minimum of 1 year to develop confidence within their nursing role. In contrast, a study completed 10 years later, by Kovner et al. (2014), suggested that an estimated 17.5% of NGRNs leave their first nursing job within the first year, and one in three (33.5%) leave within 2 years.

Review of the Literature on Reality Shock Theory

Kramer (1974) suggested that reality shock is the reason that NGRNs leave the nursing profession. When an individual's expectations do not match with reality, the

individual would either modify their expectations or continue to search for an environment in which reality did match their working expectations. Kramer continued her research to develop strategies to assist with each transitional stage to divert NGRNs from leaving the acute care environment. Strategies included promoting autonomy (Schmalenberg & Kramer, 2006) and encouraging and developing positive nurse-physician relationships (Schmalenburg & Kramer, 2006).

While Kramer's proposed strategies (1974) which are theoretically sound for identifying anticipatory psychosocial stages expected of the transitioning nursing graduate; they failed to be useful for decreasing nursing attrition among first-year nursing graduates (Kramer, 1974; Schmalenburg & Kramer, 2006). Developing positive nurse-physician relationships has been successful in promoting nursing retention (Laskowski-Jones, 2010). Other interventions demonstrate a positive correlation with nursing retention for the NGRN include adequate orientation periods (Henderson et al., 2015; Henderson & Eaton, 2013), supportive work environments (St-Martin et al., 2015), supportive relationships from nursing leadership and coworkers (Pan et al., 2015), and a sense of belonging by the NGRN (Duchscher, 2008, 2009, 2012).

Benner’s novice to expert theory (1984) was founded upon the initial works of Kramer (1974), who identified that NGRNs' transition through the specific psychosocial development and acquire skill sets which closely correlate with these transitional stages. Benner (1984) also postulated that skill competency is acquired after an extended period of working as a nurse, identifying, and implementing clinical decisions which evolve from maturing confidence and self-efficacy which comes from a mentoring experience.

Duchscher (2009) expanded upon Kramer's original reality shock theory (1974) and completed longitudinal studies of NGRNs. Duchscher's studies (2008, 2009, 2012) all indicated that reality shock experienced during the transitioning period is a constant variable for all nurses whether the new nurse is male, female, or has an advanced education (2012). Duchscher (2008, 2009, 2012) demonstrated that NGRNs did not want autonomy to make independent decisions but required the ongoing assistance of seasoned nurses to validate their critical thinking and decision-making skills (Duchscher, 2009). Duchscher (2008) expanded upon Kramer's reality shock (1974), developing her transition theory. Transition theory is time sensitive in that issues of transition are prescriptive and related to the developmental level of the new staff nurse. Duchscher (2008, 2009, 2012) indicated that: all NGRNs experience transition shock as they graduate and begin working as a new staff nurse within the acute care setting of the hospital. Providing appropriate support during this period of transition can improve retention rates (Duchscher, 2009). Appropriate support begins with preparation from nursing educators and continues with increased orientation times with nursing assignments that gradually increases in complexity as the NGRNs' skill level increases. Supporting NGRNs with caring preceptors, mentors, and seasoned staff nurses also contribute to the retention of NGRNs (Duchscher, 2009, 2012).

The reality shock theory has been used to study role attainment (Duchscher, 2009; Kumaran & Carney, 2014; Sparacino, 2016; Stacey & Hardy, 2011), learning needs of NGRNs (Dyess & Sherman, 2009; Stacey & Hardy, 2011), and nursing attrition (Stacey & Hardy, 2011). Results from these studies showed NGRNs complete a psychosocial

transitional period during their first year as a nurse (Kramer, 1974). Learning needs vary within these transitional stages depending on the level of confidence and self-efficacy experienced by the NGRN (Dyess & Sherman, 2009; Stacey & Hardy, 2011). Reality shock (Kramer, 1974) and transitional theory (Duchscher, 2008, 2009, 2012) identify phases of psychosocial adjustment and socialization experienced by new nurses. Implementing appropriate interventions during these anticipated phases could serve to decrease the attrition rates among NGRNs.

Kramer's reality shock theory (1974) was an appropriate framework for examining NGRNs' lived experiences of transitioning from student to staff nurse. Lived experiences of NGRNs are expected to be varied. Previous psychosocial development of the NGRN is expected to contribute to the intent to remain within the nursing profession and the NGRNs' medical unit. Reality shock theory (Kramer, 1974) addresses the psychological and emotional development of the NGRN during the first year and provided a solid foundation from which to examine the NGRNs' personal experiences of caring behaviors as outlined by the QCM© (Duffy, 2013).

Review of the Literature on Quality Caring Theory

Jean Watson developed the quality care theory (1988), states caring can be conclusively demonstrated and practiced interpersonally only, resulting in the satisfaction of specific human needs. Watson's theory includes seven assumptions of caring and 10 caring factors. The seven assumptions state:

1. Caring can be effectively demonstrated and practiced only interpersonally.

2. Caring consists of carative factors that result in the satisfaction of certain human needs.
3. Effective caring promotes health and individual or family growth.
4. Caring responses accept person not only as he or she is now but as what he or she may become.
5. A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
6. Caring is more “healthogenic” than is curing. A science of caring is complementary to the science of curing.
7. The practice of caring is central to nursing.

The 10 caring factors state:

1. Sustaining humanistic-altruistic values by practicing loving-kindness with self and others.
2. Being authentically present, enabling faith and hope and honoring others.
3. Being sensitive to self and others by cultivating own spiritual practices, beyond ego self to transpersonal self.
4. Developing and sustaining loving, trusting-caring relationships.
5. Allowing for expression of positive and negative feelings — authentically listening to another person's story.

6. Creatively problem-solving through caritas process — full use of self and artistry of caring-healing practices via use of all ways of knowing/being/doing/becoming.
7. Engaging in transpersonal teaching and learning within context of caring relationship.
8. Creating a healing environment at all levels; subtle environment for energetic authentic caring presence.
9. Reverentially assisting with basic needs as sacred acts, touching mind/body/spirit of other; sustaining human dignity.
10. Opening to spiritual, mystery, unknowns- allowing for miracles.

Watson developed her theory of Human Caring in (1988) and continued to expand upon this theory through 2008. Watson's theory focusses on the caring behaviors of the nurse and her ability to be open and present in the moment with the patient.

Caring behaviors are considered the hallmark of a nurse's work (Watson, 1988). Multiple nursing theorists have provided insights regarding the benefits related to the caring aspects of nursing. Theories regarding caring behaviors vary with each nursing theorist, and their respective theories (Benner, 1984; Benner & Wrubel, 1989; Boykin & Schoenhofer, 2001; Duffy, 2003, 2009, 2013; Leininger, 1991; Nightingale, 1860; Ray, 1989; Roach, 1984; Swanson, 1993; Watson, 1988, 2008). Duffy's QCM© was conceptualized from Watson's early works (1988) and expanded upon the relational aspects inherent within human caring (Duffy & Hoskins, 2003; Duffy, 2009, 2013). Both Watson (1988) and Duffy (2003, 2009, 2013) addressed the need for human caring in

nursing and offered somewhat different perspectives of their theories. Watson's focus (2008) is based on implementing caritas for the patient to promote positive patient outcomes. A Carita is considered a caring practice (Watson, 2008). Duffy (2009) suggests the implementation of caring behaviors among the healthcare team has a direct effect on patient outcomes. A healthcare team that experiences caring behaviors among its members will project these behaviors onto their patients (Duffy, 2009). Duffy (2013) revised her model to suggest positive outcomes result when there is a relationship-centered focus.

Duffy's research (2003, 2009, 2013) demonstrated that when individuals feel cared for, goals are more readily attainable dan positive outcomes were more likely to occur. Relationship-centered caring places the specific needs of the individual as the primary goal. When the needs of the individual were met, positive outcomes were observed. Duffy (2009, p. 35) describes the QCM© as a comprehensive framework which encompasses four caring relationships: (a) self, (b) patients and families, (c) each other, and (d) communities. Within this model are 8 caring factors which operationalize this model: (a) attentive reassurance, (b) basic human needs, (c) encouraging manner, (d) mutual problem solving, (e) affiliation needs, (f) healing environment, (g) human respect, and (h) appreciation of unique meanings.

The caring theory has been utilized to study the nurse-patient relationship and the positive outcomes resulting from the demonstration of these behaviors. Benner and Wrubel's primacy of caring theory (1989) suggests caring practices involves client advocacy, which supports client growth and development. Attending behaviors directed

at the client allows the nurse to determine what is essential to the client and to include this information as part of the clinical judgment. Including the aspects of care which are essential to the patient, supports the patient in the recovery process.

Swanson's theory (1993) postulates "Caring is the essence of nursing and is the distinct, central, unifying form of control (p. 352)." Transcultural nursing focuses on both differences and similarities among persons from diverse cultures. Nurses must be culturally competent and provide care reflective of the client's culture. Addressing cultural needs demonstrates a holistic approach of caring for the patient.

Nightingale (1860) theorized caring was demonstrated through the management of the patient's environmental factors. Environmental factors included clean water, pure air, appropriate temperatures, appropriate food, and the observation of these factors on a patient's health. Ensuring these environmental factors were provided for the patient improved the patient's condition. The provision of these environmental influences was a demonstration of caring behaviors by the nurse.

Lartey et al. (2014) conducted a systematic review that identified five categories of interventions which contributed to nursing retention. These five categories all included relationship-centered approaches such as nursing practice models, teamwork approaches, leadership practices, organizational strategies, and personal strategies. Combining an understanding of role transition with the implementation of QCM© behaviors will assist nursing educators, nursing administration, practitioners, seasoned nurses and healthcare organizations to appropriately support and facilitate the growth and retention of the NGRN at a time when a radical change is needed to retain NGRNs. The

QCM© has been incorporated in leadership, education, patient safety, and clinical practice settings, making caring relationships a priority among staff and patients (Duffy, 2013).

A review of the literature reveals studies which have incorporated the science of caring as the framework for exploring nursing retention. Boykin et al. (2013) provided techniques for transforming entire health care systems with the use of caring science, resulting in increased effectiveness, productivity, quality outcomes for patients and increased nursing retention. Van Wijlen (2017) utilized the science of human caring to describe moral distress experienced among NGRNs and how self-care and caring environments combat compassion fatigue and moral distress. Wilson et al. (2015) demonstrated that NGRNs who participated in caring groups during their transitional period reported feeling supported, not alone, and greater job satisfaction including retention. A study conducted by Spiva et al. (2013) found supporting nurses during transition resulted in NGRNs; feeling nurtured, improved communication and time management skills, and increased confidence and professional growth.

Theory Rationale

Four caring factors were chosen from Duffy's QCM© to be used in combination with Kramer's reality shock theory (1974) for this study. These caring factors included (a) attentive reassurance, (b) encouraging manner, (c) mutual problem solving, and (d) affiliation needs. Caring factors from the QCM© were selected for this study as it is a mid-range theory suitable for qualitative research. NGRNs report a continual lack of human caring exhibited by coworkers and leadership in the form of bullying and

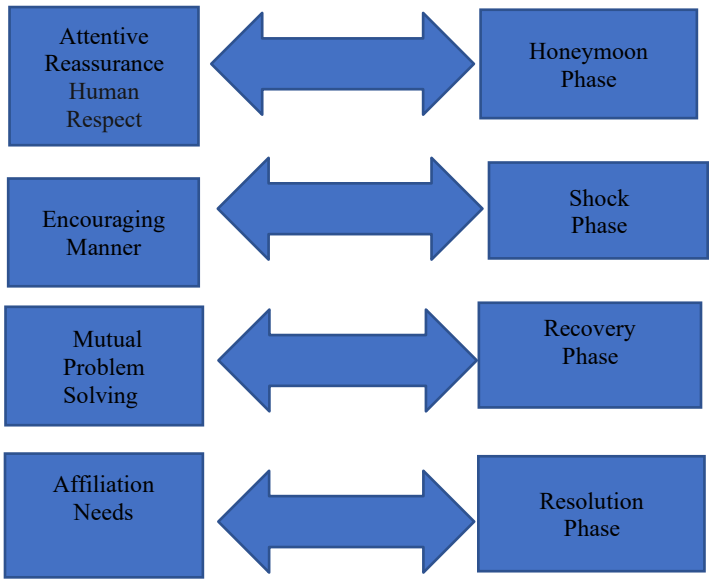
incivility as a main reason for leaving their employment during the first year of practice (Hodgins et al., 2020). Kramer's theory (1976) demonstrates the anticipated psychological development stages of which the NGRN is expected to encounter during their first year of practice. Duffy's QCM© postulates that positive results occur when individuals experience caring, supportive behaviors from coworkers' appropriate to the situation (2013). Examining the lived experiences of transitioning NGRNs by combining Kramer's theory (1976) and Caring Factors 1, 3, 4, 5, and 7 from Duffy's QCM© (2013), provided the research lens for determining if implementing caring behaviors during the NGRNs' first year of transition could improve retention rates for NGRNs.

