

**The journey from new graduate to proficient nurse  
in the Intensive Care Unit:  
A descriptive phenomenological study**

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# Declaration

I declare that:

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committee (where required).

.....

Farida Saghafi

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## ABSTRACT

### **The journey from new graduate to proficient nurse in the Intensive Care Unit:**

#### **A descriptive phenomenological study**

**Aim:** The rationale for study was the increased need for critical care services, the shortage of experienced critical care nurses, and the unidentified factors affecting nurse retention after completion of New Graduate/Transition to Practice Program in the critical care area. New graduate nurses were provided with an opportunity to share their experiences as they developed and achieved levels of proficiency over time in Intensive Care Unit (ICU). Although most new graduate nurses in New South Wales (NSW) progress through a Transition to Practice Program, limited research has been conducted concerning their lived experience of what they deem to be important about entering and remaining in the work force, especially in ICU. The day-to-day experiences of the participants in an ICU in NSW were explored in order to gain insights into how that experience impacted on the ways in which the neophyte nurse acclimatised and gradually advanced in proficiency and to understand how the experience changed over time.

**Design:** A descriptive phenomenological approach involving graduate nurses was deemed the most appropriate method to discover their lived experiences. The study design comprised three phases: 1) conducting a survey to assist in the development of interview questions, 2) undertaking semi-structured interviews with ten new graduate nurses in ICU, and 3) repeat interviews two to four years later with five participants from Phase Two. Data was collected using in-depth, semi structured audio-recorded interviews that were transcribed, coded, and analysed using Colaizzi's approach, until themes emerged. Benner's model of novice to expert was used as a philosophy to reveal how knowledge and skills acquisition for new graduate nurses occurs in ICU.

**Findings:** The five dominant themes that emerged from Phase Two were *Perception of ICU, Feelings, Interaction with others, Expectations of performance, Journey of novice nurse*. Phase Three of study generated the following themes: *Perception of ICU, Feelings, Interaction with others, Expectations of performance*. The nurses while completing their nursing degree find ICU a desirable workplace to start their career after graduation. ICU is perceived as a stimulating learning environment. The nurse changes



within themselves as they acquire skills, knowledge, and the attitudes of an ICU nurse. They become accepted in the ICU environment and move towards proficiency as a professional learner.

**Conclusion:** In the process of learning and constructing the meaning of the journey from new graduate to proficient nurse, multiple factors affected how participants perceived the phenomenon in ICU. These factors for new graduate nurses were:

- unclear level of expectation
- perceptions of the ICU environment (overwhelming or conversely challenging but fulfilling)
- receiving feedback (negative or conversely positive)
- Interaction with others (being excluded or conversely being included as part of the team)

The factors affecting the nurses with two to four years experience perception were:

- higher levels of expectations (broader roles and responsibilities)
- perception of ICU environment (challenging and yet fulfilling)
- interaction with others (mentoring and supervising, giving support)

In dealing with reality of the workplace, the new graduate nurse did not seem well prepared. Negative feelings that emerged during New Graduate/Transition to Practice Program were due to not understanding, or not accepting, the meaning of 'being a novice' and that level of expectation. As the journey of participants progressed, they were continuously involved in professional learning and they achieved different levels of proficiency. This research identified key professional and personal changes on the journey from novice to proficient nurse in ICU. The participants initially expressed feelings of self-blame but, as they became more proficient, and although had not yet reached the expert level, they were able to adopt critical self-reflection attributes.

**Recommendations:** New graduate nurses practising in ICU need more than clinical nursing knowledge and skills. They need to be prepared for practice. This can be achieved by including ICU clinical placement in the third year of undergraduate program, training in time management, communication, and critical thinking skills. Retaining

nurses who have completed New Graduate/Transition to Practice Program in ICU requires maintaining stimulating learning environment through targeted supportive educational planning. This consists of preceptor and mentor training, practicing evidence based nursing, and developing team/organisational learning.