Appropriate caring behaviors chosen from Duffy's QCM© (2013), combined with the psychological adjustment phases of Kramer's reality shock (1974), are shown in Figure 2. Attentive reassurance (Duffy, 2003) and the honeymoon phase (Kramer, 1974) are interconnected in that within the honeymoon phase the NGRN is in a blissful state excited to be finished with nursing school and working as a nurse. Attentive reassurance by other nurses on the unit would be expected caring behavior exhibited at this time, due to the inexperience of the NGRN. During the shock phase (Kramer, 1974), an encouraging manner (Duffy, 2003) is necessary to support the NGRN as they are experiencing stress, conflict, and the realization that nursing school did not adequately prepare them for all the demands of a nursing career. When NGRNs enter the recovery phase (Kramer, 1974), they begin to objectively examine their career, coming to terms with the reality of the situation. During this phase, mutual problem solving (Duffy, 2003) provided to the NGRN by other team members, would be an appropriate demonstration

of caring. In the final resolution phase (Kramer, 1974) experienced by the NGRN, the decision is made to either remain within their position as a nurse or seek a position which fulfills their employment expectations. Fostering the NGRNs' need for affiliation (belonging) at this time, would be an appropriate caring behavior to be exhibited by the NGRNs' colleagues.

Figure 1

Comparison of Quality Caring Model with Reality Shock



Note. The QCM© relationship to Reality Shock (Chancey, 2018).

Duchscher (2012) reported that 40% of working nurses would not encourage someone to enter the field of nursing as a profession. Despite this, every year, NGRNs enter the workforce eager to make the transition from nursing school to clinical nurse. Often, these nurses begin their new work experience unprepared for what their coworkers' may call, "the real world of nursing" (Pennbrant et al., 2013). Many nursing leaders believe NGRNs begin working unprepared for the role they have chosen

(Vuckovic & Landgren, 2020; Tapping et al., 2013). The term, practice gap, is commonly used to support this observation of nursing leadership (Hickerson et al., 2016; Kumaran & Carney, 2014). Instead of finding the expected, necessary support for transitioning from nursing student to working nurse, NGRNs find they are required to navigate the stressors of the acute care work setting successfully without the assistance of coworkers (Hodgins et al., 2020; Parker et al., 2014; St-Martin et al., 2015). For NGRNs who do remain employed as nurses, they are observed repeating the same bullying and uncivil behaviors, condoning them as "rites of passage" (Hodgins et al., 2020).

Literature Review Related to Key Study Variables

Nursing Shortages

Employing and keeping NGRNs in the hospital setting is a crucial step in addressing the nursing shortage. Newly registered nurses could revive an aging workforce and decrease the workload of nurses who are stressed out, tired, and overworked (American Association of Colleges of Nursing, 2009; Peterson et al., 2008; Schaufeli & Salanova, 2014). Developing and maintaining an NGRN is more cost-effective than cycling NGRNs from Associate Degree Nursing programs yearly (Jones, 2008). Occupational Employment Projections from 2012-2022 provided by the Bureau of Labor Statistics (2017) indicate that with an aging workforce of nurses and citizens, the nursing shortage will continue (Figure 2).

Figure 2

Employment Projections and Replacement Needs

Selected Employment Projections and Replacement needs									
Replacement Needs by Detailed Occupation (Numbers in thousands)			Employment Projections by Detailed Occupation						
			Employment				Change, 2012—22		Job openings due to growth and replacements
			Number		% of U.S. total employment				
2012 National Employment Matrix title and code		2012—22 Replacement needs	2012	2022	2012	2022	Number	%	
Registered nurses	29-1141	**525.7**	**2,711.5**	**3,238.4**	1.9	2.0	**526.8**	19.4	**1,052.6**
Nurse anesthetists	29-1151	6.8	35.2	43.9	0.0	0.0	8.8	24.9	15.6
Nurse midwives	29-1161	1.2	6.0	7.7	0.0	0.0	1.7	28.6	2.9
Nurse practitioners	29-1171	21.4	110.2	147.3	0.1	0.1	37.1	33.7	58.5
RNs and APRNs		**555.1**	2,862.9	3,437.3	2.0	2.1	**574.4**	20.1	**1,129.6**
Nursing instructors and teachers, postsecondary	25-1072	10.2	67.8	91.8	0.0	0.1	24.0	35.4	34.2
Licensed practical and licensed vocational nurses	29-2061	180.3	738.4	921.3	0.5	0.6	182.9	24.8	363.1
Nursing assistants	31-1014	281.4	1,479.8	1,792.0	1.0	1.1	312.2	21.1	593.6

Note. Source: Bureau of Labor Statistics (2017).

Associate Degree Nursing Programs

An Associate Degree Nursing (ADN) Program provides a fundamental foundation of nursing skills and concepts which can be completed within two to three years of coursework. Once course requirements are met, the individual can take a licensure examination to become a registered nurse. Acquiring a Registered Nurse license permits the individual to provide nursing services as a registered nurse. An ADN program provides individuals interested in pursuing a career as a registered nurse education in a condensed format, with an Associate's educational degree (National Council of State Boards of Nursing, 2017). Associate Degree Nursing programs are one suggested solution for addressing the nursing shortage. Other solutions include appropriate

orientation programs (Parker et al., 2014), providing a regular preceptor (Verret & Lin, 2016) and making a mentor available to the NGRN (Chen & Lou, 2014).

Transitioning of the Newly Registered Nurse

It is estimated that by 2022, there will be a need for 3,238.4 million additional nurses to replace those nurses who have retired or left the nursing profession (U.S. Bureau of Labor Statistics, 2013). The process of nurses transitioning from nursing school into nursing practice has been studied extensively over the past four decades. Transitioning from nursing school to working nurse requires professional and personal changes and commitments. New nurses must acclimate to a new work culture, with varying twelve-hour shifts (Teoh et al., 2013). Nursing skill sets learned in nursing school are implemented such as time management changes from completing written assignments to completing healthcare tasks on time, while dealing with varying types of interruptions. Delegating tasks and ensuring other members of the nursing team complete those tasks is now required. Becoming socialized to the culture of the nursing unit becomes a necessary task for professional survival (Teoh et al., 2013).

If others like a new nurse on the nursing unit, the nurse is more likely to fit in and be supported by other senior nursing staff, administrators, patients, families, and physicians. In contrast, nurses who are not well-liked, report a more difficult time with the transitioning process (Zinsmeister & Schafer, 2009). Nurses who feel a sense of connection to their peers and the institution are more likely to remain with their employer (Wu et al., 2012).

Each year, newly registered nurses' (RNs) transition from nursing school to the acute care setting of the hospital. Some of these nurses' transition successfully to their new environment, and some do not. Successful transition from nursing school to the acute care setting is feasible with proper socialization. A gap in the literature existed as to what lived experiences contribute to the retention of those nurses who survive their first year and continue to flourish within the profession. Adequate nurse staffing levels contribute to positive patient outcomes (Agency for Healthcare Research Quality, 2017). Positive patient outcomes may include decreased length of stay decreased infection rates, decreased post-operative complications, decreased medical errors, and a decrease in verbal abuse, and falls (Dyess & Sherman, 2009).

The Hospital as an Organization

Nationwide, hospitals report that they provide orientations designed to familiarize the new nurse with the policies of the organization (Kutney-Lee et al., 2013). Many hospitals believe newly hired graduate nurses should possess the skills to care for patients adequately (Armstrong, 1974; Benner, 1984; Berkow et al., 2008; Casey et al., 2011). Financial constraints imposed by the organization eliminate the options of extended orientations, preceptors, and mentors (Kutney-Lee et al., 2013). New nurse orientations are frequently expedited without focusing on the development of the new nurse. Without appropriate staff development, nurses quickly experience burnout and make alternative employment decisions (Cottingham et al., 2011; Fox, 2010; Persaud, 2008; Smith, 2008; Verret & Lin, 2016).

Hospital-Based Nursing Overview

A registered nurse working within a hospital provides and coordinates the care for a group of patients, in a specific clinical unit. This care includes assessing patients' conditions with available objective and subjective data and documenting these findings in the patient's chart or Electronic Health Record (EHR). Medication administration and the provision of prescribed treatment modalities are provided while operating and monitoring medical equipment. The provision of patient and family education and emotional support are also included in the role of the nurse (Bureau of Labor Statistics, 2017). A substantial portion of hospital reimbursement is provided by the Centers for Medicare and Medicaid Services (CMS). Nursing retention is pivotal to positive patient outcomes and patient satisfaction which drive the revenue cycle (Herbert, 2012).

Nursing Leadership's Effect on Nurse Retention

A change in the current culture of thinking among hospital organizations and nursing leaders could promote nursing retention among NGRNs. These changes include implementing Evidenced Based Practice (EBP) guidelines for implementing change (Fleiszer et al., 2016). Employing and maintaining NGRNs requires a commitment to staff development (St-Martin et al., 2015). The literature demonstrates that those organizations who treat their employees as assets are the most successful of organizations (Henderson et al., 2015; O'Reilly & Pfeffer, 2000).

Authentic leadership consisting of transparency, openness, and trustworthiness promotes employee engagement and increases job satisfaction (Carsten et al., 2008). Nursing leadership plays a significant role in creating healthy working environments for

newly graduated registered nurses (Brady Germain & Cummings, 2010). Unhealthy working environments contribute to depression, anxiety, and other physical disorders experienced by nurses (Peterson et al., 2008). A study conducted by the Canadian Nurses Association (2006) revealed nurses' rate of illness related absenteeism was 58% higher than the overall labor workforce (7.9% vs. 5.0%).

Transformational leadership practices are seen in those leaders that hold themselves personally accountable while connecting with their strengths and values. They are willing to experiment with new behaviors and act. They have a mindset of curiosity rather than judgment and look for the opportunity in change (Fischer, 2016). Healthcare facilities who encourage transformational leadership styles among their management are more likely to retain NGRNs and demonstrate a higher quality of work (Lavoie-Tremblay et al., 2015). In the systematic review completed by Lartey et al., (2014), demonstrated that leaders who demonstrate the caring behavior of developing relationships with their staff, tend to promote nursing retention among those staff members.