## Glossary of Terms

Term	Explanation
Burnout	emotional exhaustion due to prolonged work stress (Maslach, 2003)
Competent	a nurse with two to three years experience who sees their actions in terms of long-range goals or plans (Benner, 1982, pp. 404-405).
Confirmability	the data represents the information participants provided and the interpretations of those data are not invented by the inquirer (Lincoln & Guba, 1985b, p. 299).
Credibility	confidence in the truth of the data and interpretations of them (Lincoln & Guba, 1985b, p. 300).
Critical reasoning	the process by which clinicians collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process(Levett-Jones et al., 2010, p. 516).
Dependability	the stability ( reliability ) of data over time and conditions (Lincoln & Guba, 1985b, p. 299).
Intensive Care Unit	a section of hospital with specialised staff and specific equipment where patients with life threatening illnesses, injuries or complications are treated and nursed (College of Intensive Care Medicine of Australia and New Zealand, 2011).
Interprofessional relationships	the development of a cohesive practice between professionals from different disciplines (D'Amour, Ferrada-Videla, San, Rodriguez, & Beaulieu, 2005).
Interpersonal communication	a cyclic, reciprocal, interactive, and dynamic process, with value, cultural, and cognitive variables, that influence transmission and reception (Arnold, 2011, p. 13).
Interpretive phenomenology	focuses on describing the meanings attributed by individuals being in the world and how these meanings influence the choices that they make (C. Carpenter, 2013) .
New Graduate Nurse	one who has completed a Bachelor of Nursing course and is registered with the Nursing and Midwifery Board of Australia in the last 6 months.
New Graduate Nurse Program Transition to Practice Program Transition to Professional	a 12-month program offering new graduate nurses and midwives consolidated clinical support and education study days, which go beyond normal orientation and induction of new employees. It includes opportunities for rotations to different areas of the organisation (NSW Ministry of Health, 2013, p. 5).

Term	Explanation
Practice Program  Early Graduate Nurse and Midwife Programs	
Novice	a beginner with no experience with the situation in which they are expected to perform tasks (Benner, 1982, p. 403).
Proficient	a nurse who perceives situations as wholes, rather than in terms of aspects; a proficient nurse knows what typical events to expect in a given situation and how to modify plans in response to those events (Benner, 1982, p. 405).
Reality Shock	shock-like reaction that occurs when as individual who has been reared and educated in that subculture of nursing that is promulgated by schools of nursing, suddenly discovers that nursing as practised in the world of work is not the same - it does not operate on the same principles (Kramer, 1985, p. 891).
Transferability	the extent to which findings can be transferred to or applied in other settings or groups (Lincoln & Guba, 1985b, p. 297).

# Chapter 1

## Introduction and Background

*In this chapter, the reader is orientated to purpose and outcomes of the research. Background information that provides a rationale for the research is presented. A descriptive phenomenological design is used to explore the phenomenon of interest. The purpose, significance, and limitations of the study are highlighted. The research plan is described and a brief overview of the study is given.*

### 1.1 Introduction

The changes and improvements in patient management, both clinically and technologically, in intensive care nursing, increase the need to adapt quickly, effectively and efficiently. This may cause additional pressure for the new graduate nurse, still grappling with the transition from student to the role of registered nurse. There has been much research about the phenomenon of the transition of the new graduate nurse (Gerrish, 2000), however, there is a paucity of research about the experience of being a new graduate nurse in an ICU. The purpose of this research, therefore, is twofold: firstly, to explore the meaning of being a newly qualified nurse (graduate) in an ICU, gain insight into how this experience impacts on the way the new graduate nurse acclimatises and gradually becomes a proficient nurse; and, secondly, to understand how this experience changes over time.

The impetus for this study arose from reflections on my own experiences and observations of newly qualified nurses. My experience of working for 18 years in different roles in ICU has given me enough confidence to deliver optimum care to critically ill patients. One of my experiences of working in ICU has been satisfaction with experiences that are common in ICU such as being part of a Cardio-Pulmonary Resuscitation (CPR) team or weaning a patient off a ventilator after couple of days. However, when I thought about new graduate nurses I wondered what their experience was in such an environment. A number of questions immediately came to mind that might impact on providing positive experiences, increased job satisfaction, role adaptation and improved retention such as (C. Jackson, 2005):

- how do new graduates feel about this role?
- what are their needs? Are they being met?
- why do they desire to work in an ICU?
- does this experience influence their future careers?
- does it encourage them to see themselves as skilful expert nurses in the next few years or might a negative experience cause them to leave ICU or the nursing profession for good?