Newly Registered Nurse's Readiness for Practice

An ongoing issue in the nursing profession is the apparent practice gap which exists between what is taught in nursing education programs and the knowledge which is needed to practice successfully as a clinical nurse. Nursing programs conclude they are providing the education needed to practice as a clinical nurse successfully. Acute care settings of hospitals' report new nurses do not have sufficient knowledge to practice as a clinical nurse. This practice gap is not new. It was first identified in the literature by

Armstrong in 1974 and continues to be an area of concern according to the literature (Benner, 1984; Dyess & Sherman, 2009; Ebright et al., 2004; "Editorial advisory board", 2008; Kantar, 2012; Lee et al., 2002; Long, 2004; Maben et al., 2006; Times Higher Education, 2014; Wolff et al., 2010). Frequent factors identified in the practice gap include ineffective soft skills such as time management, communication, prioritizing, coping skills, stress management, critical thinking, and clinical skills (Berkow et al., 2009; Del Bueno, 2005; Ebright et al., 2004; Henderson & Eaton, 2013; Lee et al., 2002; Smith & Crawford, 2003; Sportsman, 2010; Theisen & Sandau, 2013; Thomas et al., 2011).

Newly Registered Nurse Orientation

Inadequate orientations are frequently cited by Newly graduated registered nurses as an employment barrier. Hospital orientations frequently focus on policies, procedures, and benefits, versus providing orientation on frequently experienced clinical scenarios, and frequently used clinical equipment. Orientation program timeframes may be two weeks to one year (Parker et al., 2014). The longer the orientation program, the greater the retention rates for newly graduated registered nurses (Cottingham et al., 2011; Henderson et al., 2015; Scott et al., 2006; St-Martin et al., 2015). Preceptees' who are provided with formal education as part of their orientation process report a high level of job satisfaction (Ward & McComb, 2017).While the literature suggests preceptor programs and mentoring is effective in decreasing turnover rates for newly registered nurses' (Chen & Lou, 2014; Fox, 2010; Ingwerson, 2014; Persaud, 2008; Richards & Bowles, 2012; Smith, 2008; Verret & Lin, 2016), precepting and mentoring have

different meanings and provide different benefits when utilized accordingly. A mentor is considered a confidant, a trusted advisor, and someone with experience, how can be trusted as a consultant and a counselor (Zhang et al., 2016). A mentor often serves as a role model for those seeking advice, and in the process of a transitional change. A preceptor is an individual who serves as a guide to an employee by describing specific employment expectations of an employer or an organization (Pasila et al., 2017). Previous studies have examined the experiences of newly graduated registered nurses (Al Awaisi et al., 2015; Duchscher, 2009; Duchscher, 2012; Dyess & Sherman, 2009; Pennbrant et al., 2013; Kramer, 1974; (Kosmoski & Calkin, 1986); Tapping et al., 2013). Evidence-based practice demonstrates that hospitals who provide newly registered nurses with adequate orientation, support from preceptors, and mentoring, can be effective in retaining newly graduated registered nurses beyond their first year of practice.

Preceptorship

Effective preceptorship programs vary in their intensity and organization. The most successful preceptorships provide both a didactic and a clinical component, allowing the immediate application of academic knowledge within the clinical setting (Omer & Moola, 2018; Loughran & Koharchik, 2019). Preceptees report a feeling of connection to the staff and the organizations when an orientation occurs with a preceptor Sedgwick & Rougeau, 2010). A sense of belonging encourages individuals to remain in their place of employment (Omer & Moola, 2018).

Unclear Role Expectations

Newly graduated registered nurses' frequently report experiencing a lack of unclear role expectations. These nurses reported not feeling confident contacting physicians to discuss patient issues, overwhelmed with the workload, unprepared to handle patients with mental health issues and dementia (Parker et al., 2014; Kumaran & Carney, 2014). Depending on the availability of preceptors and orientation programs, newly registered nurses may be expected to assume responsibilities and roles, for which they are not prepared (Dyess & Sherman, 2009). New nurses report nursing school does not prepare them for the role of graduate nurse (Sherman, 2010). Newly registered nurses cite unclear role expectations, as a reason for leaving their first assigned units, the organization, and the profession (Duchscher, 2012; Dyess & Sherman, 2009; McCalla-Graham & De Gagne, 2015).

Bullying and Incivility

Newly graduated registered nurses' transitioning to clinical practice report they have experienced bullying and uncivil behavior from other nurses on their units and from nursing administration (Flateau-Lux & Gravel, 2013; Johnson & Rea, 2009; Spence Laschinger et al., 2012). Some of these same nurses' report their exposure to bullying and uncivil behaviors first started in their nursing education programs (Luparell, 2011). Nurses account episodes of bullying from their nursing instructors and classmates (Ibrahim & Qalawa, 2016). Bullying behaviors have been reported within clinical rotations (Smith et al., 2016). Bullying and incivility are one of the most frequently cited

reasons newly registered nurses' leave their first assigned units, the organization, and the profession (Johnson & Rea, 2009).

When bullying and incivility are permitted to prevail within an organization; the result is an organization which has great difficulty recruiting and retaining patients and staff. A hospital organization which permits bullying and incivility among its staff can expect to experience decreased organizational and unit morale. Hospital expenses increase in the form of increased sick time, employee turnover, decreased patient admissions, and decreased patient and staff satisfaction scores (Cleary et al., 2010; Edmonson & Zelonka, 2019; Flateau-Lux & Gravel, 2013; Lim & Bernstein, 2014; Skehan, 2015).

Retention Strategies for Newly Graduated Registered Nurses

Addressing the increased turnover for newly registered nurses' includes: decreasing the learning/practice gap (Benner, 1984; Dyess & Sherman, 2009; Ebright et al., 2004; “Editorial advisory board”, 2008; Kantar, 2012; Lee et al., 2002; Long, 2004; Maben et al., 2006; Times Higher Education, 2014; Wolff et al., 2010), promoting a zero tolerance regarding bullying and incivility (Flateau-Lux & Gravel, 2013; Ibrahim & Qalawa, 2016; Johnson & Rea, 2009; Luparell, 2011; Smith, 2016; Spence Laschinger et al., 2012), clearly defining role expectations, (Dyess & Sherman, 2009; Kumaran & Carney, 2014; Parker et al., 2014; Sherman, 2010), and providing adequate orientation programs (Parker et al., 2014; Cottingham et al., 2011; Henderson et al., 2015; Scott et al., 2006; St-Martin et al., 2015). The literature also suggests preceptor programs and mentoring are effective in decreasing turnover rates for newly registered nurses'- while

promoting job satisfaction (Chen & Lou, 2014; Fox, 2010; Ingwerson, 2014; Persaud, 2008; Richards & Bowles, 2012; Smith, 2015; Verret & Lin, 2016), within the context of the Quality Caring Model© (Duffy, 2009, 2013). A mentor or preceptor who provides appropriate caring behaviors during the appropriate transitional phase (Kramer, 1974), could improve nursing retention of NGRNs (Figure 2).

An appropriate caring factor (Duffy, 2013) which would be required during Kramer's reality shock (1974) Honeymoon phase, would be attentive reassurance combined with human respect. Attentive reassurance means being physically present with the NGRN while conveying a positive, optimistic outlook could be accomplished by rounding with the NGRN or working on projects with them. Listening, supporting, acknowledging their achievements, and encouraging growth from failures validates the NGRN, and demonstrates attentive reassurance. Treating the NGRN with Human respect shows that the NGRN is valued as an individual, as are their unique contributions to the organization (p. 191). During the honeymoon phase (Kramer, 1974), the NGRN is in a state of bliss over being employed and is unable to see the reality of the present situation.

An encouraging manner (Duffy, 2013) is the appropriate caring factor for the shock phase (Kramer, 1974). Using an encouraging manner with the NGRN during all verbal and non-verbal interactions would be displayed as nodding with encouragement and providing verbal phrases of encouragement when the NGRN engages in a risk-taking event. Identifying excellent and challenging behaviors during a formal disciplinary process fosters growth and role development of the NGRN. An encouraging manner empowers the NGRN and encourages continual risk-taking behaviors (p. 91). The shock

phase (Kramer, 1974) represents the NGRN's reality that they are not prepared for their current role as a new nurse.

Mutual problem solving (Duffy, 2013) is the appropriate caring factor to be implemented during the recovery phase (Kramer, 1974). Mutual problem solving (Duffy, 2013) occurs when the mentor or preceptor provides the NGRN with information which facilitates decision making. Information is provided in a safe environment allowing the NGRN to see the bigger picture, explore alternatives, validate perceptions, and brainstorm a course of action (pp. 190-191). The recovery phase (Kramer, 1974) is when the NGRN accepts the reality of their role within the organization and is trying to determine if the current reality of their role aligns with their values and beliefs.

Affiliation needs (Duffy, 2013) is the caring factor which aligns with the resolution phase (Kramer, 1974). The NGRN needs to feel they belong to an extended family of employees. This need can be met by including them in celebrations and work initiatives and respecting staffing and scheduling needs (p. 195). It is during the resolution phase (Kramer, 1974) that the NGRN has decided to remain in their current role in the organization.

Implementing caring factors (Duffy, 2013) during transitional phases (Kramer, 1974) would be most successful when a mentor provided these caring factors. A mentor provides the newly graduated registered nurse a confidant, providing an outlet for decreasing stress. Providing an outlet for new nurses decreases stress and encourages role adaptation while promoting employee retention (Zhang et al., 2016). Mentors contribute to role mastery and retention of new nurses (Chen & Lou, 2014; Fox, 2010; Persaud,

2008; Verret & Lin, 2016). A systematic review completed by Abdullah et al. (2014) demonstrated mentorship practices produce varying outcomes on mentees. Positive behavioral changes were cited as one such outcome of a successful mentor and mentee relationship. Successful retention practices have been shown to occur when the newly graduated nurse is paired with a mentor following the completion of orientation (Chen & Lou, 2014). A mentor-mentee relationship develops the NGRN's confidence and self-efficacy. A pilot study completed by Bay et al. (2015) demonstrated that appropriate mentorship contributes to the development of advanced skill sets and leadership, early in a nurse's career.

The provision of preceptors and mentors provides a foundation from which meaningful relationship development can be established with the NGRN. Appropriate caring behaviors are demonstrated verbally and non-verbally. Verbal behaviors convey respect, support, attention, protection, and promote affiliation needs (Duffy, 2013). Exhibited non-verbal behaviors include: dressing professionally, facing the individual using a relaxed, attentive body posture, providing attention, not allowing outside or verbal interruptions during dialogue, demonstrating attentive listening skills by nodding while an individual is talking, and listening for cues to underlying feelings, maintaining appropriate personal space, making eye contact, smiling, providing soft, gentle, touch, and exhibiting enthusiasm, demonstrate caring for another individual (Duffy, 2013).

Missing from the literature are studies of how the implementation of appropriate caring behaviors provided at the specific transitional stage, may promote retention of the NGRN during their first year of clinical practice. A qualitative phenomenological study is

the most appropriate method for this inquiry. Findings of this study will contribute to the body of knowledge related to nursing retention, benefitting educators, nursing leadership, healthcare organizations, policy, clinical practice, patient safety, quality health outcomes, and future NGRNs.

Summary and Conclusions

Transitioning from nursing school to the acute care environment of the hospital requires a period of adjustment. Successful adjustment and retention occur when the NGRN is given the appropriate tools to be successful such as appropriate orientation with a consistent preceptor and access to a mentor. These tools constitute the formation of relationship building. Reality shock has been used to study the transitional phases of NGRNs successfully' (Kramer, 1974). The QCM© (Duffy, 2003, 2009, 2013) demonstrates that when staff feels cared for patients' experience improved quality outcomes. This study examined the NGRNs' lived experiences of transitioning, their perceptions of experience caring behaviors during this transition, and whether their experiences contributed to their intent to stay or leave their nursing employment and the profession. The intended methods of this study are discussed in further detail in chapter 3.

Chapter 3: Methods

The purpose of this phenomenological study was to examine the lived experiences of a first-year cohort of Florida NGRNs working in the acute care setting of the hospital, and their perceptions of the caring behaviors exhibited by nursing staff during their first year of transition. The definition of NGRN is a newly graduated registered nurse employed in their first position in the hospital. Major sections of this chapter include research design and rationale, the role of the researcher, methodology, and issues of trustworthiness. The phenomenological design is discussed in the research design section as the selected approach for examining the lived experiences of the NGRN within their first year of professional practice. My role as a researcher was to serve as the instrument of the study, which is addressed in the section regarding the role of the researcher. The methodology section describes the intended participant population and participant inclusion and exclusion criterion. Issues of trustworthiness include the ethical issues of participant's rights, intentions to preserve participants privacy, and how the data collection process adds to the trustworthiness of the results.

Research Design and Rationale

This study is a qualitative design using a phenomenological approach to examine the lived experiences of NGRNs and of the caring behaviors they experienced from other staff nurses in their first year of employment. Open-ended, semistructured interview questions (Appendix A) were used to interview each participant allowing participants to provide greater depth to their answers (Creswell, 2013). Participant responses were audio recorded and transcribed to ensure accuracy. Once transcribed, these process recordings

were provided to each participant to review for accuracy. Process recordings were examined for emerging themes. Participants' responses are included in the dissertation as narrative quotes.

A qualitative phenomenological design was appropriate for this study because the study was designed to examine the lived experiences of each participant. Providing open-ended, semistructured interview questions allowed the participants to reflect upon their experiences and encouraged participants to expand upon the questions if a rapport had been established with the researcher (Creswell, 2013). Audio recording, transcribing, and submitting participant responses for their review, ensured the accuracy of understanding between the researcher and the participant (Creswell, 2013).

Research Questions

The primary research questions for this phenomenological study were:

RQ1: What is the lived experiences of a first-year cohort of Florida NGRNs working in the acute care setting of the hospital?

RQ2: What are the perceptions and experiences of NGRNs working in a Florida hospital related to feeling cared for?

An interview guide (Appendix A) was used to prompt participants to ensure rich data was received if these topics were not discussed during the interview process.

Phenomenological Research Tradition

This study is a qualitative design using a phenomenological approach examining the lived experiences of NGRNs in their first year of professional practice and their perceptions of the caring behaviors they experienced from RNs with whom the NGRNs

have worked. Open-ended, semistructured interview questions were used for the interview to allow participants to provide depth to their answers (Creswell, 2013). I used a phenomenological approach to be able to understand the NGRN's individual perceptions or experiences within the particular context or situation of the caring behaviors experienced during their first year of practice and to capture the ways in which NGRNs experienced this phenomenon within the context in which the experience occurred (Giorgi & Giorgi, 2003).

Participant responses were audio recorded and transcribed to ensure accuracy. An audio recording was completed with each participant to ensure the accuracy of the interview questions. An observational field journal was kept, and notes were recorded regarding specific participant observations and specifics related to each participant. A transcribed copy of interview answers was provided to the participants to review for accuracy. Upon participant confirmation of response accuracy, audio recordings and my observational journal were analyzed for emerging themes.

A qualitative phenomenological design was appropriate for this study because this study was designed to examine the lived experiences of each participant (Creswell, 2013; Patton, 2015). Phenomenology by design yields rich, thick descriptions of participants experiences by asking participants the two broad questions of: (a) What have you experienced? and (b) What situations have influenced your experiences (Creswell, 2013)? Using a phenomenological study design allowed me to obtain a description of the caring behaviors experience by NGRNs, allowing me to analyze and reduce the data to significant statements and themes. This process required using textural data analysis

(participants experience of caring behaviors) combined with structural analysis (how participants experienced caring behaviors) to determine the essence of NGRNs' experiences (Creswell, 2013).

Providing open-ended, semistructured interview questions allowed the participants to reflect on their experiences. It also encouraged participants to expand upon the questions if rapport has been established with the researcher (see Creswell, 2013). An audio recording of the interview allowed me to look for congruency between the participants answers (see Rudestam & Newton, 2015). Transcribing and submitting participant responses for their review ensured accuracy of understanding between myself and the participant (see Creswell, 2013).

Role of the Researcher

In a qualitative research study, the researcher is the study instrument (Creswell, 2013). As such it is of utmost importance that the researcher is experienced with interview techniques. I have a master's degree in mental health counseling and extensive experience conducting interviews. My role as a researcher was to be an observer-participant (Creswell, 2013). An observer-participant is an individual who observes the study participants and participates in some manner. I conducted interviews while documenting the participants' responses. I encouraged the self-expression of participants' answers by asking the participant to describe what they experienced, where they experienced it, how they felt regarding the experience, what they said during this experience, and how this experience had impacted their lives. Additional questions were asked based on the participant responses to the semistructured interview questions

provided. It was crucial for the researcher not to influence the answers provided by the participants. This was achieved by guarding against verbal responses such as agreeing or disagreeing with the participants' answers. I was cognizant of non-verbal behaviors expressed through body language such as eye contact, posturing, nodding of the head, smiling, and frowning (Creswell, 2013).

This study was not conducted at my work environment to eliminate the potential for personal or professional relationship involvement with any of the participants. Research participants were given a $5.00 Amazon gift card at the completion of their interviews to thank them for their participation.

Methodology

Participant Selection Logic

Newly graduated registered nurses who have graduated from a college in southern Florida and are beginning their nursing careers in a southern Florida hospital were recruited for this study. Participants selected were NRGRNs in the first year of their professional practice. Hospital human resources and staff development personnel were asked to support this research by allowing me to speak at new hire orientation, distribute a flyer, and post these same flyers on each unit in the hospital.

Criteria for Inclusion. Purposive, convenience sampling was used to recruit NGRNs who are working in their first year as a registered nurse in the acute care setting of a hospital. This sampling method is congruent with the method of phenomenological research study recruiting participants who can provide significant information regarding the phenomenon of interest (Rudestam & Newton, 2015). I recruited RN graduates who

have received their registered nurse licensure and were working in the hospital setting in their first year of practice. The demographic questionnaire (Appendix B) was used to reiterate the criteria of being an NGRN within their first year of practice.

The inclusion criteria for participation were:

- graduate nurse from a southern college in Florida
- licensure as a registered nurse in Florida
- in the first year of professional nursing practice
- willing to sign an informed consent
- willing to participate in an audiotaped interview

The exclusion criteria were previous work experience in an acute care environment as an LPN. This is because nurses working as LPNs would have already experienced a psychosocial adjustment period making their participation in this study invalid.

There is no set number of participants required for a qualitative study (Patton, 2015). The number of participants chosen for a qualitative study is based on the study, the purpose of the study, and what the researcher hopes to obtain from the study (Patton, 2015). My goal was to recruit 12 to 15 participants which would allow me to obtain a depth of experience while factoring for participants who may withdraw from this study (Patton, 2015). My goal of 12 to 15 participants was a significant number of participants for a phenomenological study when the purpose of the study is to obtain the essence of the experience from participants (Rudestam & Newton, 2015) and to achieve saturation. Saturation within the sample size occurs when the participants are responding in the same way to the questions, and no new information will be gleaned with additional interviews

(Patton, 2015). A flyer describing the study, participant criteria, and incentive was posted on all the nursing units within rural hospitals in the Southeastern US. Interested participants were asked to contact me by email.

Instrumentation

Interview Questionnaire

The data collection instrument was a list of 7 open-ended questions (Appendix A) designed to explore what caring behaviors the NGRN experienced during their first year of nursing practice. Semistructured interview questions served as a guide for both the researcher and the research participant (Creswell, 2015). The interview questions contained within the interview questionnaire focused on the experiences of the NGRN. Content validity was completed based on Creswell's (2015) recommendations which include: (a) the inclusion of my understanding of the philosophical tenets required for a phenomenological study, (b) examination of the lived experiences of NGRNs and their perceptions of caring behaviors exhibited towards them within their first year of nursing practice is an actual phenomenon, (c) Moustakas' (1994) data analysis was be used, (d) the essence of the participants experiences were described with the context in which they occurred, and (e) I remained reflexive throughout the study.

Procedures for Recruitment, Participation, and Data Collection

Participants were required to complete an informed consent form prior to participation. I collected data from each participant in the form of an interview, utilizing open-ended questions to learn about the essence of the participant's lived experiences (Appendix A). Each interview was audio recorded, and field observation notes were

documented for each interview. There were 13 participant interviews conducted and each interview lasted approximately 60 minutes. All transcribed interview recordings were provided to each research participant for review, to ensure I captured the essence of their lived experience. If changes were needed the participant agreed to inform me of those changes. None of the participants requested a change from their initial transcribed recording.

Interview Protocol

Interviews were conducted at a public place, in a private location. Interview locations were chosen by the participant. Interview questions (Appendix A) were read to each participant to keep my data collection method organized and ensure similar questions were asked of each participant that revealed rich data. Each interview was audiotaped. An observational field journal was used for making observational notes of the participants' non-verbal communication (eye contact, body position, restlessness, relaxed posture). I assigned each participant a number to maintain confidentiality. review, as a token of appreciation for their time. Each interview was transcribed and provided to the participant to review for accuracy. Each participant was provided a $5.00 Amazon card at the completion of their interview review as a token of appreciation for their time and participation. All participant interviews were transcribed within 24 hours. This data was analyzed for emerging themes. Audio recordings of Interviews. All interviews were recorded upon the consent of the participant. An informed consent was obtained and signed by each participant prior to the initiating of and recording. These consent forms were reviewed with the participant, and verbal permission to initiate audio

recording was obtained. Audiotaping was the most accurate method for ensuring that each participant's answers were accurate and complete while allowing me to provide my complete attention to the participant. Providing my complete attention to the research participant made the participant feel valued and allows the researcher to make observations regarding the participant's body language (Creswell, 2013). Each participant was provided a number which correlated with the participant's name to ensure privacy. Interviews were transcribed and provided to the participant to review. If the participant felt that changes were needed to adequately reflect their experience, then they were to inform me. None of the participants requested a change to their transcribed interview. All audio recordings are secured in a locked file cabinet within my home office.

Observational Field Journal

A field journal allows the researcher to make observational notes related to the interview process and serves as a source for documenting interactions and making notes pertaining to areas of interest (Rudestam & Newton, 2015). The observational field journal provided supplemental information that was used for data collection and analysis and contributed to the trustworthiness by providing additional, relevant information.

Data Analysis Plan

A total of 13 research participants were interviewed allowing for saturation of lived experiences to be presented. Saturation within the sample size occurs when the participants are responding in the same way to the questions, and no new information will be gleaned with additional interviews (Patton, 2015). Data for analysis included anything that was said, heard, or communicated to me while I am conducting this study. All data

collected through interviews, audio recordings, and the observational field journal was directly connected to the research questions:

RQ1: What are the lived experiences of a first-year cohort of Florida NGRNs working in the acute care setting of the hospital?

RQ2: What are the perceptions and experiences of first year NGRNs working in a Florida hospital related to feeling cared for?

I analyzed my data using Raven's eye. This assisted me with the organization and analysis of all research data collected.

Discrepant Cases

All data collected had meaning. I anticipated the collection of data which may not align with other major themes or categories evident in this research study. This is a result of collecting data from participants who had different perspectives of the same research phenomenon. The inclusion of discrepant data increases research validity (Maxwell, 2013) and allows the reader to formulate their conclusions based on all the evidence presented. The method chosen for data analysis of this study is based on Maxwell's (2013) simplified version of Moustakas (1994).

- The first step was to describe the researcher's personal experiences of the research phenomenon. Describing the researcher's personal experiences permits the researcher to separate personal experiences from those of the research participants.
- Step 2 requires the researcher to develop a list of significant statements. Statements from interviews, observational notes, and the field journal

regarding how participants experienced the phenomenon are listed, providing for horizontalization of the collected data. Each statement is considered to have equal worth. A list of non-repetitive, nonoverlapping statements was developed related to the significant statements.