The significance of researching issues surrounding the experiences of new graduates in an intensive care environment and the meaning of being a new graduate in ICU as a phenomenon is important. Answers to such questions lends itself to a phenomenological approach, where the objective is to identify the essence of the behaviour (Kleiman, 2007). Therefore, it is important to understand the philosophy that underpins the phenomenological approach.

Phenomenology as a philosophy is the study of social reality from the perspective of the individual in the situation (Schutz, 1962). To guide data collection and the analysis process, protocols have been developed by phenomenologists including Colaizzi (1978), Giorgi (1979), Schutz (1962) and Van Kaam (1959).

In this study, the phenomenon of being a new graduate nurse in ICU is explored. However, what being a new graduate nurse means will be different for each individual as each has diverse previous experiences. Since 2010, most new graduate nurses in NSW have progressed through a New Graduate Program. In some states, this is referred to the *Transition to Practice Program* (see p. 4). There is limited research concerning the lived experience of the novice nurse in ICU and what they deem important about entering the work force and continuing in nursing, particularly in highly technical environment.

## **1.2 The structure of the study**

The study consisted of three phases, Phase One, Phase Two, Phase Three. Phase One involved surveying eighteen new graduate nurses in their first six months of the New Graduate/Transition to Practice Program, who worked in different clinical areas. This survey helped in the development of the interview questions. Phase Two and Three

illustrated the journey for the participants. Phase Two consisted of interviewing ten new graduate nurses working in ICU (describing the beginning of their journey). Phase Three involved re-interviewing five of the participants from Phase Two (reflecting on the developmental stage of their journey). Data from Phase Two were compared with that of Phase Three. Figure 1.1 outlines the structure of the study.

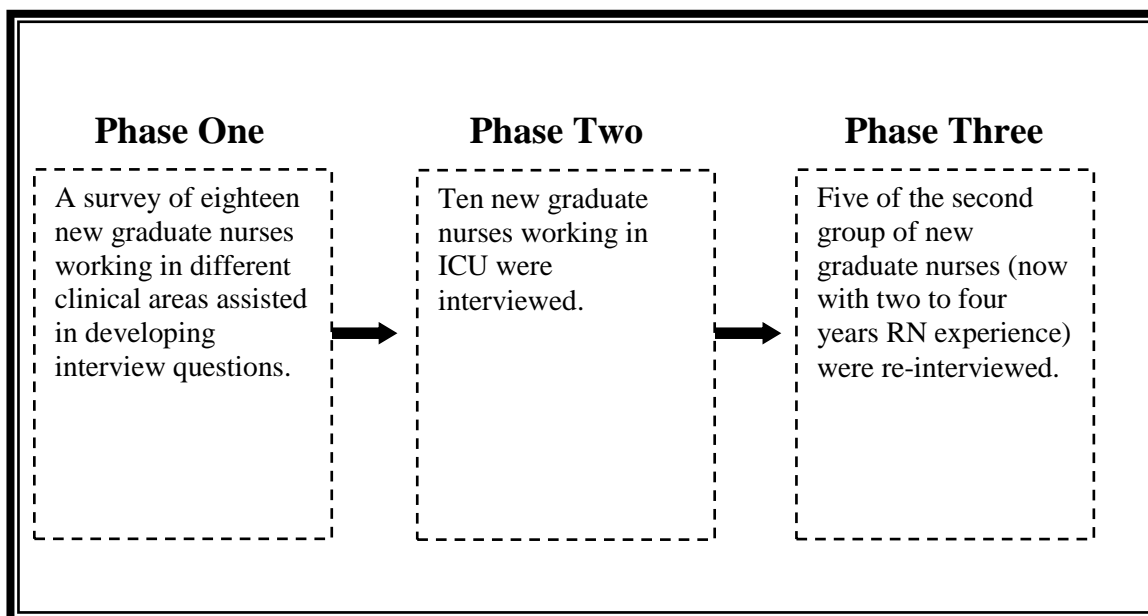


Figure 1.1 Structure of the study as it progressed through three consecutive phases.

### 1.3 Background

Most new graduate nurses in NSW, after completing a pre-registration university degree, progress through a New Graduate Program (Transition to Practice Program) in their first year of practice. This program was designed almost two decades ago to ease the role transition from student to employee registered nurse.

Many nurses choose specific clinical areas where they propose to practice as registered nurses, based on their undergraduate (pre-registration) clinical practicum experiences. Studies suggest that working in an adult acute care setting, such as critical/intensive care, is significantly more desirable for student nurses than other areas of nursing practice (McCann, Clark, & Lu, 2010). This may be attributed to the high levels of technology in use in intensive care as first described by Happell (1999). In a recent survey of final year nursing students from a multi-campus Australian university, Halcomb, Salamonson, Raymond, and Knox (2011) reported that the main reasons for choosing critical care

nursing were: varied and challenging work; opportunities for professional development; and working one-on-one with patients. Unfortunately, a desirable experience for the pre-registered student cannot always be replicated for newly registered nurses. Yet, critical care has proven to be one of the most desirable specialities chosen by new graduates (Halcomb et al., 2011). This environment exposes them not only to reality shock, common among new graduate nurses, but also to stress about their performance resulting from the acuity of the patients and the need for critical thinking (Kramer, 1974; Li & Lambert, 2008).

The process of transition from student to registered nurse is a stressful experience. Numerous studies relating to new graduate nurses have been conducted since 1974, and they describe: reality shock (Rush, Adamack, Gordon, Lilly, & Janke, 2013); inadequate preparation in pre-registration courses for the work situation (Walker et al., 2013); different culture between the educational institution and the hospital setting (Romyn et al., 2009); lack of support during the initial period post qualification (Szutenbach, 2013). The unexpected increase in responsibilities following registration and awareness of their own accountability is highlighted as sources of stress for new graduate nurses (E. M. Chang & Hancock, 2003). Another cause of anxiety for newly qualified nurses is deficits in management and organisation skills (Clark & Springer, 2012). They usually feel under pressure to complete the ward routine before the next shift (Pellico, Brewer, & Kovner, 2009). However, the transition seems to be easier if the New Graduate /Transition to Professional Practice Program in the hospitals includes better support (p.22).

### **1.3.1 Transition to Professional Practice Program**

Historically, nursing preparation in Australia was conducted in hospital training schools. From the 1970's onward, there were numerous inquiries into nurse education. In 1978, the Tertiary Education Commission reported issues relating to hospital based nurse education and training, such as, inadequate preparation, quality of nursing care, and lack of qualified nurse educators. Finally, on 24 August 1984, the Commonwealth government announced the transfer of registered nurse preparation from hospitals to higher education institutions (Department of Education Science and Training, 2001).

Further review of changes to nurses' education brought debates about the clinical skills of new graduates and what was expected after employment in the hospitals (Levett-Jones,



2005). It was recognised that the new graduates from universities were different in terms of starting competencies from those prepared in hospital based training programs (apprenticeship). In 1988, the NSW Department of Health provided funding for the introduction of a structured orientation program in health care facilities employing newly registered nurse. Since 1989, the majority of acute care health facilities offer specific programs to support new graduate nurses, in order to facilitate a smooth transition from student to the role of registered nurse. Whilst graduate nursing programs are desirable they are not compulsory. The programs vary in length from 6 to 12 months and components of the program are: orientation, preceptorship, clinical rotation, in-service education, study days, and overall supervision by clinical co-ordinators (Department of Health and Human Services Tasmania, 2012; Department of Health Australian Capital Territory, 2012; Department of Health Northern Territory, 2012; Department of Health Queensland, 2012; Department of Health South Australia, 2012; Department of Health Victoria, 2012; Department of Health Western Australia, 2012).

Although the aim of New Graduate/Transition to Practice program in all states is the same, each state and health facility in Australia follows its own model for new graduate transition (Table 1.1). For example, in a facility in Victoria new graduate nurses start the program with two weeks of orientation/supernumerary period. During this time, they will undertake skills workshops (including activities such as intravenous practical skills, safety with medications, and documentation) and also a comprehensive hospital orientation (The Royal Melbourne Hospital, 2012). In a facility in NSW, they may commence the program with a three-day hospital, nursing transition program orientation. Participants are offered the choice of a dedicated stream to spend 12 months in one speciality or the option of rotating through two clinical areas within the program. New graduates are required to attend two study days during the program based on topics of clinical relevance. They are also encouraged to undertake and contribute to specific learning activities such as clinically relevant educational in-services, and case study presentations provided by clinical areas (St Vincent's Hospital, 2012).