- In Step 3, the significant statements were grouped into larger "meaningful units" or themes.
- Step 4 required the researcher to write a description of "what" the research participants experienced related to the phenomenon, known as "textural description," of the experience which includes verbatim examples.
- Step 5 required the researcher to write a description of "how" the experience happened; known as the "structural description." The focus is on the setting and context of the phenomenon.
- Step 6 required the researcher to write a composite description of the phenomenon, known as the "essence" of the phenomenon. The essence incorporated the textural and structural descriptions informing the reader of "what" the participants experienced with the phenomenon and "how" they experienced it.

Debriefing

Debriefing provides reflexivity for the researcher and the participant and begins the data analysis process (Maxwell, 2013). A debriefing occurred at the conclusion of each participant interview. After each interview, I recorded observations in my field

journal related to non-verbal communications such as eye contact, facial expressions, body posture, and congruence, with verbal and non-verbal communication which occurred during the interview. Throughout this study, I consulted with my research committee. My committee are the experts, and their feedback served to make me aware of any personal biases and assumptions (Maxwell, 2013).

Issues of Trustworthiness

Verification of research findings is a crucial element of qualitative inquiry and should include peer review, persistent observation, triangulation, clarification of researcher bias, negative case analysis, rich and thick descriptions, member checking, and or external audits (Lincoln & Guba, 1985).

Credibility

Member checks are crucial for establishing credibility in a qualitative study (Lincoln & Guba, 1985). For this research study, participants were asked to review the transcribed recordings to ensure the accuracy of their statements, ask questions, and voice additional opinions, contributing to the critical analysis of the data obtained. Corrections and additions would have been made if requested by the participant. None of the participants requested any changes of their transcribed interview. Participant's approval of the data confirms this researcher appropriately captured their thoughts, feelings, and the essence of their lived experiences related to this study phenomenon, as recommended by Maxwell (2013).

Peer review was an additional technique used to contribute to the credibility of this research study. Peer review reduces the probability of the researcher's personal bias

and inaccurate conclusions of the research data (Maxwell, 2013). Feedback for this study was provided on an ongoing basis by my dissertation committee persons. The review of my interview questions by an expert panel also increased the validity of this study.

Transferability (External Validity)

Transferability or external validity evaluates the extent to which the findings of a study can be applied to other situations (Bailey, 2007). Transferability of these research findings could benefit hospital administrators, nursing educators, staff developers, and human resource personnel. I ensured transferability by providing rich descriptions of both the study phenomenon and the experiences of the participants. Sufficient contextual information about the research site was provided to allow the reader to make appropriate determinations (Lincoln & Guba, 1985).

Dependability (Reliability)

Dependability of a study can be enhanced in numerous ways (Silverman, 2014). One example of dependability was the utilization of quality tape recorders and tape for obtaining interviews. Transcribing of these interviews contributed to dependability as I transcribed not only the participant's words but the pauses and overlapping verbal responses provided by the participant. Transcriptions included participant pauses and overlapping verbal responses.

Confirmability (Objectivity)

Qualitative researchers maintain research objectivity through confirmability (Shenton, 2004). My research questions were formulated to explore the lived experiences of NGRNs as they transitioned from nursing school to the acute care environment of the

hospital, and the caring behaviors they experienced from nurses they work with. As a nurse of 28 years, I can remain objective in this study as I did not transition from nursing school to the acute care environment upon graduation. Results of this study are based on the reported lived experiences of NGRNs which included their thoughts, feelings, and perceptions of this experience.

Ethical Procedures

Informed Consent

Informed consent forms provided to, and reviewed with participants, protect participants rights of participation and privacy even when the research study poses a minimal threat (Creswell, 2013). The informed consent form indicates that (a) the participant's involvement in the research study is voluntary, (b) this study involves minimal to no risk, (c) there are no associated costs with this study, (d) the participant's identity and responses will be kept confidential, (e) participants may withdraw from the study at any time without an explanation, (f) the participant's place of employment, nursing educators, and nursing scholars may benefit from the results of this study. All participants were required to sign an informed consent acknowledging their understanding of the study criterion and their rights as participants within this study.

Institutional Approval

Walden University's Institutional Review Board (IRB) requires strict compliance with established rules and ethics. It was my understanding that before initiating any research for this study, approval must be granted by the Walden IRB. Approval for this study was obtained by completing a detailed IRB application for Walden University.

Once Walden IRB granted permission to begin my study, I begin to contact potential participants using approved facilitators, flyer, face-to-face, and email.

Confidentiality, Privacy, and Data Storage

Information obtained from participants is strictly confidential. Providing each participant with a number allowed for increased confidentiality. Narrative data provided does not include any information which could connect the participant with a specific hospital, college, or university. This study did not pose any undue harm to the participants. None of the participants reported any psychological distress. If participants had reported any psychological distress, they would have been provided with a counseling referral for anxiety if needed, based upon their geographic location. All participants were adults over the age of 18 who were informed of their rights and given the option to participate or not participate in this study. Participants had the right to withdraw from this study at any time.

All audio recorded interviews were transcribed immediately to ensure accuracy. Electronic data, audio recordings, and transcripts are saved on two thumb drives and secured in a locked file cabinet. All data obtained from this study is secured in a locked file cabinet within my home office. All research data will be retained for five years, accessible only to me. After five years, all hard copies will be shredded, and existing thumb drives will be erased.

Summary

This chapter included an overview of the phenomenological qualitative research approach describing the lived experiences of NGRNs transitioning from nursing school to

the acute care environment of the hospital and the caring behaviors they experienced from other nurses they worked with. The research methodology was explained, participant criteria and selection methods were provided. Issues of trustworthiness related to credibility, transferability, dependability, and confirmability were presented. Plans for addressing the ethical issues of confidentiality, privacy, data storage, and security, and participant's rights were reviewed. Chapter 4 includes a detailed discussion of the results of this phenomenological study with participant's interview responses and the significant themes apparent from these responses.

Chapter 4: Results

Thirteen NGRNs were interviewed to provide information about their transitional experiences. Chapter 4 includes a presentation of these findings, a review of the research questions, the process for recruiting research participants, demographics for each research participant, how data were collected, stored, and analyzed. A description of the data analysis process is included that addresses steps used to verify data accuracy and the quality of the data obtained. Major themes and subthemes were identified and are presented in order of significance. A summary of findings is included within this chapter. The purpose of this phenomenological study was to examine the lived experiences of a first-year cohort of Florida NGRNs working in the acute care setting of the hospital, and their perceptions of the caring behaviors exhibited by nursing leadership and other nursing staff during their first year of transition to nursing practice.

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The recruitment of research participants was conducted as described in the study design. The response rate was low, which was unanticipated. The response rate was 16. From 16 participants who expressed interest in participation, 14 were identified as meeting the criteria set forth in the study design; The inclusion criteria for participation were:

- Graduate Nurse from a southern college in Florida
- Licensed as a Registered Nurse in Florida
- in the first year of professional nursing practice
- willing to sign an informed consent

- willing to participate in an audiotaped interview

The exclusion criteria were previous work experience in an acute care environment as an LPN. One participant decided not to participate.

Participants were geographically located across the state of Florida. Some of the participants scheduled for interviews were hesitant to be interviewed and reported to me that they were somewhat nervous to be interviewed. During the interview process, any participants who appeared to be nervous or hesitant were made to feel at ease by developing a rapport with them prior to the interview process. All research study participants participated freely, providing in depth information about their transitional experiences. The NGRN organizational environment is a fast paced, demanding, and very dynamic setting. Historically, the training process for the NGRN has been to complete medical surgical clinicals, care for 1-2 patients during their shift, and provide extensive medication lists and care plans for their assigned patients. Upon graduation, the NGRN transitions to a staff nurse position with a patient load of 6 patients per assignment.

Demographics

Study participants were limited to NGRN working in their first year as a clinical nurse in the state of Florida. Study participants were recruited using a web page and word of mouth from other study participants. Table 1 provides a description of NGRN participants by age, gender, education, ethnicity, and paramedic status. Age distribution ranged between 22 and 42 years of age. The two genders of man and woman were represented in this research study. The number of male participants was 4 (31%). The

number of female participants was 9 (69%). Education level included participants with associate degree, bachelor's degree and previous paramedic training which required 2 years of training. The number of participants with an associate degree was 8 (62%). Two participants had earned a bachelor's degree in nursing. Four study participants interviewed were Hispanic (31%). Among the Hispanic study participants interviewed, one was male and three were females. Nine White, non-Hispanic study participants were interviewed that included 3 males and 6 females. The number of participants that had paramedic training prior to becoming a RN was 4. All study participants with previous paramedic training were female.

Participants interviewed worked in various acute care settings within the state of Florida. Four participants were paramedics who transitioned to RN through a transitional bridge education program. Different perceptions were observed among gender, ethnicity, and previous vocational experience with regards to caring behaviors (Table 1).

Table 1

*Selected Demographic Characteristics of Research Participants (*N*=13)*

Participant	Age	Male	Female	White, non-Hispanic	White, Hispanic	ADN	Paramedic	BSN
1	27		X		X	X		
2	24	X		X				X
3	22	X		X		X		
4	42		X	X		X		
5	23		X	X				X
6	37		X		X	X		
7	23		X		X	X		
8	38	X		X		X		
9	25	X			X	X		
10	33		X	X			X	
11	28		X	X			X	
12	23		X	X			X	
13	25		X	X			X	

Note. Mean age was 28.5.

Summary of Demographic Statistics

Participants were recruited from a Facebook webpage and from word of mouth from other study participants. Study participants included male and female NGRN who had transitioned from nursing school to bedside nursing as a clinical nurse. Nine females and 4 males were interviewed. The mean age of the participants was 28.5 years of age.

Each of the NGRN interviewed, worked in the acute care setting of the hospital and had been employed for less than 1 year. Four participants were Hispanic. Nine participants identified as White. Education level for study participants included 8 Associate degree nurses, 2 bachelor degreed nurses and 4 participants who were certified as paramedics and had worked in the field as a paramedic prior to becoming a registered nurse.

Data Collection

The purpose of this research was to uncover and illuminate the lived experiences of the lived experiences of NGRN; it was necessary that these stories be shared. The phenomenological approach was the chosen method for sharing these stories. Data collection was completed by interviewing a sample size of 13 NGRN study participants. I used an open-ended interview guide to interview the participants to glean qualitative data (Appendix A). Interviews were conducted by telephone and recorded. Each NGRN answered questions from the interview guide. I used a field journal for contributing data into the data collection for this study.

All NGRNs participated in telephone interviews from their homes. One NGRN was interviewed per week, over a period of multiple weeks. The data were recorded using a standard audio recorder, the captured data was then transcribed onto a spread sheet for analysis. Data collection was standardized, minimizing variances in the collection process. Recruiting qualified NGRNs was a significant challenge due to the time demands of the profession experienced by the NGRN. In some cases, the interviews presented challenges due to language barriers. The language barriers were due to pronunciation of words, resulting from strong accents. To have effective communication,

it was necessary to slow the interview process, and restate words for clarity and understanding of meaning.

Semistructured Interviews

Thirteen study participants were interviewed that met the inclusion criteria previously listed. Each participant was scheduled for a formal interview once they had been prescreened to determine eligibility for this study and each completed the informed consent. Two potential study participants were excluded as they did not meet the inclusion criteria of being a registered nurse. Both individuals were referred by word of mouth from a prior study participant. Excluded participants were thanked for their interest. An interview questionnaire was incorporated into the interview process. Open ended questions were asked of each study participant depending on the how the interview was progressed, and the topics brought up by each participant. A research journal was kept during the interview process to make field notes of questions, comments, observations made, and anything requiring clarifications from the participant.

Field Notes

I made field notes for various observations that occurred during the interview process to document if further probing of an idea emerged, if verbal discomfort was observed, for statements requiring clarification, any other observations that I believed might be important during the data analysis. I kept field notes in the notebook with the transcribed interviews and reviewed them with the transcribed data during the coding of themes and subthemes.

Researcher's Journal

My research journal was crucial for the data analysis process. I divided the journal into sections to assist with organizing data for data analysis. The journal included informed consents, demographic data, transcribed interviews with correlating field notes and a notes section. After the interview was transcribed, I assigned a number to the transcription to eliminate identifying demographic data. The transcribed interview was provided to each participant to ensure I captured the essence of their story. Participants were asked to respond back if their story required clarification. No responses were received back from the study participants

Data Analysis

The outcomes were mixed. The results demonstrated that there were NGRNs who did experience caring behaviors during their transition from student nurse to staff nurse. Female NGRNs felt that the caring behaviors were more positive than they had experienced withing their Paramedic programs. Culture differences were observed among the NGRN. The Hispanic NGRNs stated they experienced caring behaviors, whereas non-Hispanic NGRN reports of caring behaviors were mixed. Male NGRNs reported experiencing caring behaviors was skewed because they were asked to perform more physical tasks such as lifting and transferring, than their female counterparts. No differences were reported by the NGRNs related to their academic history. Major themes and subthemes were identified and presented in Table 2.

Table 2

Major Themes and Related Subthemes

Major Themes	Subthemes
NGRNs and Paramedics Transitioning into the Role of Clinical Nurse	Role Transition
Caring Behaviors Experienced	Relationship Development
Applying previous knowledge to clinical Practice	Skills, Experience & Education • Associate Degree students • Paramedics • Bachelor Students
Cultural Differences and Transitioning	Gender Ethnicity • White American • African American • Hispanic American

Evidence of Trustworthiness

Verification of research is a crucial element of inquiry (Lincoln & Guba, 1985). Issues of trustworthiness include the ethical issues of participants' rights, intentions to preserve participants privacy, and how the data collection process adds to the trustworthiness of the results (Creswell, 2013). A field journal was incorporated as supplemental information and was used for data collection and data analysis further

contributing to trustworthiness. Field journal findings will be further examined within this chapter.

Credibility

Participants were asked to review the transcribed recordings for accuracy. There were no substantive changes recommended by the participants. Participants review and approval of transcripts confirmed that their experiences, thoughts, beliefs, and feelings were captured. At the completion of the study, peer review was sought to decrease researcher bias (Creswell, 2013). For the purpose of this study, peer review feedback was obtained from this writer's dissertation chair and qualitative content expert committee member. A significant aspect of credibility for this research was derived from the feedback of the dissertation committee.

Transferability

Research findings could benefit hospital administrators, nursing educators, staff developers, human resource personnel and other researchers. Rich descriptions of both the study phenomenon and the experiences of the participants were included from this study. Sufficient contextual information about the research site is provided allowing the reader to make appropriate determinations (Lincoln & Gubba, 1985).

Dependability

The effectiveness of caring behaviors experienced by NGRN may have an impact on turnover. This study reflected that most of the NGRN felt they experienced caring behaviors. The turnover rate for this research was considerably lower than the rate identified in chapter 3 [Nursing Solutions Incorporated (NSI) report (2016)], concluding

that there is a relationship between caring behaviors and the lived experiences of NGRN as previously cited by (Kumaran & Carney, 2014; McCalla-Graham & De Gagne, 2015). This is significantly less than the literature suggests (Nursing Solutions, 2016).

Confirmability

My research questions were formulated to explore the lived experiences of NGRNs as they transition from nursing school to the acute care environment of the hospital, and the caring behaviors they experienced from nurses they work with. Defining objectivity from the researcher's perspective required that this research would not be made on personal/professional experiences. The focus was on peer reviewed, secondary research (Creswell, 2013), and the primary data gathered through the questionnaire.

Results

The purpose of this study was to explore the lived experiences of NGRN as they transitioned from graduate nurse to clinical nurse at the bedside. The findings that follow, provide the terms used to label these experiences which was derived from the study analysis. The research questions and questionnaire were examined to provide further insight into the responses provided by each research participant. Narrative responses are included to provide additional credibility for this study.

Themes and subthemes were identified and included as part of the research analysis when many of the participants responded, identifying the same transitional experience. Participants' verbatim responses were included in the results which follow.

Any grammatical and slang language were included to represent research participants' accurate descriptions of their lived transitional experiences.

Theme 1: Transitioning from NGRN into the Role of Clinical Nurse

Transitioning into the role of clinical nurse was determined to be the most complex of the themes identified from the interviews conducted with the research participants. The subtheme within this major theme was identified as Role transition. Role transition posed the most challenges including adjusting to the transition, orientation, fear/confusion, caring behaviors experienced, gender observances during transition, time management, multitasking, delegating to others, interactions with physicians, interactions with leadership, interactions with other staff, and balancing work life and family responsibilities. Participants were questioned regarding their transition from graduate nurse to clinical nurse. As expected, all research participants reported a blissful feeling that nursing school was over, they had passed their NCLEX, and now they could begin their careers as clinical nurses'. Responses varied relating to orientation. Orientation time frames ranged from 1-3 months. Some participants reported that they felt like they were still in nursing school during their orientation, as because they were required to attend a classroom that taught them how to complete clinical procedures that they had already learned in nursing school. Other participants reported that their orientation focused on the policies and procedures of the organization, not how to become a bedside nurse. Many research participants were frustrated that they did not feel as though they experienced a transition from nursing graduate to clinical nurse. Participants reported being turned loose with a full patient load and told to ask questions

of their preceptor if needed, while their preceptors were still carrying a full load. For example, Participant 8 noted,

> My preceptor was very helpful, but she had to carry a full patient load and help me if I needed it. I felt really bad having to ask her for help. I tried to get by the best I could.

All participants reported similar experiences, feeling that they were not prepared to begin their role as a clinical nurse "hands on" experience with patients and professional interactions with staff and physicians. Participant 4 stated, "I didn't know how to call the physician. I didn't know what to say. I was told to follow the SBAR communication form. If I could have watched the nurses call the physicians, I would have felt more comfortable." Likewise, Participant 7 noted, "When I had to call the physician, it was awkward because they didn't know who I was. They asked to speak to one of the other nurses." Furthing this theme, Participant 5 said, "I was scared to call the doctor because it was late at night, and I didn't want to wake him up. He was very nice to me."

Study participants that had previously been trained and worked in the field of emergency medicine also participated in this study. All participants (4) were female. These participants reported a smoother transitional experience to their nursing unit. Differences in transitional experiences appeared to be related to their reported ability to think critically and having been educated by male instructors and previously work experience in a predominately male work environment in a field setting.

> Participant 11 said, I was in the same orientation program as the other nursing graduates. My needs were different, but we were all treated the same. Some of the

other nurses got really upset about how the other nurses on the units talked to them. I heard the same things they did, but it didn't bother me. Training as a female paramedic is very hard. It prepared me well for nursing school. In paramedic school you are treated like a man. My instructor was a man. I was expected to act like a man. They made fun of me if I cried or acted weak. They would even give the other men a hard time telling them, you're acting like a girl. There was only one other girl in my paramedic program. They kept us separated during our paramedic clinicals.

Participant 10 shared that; Orientation was OK. I just focused on the rules, expectations, policies and where to find the policies. I didn't have a problem with anyone. Working on the nursing unit is different than working in the field. Most of the time, you have more resources and it's not as stressful. I have thick skin. I didn't let others' comments bother me too much.…some of the others made a big deal out of nothing.

Participant 12 noted, Orientation wasn't that helpful. I wish they had spent more time on how to use the EHR. Every EHR has its own nuances. The one we use is pretty easy, once you learn it. I didn't pay attention to the unit drama. In the field, you have yourself and your partner to depend on. There is no room for drama.

Participant 13 noted, Orientation was OK. I didn't care much for being taught nursing skills over again. I already learned them once. I had a license that said I was competent to practice them. It would have been good to see some new procedures that would be useful.

Participants were questioned regarding their experiences adjusting to their new role as NGRN. All participants reported difficulty acclimating to the acute care setting as the focus was on the organization, not on becoming a nurse. Reasons cited as contributing factors for difficulty acclimating to the acute care setting included: Adjusting from being in school on a consistent school schedule of Monday through Friday. In nursing school classes were held from 8:00am to 4:30 pm. Hospital schedules varied and 12 of 13 participants reported transitioning to a 12-hour shift was a change. The 4 participants who had previously worked as paramedics reported that regular 12-hour shifts required an adjustment period from what they were previous adjusted to working. One participant reported acquiring a regular schedule of 8 hours, 40 hours a week. Sleep schedule changes were cited by 8 participants. Of the participants interviewed, 8 of the 13 participants reported having to adjust to working 7pm-7am shifts, requiring an adjustment in their sleep-wake cycles. Paramedics reporting being used to working for continuous around the clock availability and described the 12-hour night shifts as less stressful than what they had previously experienced as a working paramedic.

> Participant 2 shared, “I was one of the lucky ones. I got hired to work 8-hour, day shifts.”
>
> Participant 4 responded that, working 12-hour nights was definitely a new experience for me. I have worked daylight hours my entire working life. It has become a balancing act for sure have a family. I sleep ok when the kids are in school. I don’t sleep well during the day, on weekends.

Participant 10 noted, "I was used to working 24 hours on shift. Twelve-hour night shifts in the hospital are a different kind of stress. I don't have any problems sleeping when I lay down."

Participants cited other obstacles of acclimation including time management, adjusting to the unit and organizational culture, delegating tasks to nursing assistants, and calling physicians at night.

Participant 5 shared, it was difficult as first to take care of 6 patients and find time to chart. They said that the computer would make charting easier. Most of the time I would clock out after my shift, and catch up my charting, before I went home. We were not allowed to have overtime.

Participant 4 noted, "The other nurses were standoffish with me at first. I felt like they were trying to scare me off. They acted like my nursing education wasn't good enough to prepare me to work as a nurse."

Participant 6 shared that, I had a hard time delegating to the nursing assistants at first. I was a nursing assistant. I felt strange telling them what to do."

Participant 4 communicated; I didn't know how to call the physician. I didn't know what to say. I was told to follow the SBAR communication form. If I could have watched the nurses call the physicians, I would have felt more comfortable.

Participant 7 informed me, "When I had to call the physician, it was awkward because they didn't know who I was. They asked to speak to one of the other nurses."

Summary of Theme 1: Transitioning from NGRN Into the Role of Clinical Nurse

All participants (100%) in this study reported struggles with transitioning from graduate nurse to clinical nurse. Concern was voiced that their orientation time could have been used more effectively to acclimate them to the culture of the unit and the organization. Some participants reported having trouble making the psychological adjustment from student nurse to clinical nurse. Participants reported feeling ashamed, embarrassed, uncomfortable asking for assistance with a new procedure or questioning something they were unsure of because they had not experienced the situation before. Challenges faced in the acute care setting included the need to develop time management skills, delegating, developing a work-life balance, adjusting to working 12-hour, night shifts, sleeping during the daytime, and waking physicians up at night to review patient findings. Time management skills was cited by 4 of the 13 participants. Delegating was reportedly more difficult for 1 participant who had previously worked as a nursing assistant. Previous work experience as a paramedic provided familiarity with working 12-hour, night shifts and adjusting to the unit and organizational culture, according to the 4 participants who had previous paramedic training.

Study participants that were previously paramedics reported a less stressful transition experience. All participants were dissatisfied with the orientation process; reporting that the time could have been better spent learning new procedures and focusing on potential areas of development. Prior paramedic training techniques occurring in a predominantly male oriented environment could be a strong, contributing factor for a less stressful nursing transitional experience. Previous work experience in the

field environment, requires strong critical thinking skills and independent practice. This may serve as an advantage over the study participants that did not train as paramedics and transition into nursing.

Theme 2: Caring Behaviors Experienced

Caring behaviors experienced was included as the second theme which emerged from this research. The subtheme developed from this theme was relationship development. Participants shared their lived experiences related to interactions with physicians', interactions with leadership, interactions with other staff, treatment by physicians', treatment by other staff, treatment by patients' Participants reported feeling cared for as newly hired employees. Leadership and preceptors demonstrated caring behaviors such as providing time, attention, gifts, and emotional support, during their transition into the organization.