The purpose of New Graduate/ Transition to Practice Program is to meet the needs of the newly registered nurse. The program provides a supportive environment where new graduate nurses acquire further knowledge that facilitates professional competence. New

graduates interested in working in ICU need to develop organisational skills and build confidence in their ability to care for critical patients.

Table 1.1 Summary of graduate programs across Australia- Almost every state identifies the program by a different name. This table illustrates the common aims of new graduate nurse programs at a national level.

State	Program Title	Aim	Examples of what is offered
<b>Northern Territory</b>	Graduate Registered Nurse program	To provide a broad range of experiences and specialist opportunities, excellent cross cultural experience and support as they develop Nursing skills and knowledge (Department of Health Northern Territory, 2012).	<ul style="list-style-type: none"> <li>• allocated two, or three clinical placements.</li> <li>• comprehensive orientation and induction program</li> <li>• supernumerary clinical days</li> </ul>
<b>Queensland</b>	Graduate transition program	To provide the opportunities to expand and explore new graduate nurses professional practice while working in a structured program that facilitates socialisation, clinical competence and participation within a multi-disciplinary team environment (Department of Health Queensland, 2012).	<ul style="list-style-type: none"> <li>• three four-month placements, or 12-month placements on one unit</li> <li>• paid study days</li> </ul>
<b>New South Wales</b>	Transition to Practice Programs	To provide a range of clinical experiences to equip newly graduated RNs and RMs with the necessary skills and confidence to practice as a Registered Nurse or Midwife (NSW Health Department, 2012).	<ul style="list-style-type: none"> <li>• three four-month placements, or 12-month placements on one unit</li> <li>• paid study days</li> <li>• formal orientation to the health service</li> <li>• regular debriefing</li> </ul>
<b>Australian Capital Territory</b>	Graduate Nurse Program	To provide a high level of clinical and professional support, care, feedback and guidance during the transition from student to Registered Nurse. To assist them to build upon knowledge and skills and become professional Registered Nurses (Department of Health Australian Capital Territory, 2012).	<ul style="list-style-type: none"> <li>• clinical rotation options of one to three specialities</li> <li>• specific graduate orientation day.</li> <li>• 2-day hospital and nursing orientation.</li> <li>• 2 - 3 supernumery induction days at the beginning of each rotation</li> </ul>
<b>Victoria</b>	Early Graduate Nurse and Midwife Programs (EGPs)	To provide an environment where new graduates can consolidate and further develop their knowledge, skills and competence (Department of Health Victoria, 2012).	<ul style="list-style-type: none"> <li>• two x 6 month clinical rotations</li> <li>• orientation program including paid professional study days</li> </ul>
<b>South Australia</b>	Transition to Professional Practice Program (TPPP) for Registered Nurses	To facilitate a supportive environment to enable new graduates to undertake a process of developing positive attributes and attitudes to work, skill consolidation; building clinical confidence and defining their professional responsibilities and boundaries (Department of Health South Australia, 2012).	<ul style="list-style-type: none"> <li>• allocated one or two clinical placements (6-12 months)</li> <li>• ongoing mentoring</li> <li>• paid professional development sessions</li> <li>• an extensive induction program</li> </ul>
<b>Western Australia</b>	Graduate program	To assist in transition into the nursing and midwifery workforce in a supportive environment (Department of Health Western Australia, 2012).	<ul style="list-style-type: none"> <li>• 6-monthly rotations</li> <li>• comprehensive one-week orientation on commencement</li> <li>• supernumerary days at the beginning of each rotation</li> <li>• structured study days,</li> </ul>
<b>Tasmania</b>	Transition to practice position	To build skills and experience, and lay the foundation for further career development (Department of Health and Human Services Tasmania, 2012).	<ul style="list-style-type: none"> <li>• two clinical placements</li> <li>• supernumerary time in the clinical area,</li> <li>• allocated preceptor support</li> <li>• additional professional development opportunities</li> </ul>

Rush et al (2013) in a an integrative literature review (2000- 2011) regarding new graduate nurses transition noted that despite number of published articles focusing on new graduate nurses, they could not identify best practice in transition programs. They concluded that mentoring and peer support, trained preceptors, and improved work environment would be beneficial to new graduate nurses.