> Participant 9 reported, I hate tests. When I have to take a test, I freak out. I went to work. When I get to work everybody asked me, "did you take your entrance already?" I lied and told them and my boss no, I didn't take my entrance test. I didn't feel ready for it, so I cancelled, and I made appointment for another day. My manager had a paper in her hand and said, "well, if you cancelled your appointment what is this?" She showed me I had passed. I started crying. Everyone congratulated me and they even had a party for me.

Participants 1, 2, 3, 4, 6, 7, 8 reported that their preceptor informed them that, "I am here for you. You can call me no matter what time of the day it is."

Many of these same participants reported being mistreated by the same individuals (coworkers) as nursing students, that were now showing acceptance and indifference to them as NGRNs Participants reported a disconnect between nursing school and employment from expressed comments of coworkers.

> Participant 4 embarrassingly shared, “Now that your done with nursing school, you get to learn the real way we do things here. Don’t worry, you won’t have to spend so much time giving baths.”
>
> Participant 5 was told by one nurse, “it’s time to put your roller skates on and learn how to be a real nurse.”

These statements increased the uncertainty, fear of the unknown, and increased anxiety related to their NGRN role. This resulted in a decreased honeymoon phase experience (Kramer, 1974) lasting from 1-3 months depending on the employment location of the NGRN.

Relationship development was an important aspect of the NGRN’s transitional experience. Limited interaction time between nurse and physician was perceived by the NGRN to be a barrier in relationship development.

> Participant 1informed me, All my coworkers, the doctors, and the nursing administration are very supportive of me. I love being a nurse and working on my unit. I have heard from the others (NGRN), that their experiences haven’t been as good as mine.

Participant 7 shared, “Everyone I work with has been very kind and helpful. They are always checking on me. They encourage me to seek out new learning experiences.”

Participant 8: Nursing leadership has been very good to me. Coworkers have been somewhat brash at times.

Participant 11 proudly announced, nursing leadership has treated me very well. Most of my coworkers have been supportive. There have been 1 or 2 that been very negative. Just like any other job, it takes time to learn what the job expectations are and how to fit in.

Participant 7 stated, “when I had to call the physician, it was awkward because they didn’t know who I was. They asked to speak to one of the other nurses.”

Communicating negativity to a NGRN is an example of ineffective communication and impairing relationship development. The paramedic study participants were able to navigate the difficulties presented by incivility possibly due to their previous work experience in the predominantly male, EMS environment.

Participant 12: This is my second job. I worked as a paramedic before I became a nurse. I get treated a lot better at this job, than I did at my last job.

Female Hispanic participants reported that historical experiences with dominant male relationships provided an increased tolerance for uncivil behaviors they experienced.

Participant 7 shared that, “I didn’t expect to experience caring behaviors.”

All study participants reported a strong, trusting, relationship with their preceptor.

Participant 2 responded, “My preceptor is so helpful. She is busy and I hate asking her questions. She never makes me feel that I am a bother.”

Participant 3 stated. “My preceptor has been so supportive. She told me to call her anytime if I had questions or needed support.”

Participants reported that they had developed good working relationships with other unit team members to include CNA’s, hospital ancillary staff, and other nursing coworkers. Caring behaviors by nursing leadership continued to be reported. Of the participants interviewed, 7 of 13 reported a shortened honeymoon phase (Kramer, 1974) due to staff interactions with coworkers.

Participant 2 informed that, “My team is pretty cool. I have made some work friends. I don’t do anything after work with them, but we talk at work.”

Participant 6 shared, “Most of my coworkers have my back. Most days we have fun at work. It makes the shifts go by faster.”

Participant 9 stated, “I have made friends with the house keeping staff. I see them all the time and I appreciate what they do.”

Summary of Theme 2: Caring Behaviors Experienced

Although 100 % of participants reported experiencing some type of caring behaviors; currents of incivility were still experienced, contributing to a decreased duration of the honeymoon phase (Kramer, 1974) and promoting fear and apprehension related to their role as NGRN. All study participants reported good working relationships with their preceptors. Most of the participants reported having at least one other coworker in which they had developed a relationship with. Several participants acknowledged that

incivility continues to exist. Other participants did not report incivility as a significant issue. Although negativity was experienced in the workplace, participants reported that they experienced caring behaviors by coworkers, administration, and others in the clinical setting. The caring behaviors experienced, allowed them to look past negativity which was experienced in the workplace. Participants reported that the caring behaviors experienced encouraged them to persevere in the NGRN role.

Theme 3: Applying Previous Knowledge to Clinical Practice

All participants reported that their previous educational training prepared them to begin working as a nurse. Consensus to previous nursing education was that it was not enough to prepare them for the challenges of working on the floor as a nurse, in the acute care setting. Items identified under this theme included the differences between paramedic students and regular nursing students, confidence, critical thinking, prioritizing care, organizational skills, and nursing assessments.

Becoming a nurse requires nursing experience. One participant reported that their nursing license was a license to continue to learn to be a nurse. Previously trained paramedic NGRNs reported that their experience in the field of emergency medicine provided a solid foundation in which to practice their new nursing careers. Two participants reported that they felt that they had to repeat nursing school during their hospital orientation.

> Participant 5 voiced, “I was told in nursing school that my nursing license was a license to continue to learn. I didn’t understand that until I began working as a nurse on the floor.”

Participant 11 responded with, When I was working in the field, I had to develop my critical thinking skills and sometimes I had to improvise. I had to be organized and use my time effectively. Working as a paramedic prepared me to work as a nurse. Other nurses that were in my nurse residency program didn't seem to have very good critical thinking. They were easily flustered and didn't prioritize very well.

Participant 1 shared, …I wish I had more experience working with a patient load in nursing school. We managed 1 patient during our clinicals. When I started working as a nurse, I had 6 patients. It is very hard to care for 6 patients at a time. As a nurse intern, they spent weeks reteaching me all the clinical skills I learned in nursing school. It would have been better if they had taught us something different. It would have made me feel more confident taking care of patients as a new nurse.

Participant 9 reported that, during my orientation period the instructor taught to all the skills we had previously learned in nursing school. It would have been more beneficial if they had let us float to other departments or had other departments such as surgery or respiratory present new things to us.

Summary of Theme 3: Applying Previous Knowledge to Clinical Practice

All study participants reported that previous knowledge helped support their transitional experience as a NGRN. Concerns were presented by some participants that their development would have been enhanced if the instructors they had in their nurse residency programs had assessed their previous nursing skill procedure knowledge and

expanded upon their existing knowledge base. Nurses previously trained as paramedics reported that their previous paramedic training was as asset which increased their confidence to work as a new nurse. Critical thinking skills reportedly were underdeveloped in the regular nurses compared to the nurses that were previously trained as paramedics. Nurses previously trained as paramedics reported a higher level of confidence with organizational and assessment skills, than did the regularly trained nurses.

Theme 4: Cultural Differences and Transitioning

Various cultures and cultural experiences were reported among study participants. Hispanic male and female participants, non-Hispanic males, and females, and 4 females with previous paramedic training participated in this study. Non-Hispanic males and non-Hispanic females reported the most incivility. Male and female Hispanic study participants were reportedly the least effected by incivility. The paramedic trained NGRNs were all female and non-Hispanic. The incivility they reported was culturally different compared to how they had been treated as female paramedics. All the female paramedics reported that that had previously experienced sexist behaviors from their male coworkers. These same NGRNs denied experiencing sexist behaviors from their male, nursing, coworkers.

> Participant 1who was Hispanic shared, “Everyone treated me very well. I didn’t have any problems with the people I worked with.”
>
> Participant 9 who was Hispanic stated, “everyone has been very nice to me. I haven’t experienced any problems with the other staff.”

> Participant 2 noted, “as a male, I believe I was asked to help with lifting, repositioning, and dealing with crazy or difficult patients, more than the other female nurses were.”
>
> Participant 12 shared that, The male paramedics I worked with in my educational training and in the field, treated me more harshly than they did my male counterparts. I have never experienced that behavior from other male nurses. Compared to what I experienced working as a paramedic, the incivility I experience by other female nurses is nothing.

Summary of Theme 4: Cultural Differences and Transitioning

Cultural differences were observed between gender, race, and previous educational experience. Incivility was pervasive. The differences noted were dependent upon the study participant’s perception of incivility and cultural background. Hispanics were more tolerant of the incivility they experienced than reported by the Caucasian study participants.

Discrepant Cases

The discrepant data in this study was deduced from participant 1. Participant 1 did not identify with transitional challenges expressed by the other 12 participants. Participant 1 was a 27-year-old Hispanic female, with an associate degree in nursing. She reported that everyone treated her well. She did not experience incivility from coworkers. She denied having difficulties transitioning to her role as clinical nurse and felt sorry for those that did.

Aggregate Depiction

This study aggregate depiction is the collective representation of the experiences of the NGRN interviewed for this study and their transitional experiences from student nurse to clinical nurse in the acute care setting. Most of the study participants reported difficulties with transitioning from student nurse to clinical nurse in the acute care setting. Transitional challenges included orientation, role transition, shift work, communication with physicians, and incivility experienced from coworkers. Building relationships with preceptors and other staff members served to decrease anxiety levels and build self-confidence. Having someone to confide in and depend on was significant to assisting the NGRN to persevere in their transitional role as a clinical nurse.

Summary

Chapter 4 provided qualitative data obtained from one-to-one interviews with 13 NGRN transitioning from student nurse to clinical nurse. Participants had a minimum of an Associate degree in nursing, had not been an LPN prior to obtaining the RN license, lived, went to nursing school, and worked in the state of Florida, and had been working as a clinical nurse for less than one year. Findings of this study indicated that NGRNs have difficulty transitioning from student nurse to clinical nurse in the acute care setting in hospital settings across the state of Florida. Participants reported there were factors that could have improved their initial transitional experiences. Nursing school clinicals expanded to include taking care of more than one patient at a time to develop better time management and triage skills related to patient care, instead of learning these skills as a NGRN. Improved orientation within the acute care setting of the hospital which

expanded upon their nursing education and did not reteach skills and education that had previously been taught in nursing school. Maintaining the same preceptor throughout their orientation to the hospital unit was recommended to build consistency and self-confidence. Participant 3 reported that his preceptor was occasionally floated to units in which they were not familiar. Participant 3 shared that he was told that "shadowing his preceptor during his orientation experience would be a good learning opportunity." Participant 5 shared that, "when my preceptor was floated to another unit, I was placed with a different nurse that didn't want to precept me." Learning to communicate effectively with physicians related to providing patient report and requesting order updates was another recommendation made by NGRN. Respect by all staff, at all times, was voiced as a major contributing factor for a positive transitional experience. Most participants reported that they did not feel respected by all staff, at all times. Developing a positive relationship with at least one individual on their work unit, encouraged NGRNs to persevere with their transitional experience. Chapter 5 includes an interpretation of findings, implications for social change, recommendations, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological, qualitative study was to gain insight and understanding about the lived experiences of NGRNs, as they transition to the acute care environment as clinical nurses during their first year of nursing. The lived experiences of NGRNs were studied using 4 major themes: (a) transitioning from NGRN to the role of clinical Nurse, (b) caring behaviors experienced, (c) applying previous knowledge to clinical practice, and (d) cultural differences and transitioning. The focus of this study was to learn and understand what conditions were present from the NGRNs that were successful in transitioning from graduate nurse to clinical nurse, and if caring behaviors experienced in the working environment of the acute care setting made a difference in the NGRN's intent to remain in nursing practice. Findings of this research were consistent with the current literature. Caring behaviors impact the retention of NGRNs (Duffy, 2013) Observations in this study were not present in the literature. Previously trained paramedics transitioning to the role as NGRN did not find the level of incivility shared by nonparamedic trained registered nurses.