### **1.3.2 Intensive Care Unit**

The College of Intensive Care Medicine of Australia and New Zealand defines an ICU as:

*‘A specially staffed and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening conditions. Such conditions should be compatible with recovery and have the potential for an acceptable future quality of life. An ICU provides special expertise and facilities for the support of vital functions, and utilises the skills of medical, nursing and other staff experienced in the management of these problems’* (College of Intensive Care Medicine of Australia and New Zealand, 2011, p. 1).

The concept of an ICU was developed in the early 1950s. These units were quite similar to an operating theatre recovery room. A poliomyelitis epidemic in Copenhagen in 1952 was the major stimulus for establishing a special area for critically ill patients. The first intensive care unit was established in Copenhagen in December 1953. It seemed that providing long-term artificial ventilation for these patients reduced mortality. Modern critical care units such as CCU (Coronary Care Unit) and ICU evolved in the early 1960s. In 1970s ICUs became a focus for much research, in particular, areas relating to pathophysiology, medical treatment, as well as training and specialised qualifications for staff (Berthelsen & Cronqvist, 2003; Hawker, 2009).

There are a variety of ICUs such as medical, paediatric, respiratory, surgical, neurosurgical, cardiothoracic, and trauma. Primarily they have a common function, i.e. caring for the seriously ill. The close observation and invasive treatment provided in a ICU cannot be delivered safely in general wards (Craft, Nolan, & Parr, 2004).

Nursing practice in ICU is complex and dynamic, providing a source of human contact in an area of high technology (Figure 1.2). Over the last three decades significant changes

and improvements in clinical and technological management of patients have brought with them pressures on nurses who work in this environment (Wilkin & Slevin, 2004). It is recognised that such a high technology environment with patients who are critically ill makes for a stressful atmosphere (see Appendix 1). As a result, the risk of ‘burnout’ among the nurses who work in the ICU is greater than nurses who work in other areas (Azoulay & Herridge, 2011; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009; Poncet et al., 2007).



Figure 1.2 - Complexity of care in ICU

This figure illustrates a patient receiving care from a nurse, surrounded by specialised equipment including cardiac monitoring, ventilator, dialysis machine and a number of intravenous infusions.

### **1.3.3 Interpersonal communication and interprofessional relationships**

One of the most important issues in the working life of a nurse is interpersonal communication. Arnold describes ‘interpersonal communication [as] a cyclic, reciprocal, interactive, and dynamic process, with value, cultural, and cognitive variables that influence its transmission and reception’ (2011, p. 13). Interpersonal communication has two dimensions: relationship and content. The elements of interpersonal relationship are: self-awareness, trust, respect, acceptance, sharing or transferring information, mutual understanding, collaboration and power of control (Chitty, 2011; Duldt, Giffin, & Patton, 1984).

An interprofessional relationship is defined as ‘the development of a cohesive practice between professionals from different disciplines’ (D’Amour et al., 2005, p. 1). In interprofessional relationships, collaboration is an essential element. The aim of collaboration is to address the needs of patients effectively by working cooperatively towards a common goal. Collaboration requires mutual trust, shared decision making about patient care, respect and open dialogue among members of the health care team (Burkhardt & Nathaniel, 2002; D’Amour et al., 2005).

Traditionally doctors have been trained with a focus on expertise, autonomy, responsibility, more than interdependence, deliberation, and dialogue. As a result, doctors were self-reliant and independent. Conversely, nurses have been trained to work with others and follow rules and hierarchy. Both traditions become barriers to a collaborative model (Wagner, Liston, & Miller, 2011).

New graduate nurses in ICU, as new members of the team are expected to experience interprofessional collaboration where different professions coordinate their services in a dynamic way to meet the needs of patients and serve professional needs. Concepts of sharing, respect, trust, mutual dependency and shared power are related to collaboration (D’Amour et al., 2005; The Interprofessional Commission of Ohio, 2003).

In the management of critically ill patients, an interdisciplinary approach to treatment is necessary due to the complexity of patients’ conditions and the demanding workload. Care in such areas is often seen as a medically driven speciality. However all members of the multidisciplinary team, specifically nurses, have a crucial and key role in providing patient care (Rose, 2011). Baggs & Schmitt (1997) in a grounded theory study found that power disparity was the principal barrier to interprofessional collaboration. True collaboration occurs when all disciplines within the health care team are considered as equal partners. Senior and junior staff rate interprofessional communication differently (Reader, Flin, Mearns, & Cuthbertson, 2007). Therefore, it may be asked: *What is the new graduate nurse’s experience when interacting with others?*

#### **1.3.4 Benner’s model of proficiency development**

Patricia Benner’s (2001) work has provided a crucial understanding of how knowledge and skills are acquired. Both the logical and applied aspects of her work have come to be

accepted within the principles of nursing practice and education. Her work provides a useful structure for practice development and offers an explanation as to why nurses with different levels of experience function differently.