The NGRN reports numerous struggles in transitioning from graduate nurse to clinical nurse, as a NGRN that are relevant and validate the meaning of lived experiences during their transitional period from graduate nurse to clinical nurse working the acute care setting. Chapter 5 includes a discussion of the conceptual framework, limitations of the study, recommendations, and implications for positive social change.

Interpretation of the Findings

The intent of this study was to explore the challenges faced by NGRNs transitioning from graduate nurse to clinical nurse and how they may experience reality shock may be related to caring behaviors described by (Duffy, 2013) and reality shock (Kramer, 1974). Data analysis was completed looking through the lens of Duffy's caring behavior (2013) and Kramer's reality shock (1974) and indicated that there were 4 themes and 4 subthemes. Each of these themes will be examined and discussed. According to this study, perceived levels of incivility are clearly affected by cultural and historical experiences. There was limited literature which identified specific cultural differences and caring behaviors. Research participants identified with Kramer's theory of reality shock (1974). One participant stated that the perceived negativity she experienced from coworkers shortened the honeymoon phase (Kramer, 1974) of being in her position as clinical nurse. Other participants reported that the negativity they experienced was less than previously experienced in other employment experiences. Another participant reported that she experienced caring behaviors from everyone she encountered withing organization.

Theme 1: Transitioning from NGRN to the Role of Clinical Nurse

Transitioning from student nurse to clinical nurse posed various challenges for the NGRN. Current literature speaks to the need for effective orientation, teaching soft skills such as communication with physicians and other coworkers, and practicing critical thinking which can be developed by increasing the number of patients a student cares for during their clinical rotations in nursing school. According to Shirazi and Heidari (2019),

a significant relationship exists between learning style, academic achievement, and the development of critical thinking skills. Developing critical thinking skills among nurses needs to be included in the nursing curriculum (Shirazi & Heidari, 2019). Critical thinking skills among nurses improves patient outcomes (Ali-Abadi et al., 2020; McCartney, 2017).

Limited orientation and the lack of communication skills contributed to a difficult transitional experience for NGRNs. The literature validates that NGRNs experience challenges when critical thinking skills are limited (Jefferies et al., 2018). Challenges experienced by NGRNs included adjusting from caring for more than one patient during their shift, adjusting to shift work, and having poorly developed time management skills. The majority of NGRNs began working night shifts as they began their roles as clinical nurses. Challenges specific to this included limited availability of necessary resources on night shift such as other seasoned nurses to consult regarding nursing procedures, and the physical adjustment to working during the night. Orientation was a popular concern reported by research participants. This is consistent with the literature. (Dyess & Sherman, 2009; Pertiwi, & Hariyati, 2019). NGRNs reported that orientation did not assist with the transitional process from student nurse to clinical nurse in that they were retaught clinical procedures learned in nursing school and encouraged to demonstrate previously learned clinical skills. These same NGRNs suggested that exposing them to new procedures and learning opportunities would have increased their confidence levels during their transitional period. One participant reported communication breakdown

when attempting to call a physician and provide an update related to the patient's condition.

Theme 2: Caring Behaviors Experienced

Relationship development is an important aspect for the transitioning NGRN. The NGRN encounters new challenges such as shift work, incivility, varying cultures, time management and other learning opportunities. Navigating relationship development withing the hospital and on their respective units is yet one more opportunity. Various relationships exist within the acute care setting to include nurse to physician, nurse to nurse, nurse to ancillary staff, nurse to administration. Having others to confide in and depend on during the transitional phase as a NGRN helps decrease existing anxiety levels (Duffy, 2009, 2013). The establishment of a relationship requires effective communication between sender and receiver (Park, 2017). According to Irwin et al. (2018), Preceptor relationships can influence confidence and competence. According to Concordia University St-Paul (2017), https://online.csp.edu/blog/business/interpersonal-communication-in-the-workplace interpersonal communication is a strong factor for developing strong teams. When NGRNs felt that they were part of the team, they were more content withing their new nursing role. Necessary attributes of interpersonal communication include the ability to listen actively, effectively interpret nonverbal communication, culture, and conflict resolution skills. When NGRNS were able to effectively engage in communication with the physicians, patients and other coworkers, job satisfaction was improved (Duffy, 2009, 2013). Being prepared with relevant information requested by a physician during telephone conversations is one way the

NGRN can decrease the anxiety of speaking with a physician according to Rivier University https://www.rivier.edu/academics/blog-posts/talking-it-out-improving-nurse-physician-communication

Theme 3: Applying Previous Knowledge to Clinical Practice

My findings did identify differences in the perceptions of caring behavior based on previous clinical practice. Paramedics with previous experience in high stress environments seem to adjust better to the acute care setting and perceived an increase in caring behaviors in the clinical environment. Nurses with limited clinical experience experienced fewer caring behaviors. Previous experience influenced perceptions of caring behaviors by participants. This finding was consistent with the literature regarding orientation and communication (Duffy, 2009, 2013; Irwin et al., 2018). Tacit knowledge is defined as "knowledge, which is used intuitively and unconsciously, which is acquired through one's experience, characterized by being personal and contextual" (Pérez-Fuillerat et al., 2018). The experience that the paramedics brought to the acute care setting could be considered tacit knowledge (Pérez-Fuillerat et al., 2018), with the need for an orientation process tailored to the paramedic transitioning to the bedside (Melin-Johansson, 2017).

Theme 4: Cultural Differences and Transitioning

The traditional Hispanic patriarchal structure grants the father or oldest male relative the greatest authority, whereas women are expected to show submission (Kemp & Rasbridge, 2004). Hispanic male study participants did not report experiencing incivility as they transitioned from student nurse to clinical nurse. Paramedic study

participants although Caucasian, were more tolerant of the nursing incivility because they had experienced sexist behaviors from their male counterparts in the Emergency Medical Services (EMS) environment. Trust is considered another key factor for relationship development (Blanchard Olmstead & Lawrence, 2013). Female, Hispanic NGRNs verbalized a more trusting relationship with their preceptors than did their non-Hispanic counterparts. Cultural differences among male and female nurses were evident in this research. As reflected in the literature, male nurses occupy a smaller percentage of the nursing population.

Limitations of the Study

Researcher bias is a fundamental concern for researchers (Patton, 2015). The trustworthiness of this study has an impact on the data interpretation used to identify the quality of the research study (Polit, & Beck, 2018). To overcome interviewer bias, I participated in a peer review process consulting other professional nurses about the interview questions. Significant effort was take taken to develop qualitative interview questions to ensure trustworthiness. This study was limited to the participants in the southeastern US. This is significant in that working conditions may differ from state to state. Many of these participants were from rural hospitals. Larger hospitals may have significantly more resources available for the NGRN. This research does not include the training of the nurse manager or other leadership responsible for developing the NGRN, which may be relevant to the success of the individual.

Recommendations

The empirical research conducted by this study affirmed the findings in the literature that depicts the association of caring behaviors and successful transition of NGRNs (Duffy, 2013). The literature is limited on the association between the NGRN transitional experience from student nurse to clinical nurse, and the caring behaviors they experience during their first two years of transition (Duffy, 2009, 2013). Future research on NGRNs and the effect of caring behaviors during the transitional first two years should be conducted in larger acute care settings. This venue would serve to advance the literature and provided a better understanding of the association of NGRNs and the effects of caring behaviors on the first two years as a clinical nurse. Additional qualitative studies involving paramedics who transitioned from paramedic to registered nurse would be of interest, as would interviewing male paramedics who transitioned to the registered nurse role in the acute care setting of the hospital. A mixed methods studies comparing the effect of caring behaviors would be beneficial for enhancing the current literature.

Practice Implications

This study allowed the research participants to share their lived experiences of transitioning from student nurse to clinical nurse in the acute care setting of the hospital. My recommendations are directed to (a) nursing administration of the hospital, (b) nursing program administration, and (c) further research that came directly from the research findings including providing nursing students the opportunity to care for a patient load, prior to graduating and having to assume this responsibility without instructor input and guidance. Focus more on time management skills and critical

thinking skills (Leis & Anderson, 2020). Allow nursing students the opportunity to notify the primary care provider during their clinical rounds to allow the physicians' an opportunity to become familiar with the student nurse and to build the student nurse's confidence level, prior to assuming this responsibility, when they do not have instructor oversight and guidance (How to become a nursing instructor, n.d.). Provide NGRNs with an orientation experience that builds on skills previously learned in nursing school. Introduce NGRNs to new experiences and allow other departments within the hospital to share meaningful information (Pertiwi, & Hariyati, 2019). Adopt a zero tolerance of incivility from all staff, changing the existing culture (Crawford et al., 2019). This will provide a more positive transitional working experience for all NGRNs.

Positive Social Change

My goal for contributing to positive social change was to conduct a qualitative study that provided knowledge useful for nursing educators, nursing leadership, and healthcare organizations, who wish to focus on the retention of NGRNs during their first year of transition to the acute care environment. The long-term implications encompass nursing retention, improved psychosocial adjustment for NGRNs through decreased stress and anxiety, and improved patient outcomes within the acute care environment of the hospital. Demonstrating caring behaviors with NGRNs has tremendous impact on organizational outcomes, which include positive patient outcomes (Duffy, 2009, 2013). This research identified an association of caring behaviors and the NGRNs feelings of connectedness during their initial transitional period from student nurse to clinical nurse during the first year of practice. This association provides a bases for developing

outcomes that will improve motivation, morale, and overall positive outcomes for the NGRN, patients, and the organization (Duffy, 2009, 2013). Focusing on the critical thinking skills, time management, and communication with the physician or primary care provider prior to graduation, may create a more self-confident NGRN (Irwin et al., 2018). This study identifies specific elements within the acute care environment that can be incorporated in nurse residency programs, nursing education programs, and to provide significant change in the way leadership implements staff development. The improved staff development outcome would benefit society by providing caring professionals that would improve patient outcomes.

Conclusion

The purpose of this study was to gain insight on the lived experiences of NGRNs as they transition from student nurse to clinical nurse, working in the acute care environment of the hospital. I was also interested in learning if caring behaviors exhibited by other nursing staff, nursing leadership and others in the acute care setting made a difference in the NGRN's intent to remain in the nursing profession within the acute care environment of the hospital. Key findings of this study revealed that caring behaviors exhibited towards the NGRN promote positive outcomes for remaining in the position of clinical nurse. NGRNs continue to experience incivility in the workplace from other registered nurses and that a NGRN has previous training as a paramedic, the incivility experienced is not as predominant as the incivility experienced working as a paramedic. Exposing the student nurse to a case load of patients and practice contacting physicians prior to graduation would be beneficial for the NGRN. More concise orientation periods

which focus on building on the NGRN's previous knowledge base would be a more beneficial use of the allotted orientation period provided to the NGRN. Adopting a zero tolerance for incivility among all employees would be beneficial for nursing leadership and other staff members within the acute care setting of the hospital and prolong the honeymoon phase as described by Kramer (1974), and satisfaction of the NGRN.

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Appendix A: Interview Protocol

The following interview questions will be used to obtain data for this study:

1. Tell me about your experience in transitioning from nursing school to the acute care setting of the hospital.
2. Tell me about any challenges you may have experienced during your transition.
3. Tell me about the orientation training you received when you started at this facility.
4. Tell me about the relationships you have developed with other nurses at this facility.
5. Tell me about the relationships you have developed with nursing administration at this facility.
6. Tell me about the support you have received from others during your transition as a new nurse.
7. Tell me, what if anything could have made your transitional experience better?

Appendix B: Demographic Data Form

Demographic Data

Name_____

Alias Name_____

Telephone number_____

Email Address_____

Works in a Hospital setting? How long working in the hospital? _____
What unit? _____

RN____ADN_____BSN___MSN___other

Ethnicity_____