In her research titled 'Achieving methods of interprofessional consensus, assessment, and evaluation' she applied Dreyfus and Dreyfus (1980) model with the aim of articulating knowledge embedded in nursing practice, to describe skill acquisition in clinical nursing practice and to suggest the best ways of learning for nurses in different levels of proficiency (Benner, 1982).

At first level of proficiency, a novice has learned to recognise facts and features relevant to a particular skill and act accordingly. They learn through instruction. An important aspect of this stage is that the rules that novices have learned are context-free which results in an inflexible and limited performance. Advanced beginners are able to identify global characteristics of a situation, and these can only be identified through experience. Advanced beginners are excited and eager to learn, but are easily overwhelmed with multiple tasks, interruptions. They cannot recognise subtle patient changes. A competent nurse has the confidence and ability to cope with a wide range of nursing situations, but still lacks speed and flexibility. The practice of a proficient nurse is analytical and fluid. They can recognise when the normal picture does not appear. The proficient nurse perceives a situation as a whole rather than as unconnected occurrences. Progression to the final stage of 'expert' is not as apparent or clear-cut as in the other stages. In this final stage, a nurse is not consciously aware of their practice because each specific situation immediately dictates an intuitively appropriate action. Experts typically do not rely on guidelines to understand the patient's condition and to react using the appropriate action (Benner, 2001; Dreyfus & Dreyfus, 1980).

Benner's model has been widely adopted within nursing education and research (Callaghan, 2011; Henderson, Fox, & Armit, 2008; Larew, Lessans, Spunt, Foster, & Covington, 2006). Conversely, some authors have criticised her work (Cash, 1995; Gardner, 2012; Gobet & Chassy, 2008; Hargreaves & Lane, 2001; Horrocks, 2002). The focus of this critique has been on: not being quantitative; the contentious description of expert level; lack of social knowledge or structure; no explanation on what happens in transition from one stage to other; difficulty in testing; methodological difficulties; bias

toward positive due to selection of participants and small sample size (Altmann, 2007; Gardner, 2012).

Furthermore, Altmann (2007) argues that Benner's model is more a philosophy than a theory. Philosophy is defined as the exploration of effects that underlie reality. Benner's work investigates how nursing proficiency develops and why it develops differently for each nurse. Considering this definition Benner's model fits the description of philosophy.

In this study, Benner's (2001) model of novice to expert was used as a philosophy to reveal how knowledge and skills acquisition for new graduate nurses occurs in ICU.

#### **1.4 Statement of the problem**

Increased need for critical care services and shortage of experienced nurses in Australia has already been identified. Engaging new graduate nurses to work in the critical care setting seems an option to meet the demand for critical care nurses. New graduate nurses, as primary source of staffing in health care facilities are especially drawn to critical care areas, although they might not remain in ICU after completion of their New Graduate/Transition to Practice Program (Australian Health Workforce Advisory Committee, 2002). Health Workforce Australia (HWA) 2025 identified retention of nurses in the workforce as the most significant factor in reducing the gap between supply and demand for nurses.

A review of the current literature presented in Chapter Two reveals a paucity of research regarding the experience of new graduate nurses in intensive care and how graduates progress in their profession following the completion of the initial year. There is a need, therefore, to discover and understand the experience of the journey of nurses in ICU as they develop levels of proficiency. This study gives unique insights into the complex challenges, dynamic relationships, and stressors faced by new graduate nurses and how their perceptions and experiences change over time. This could guide the development of retention strategies to effectively retain nurses in ICUs and assist them in their professional development.

## **1.5 The research question**

All qualitative designs should have an initial research question that can be defined more clearly as the research progresses (National Health and Medical Research Council, 2005). This study is a descriptive phenomenological exploration of the phenomenon, that is, the experience of new graduate nurses in the ICU. It is based on the experience of new graduate nurses in an ICU hospital in NSW. The questions that guide this research are:

1. What does it mean to be a new graduate nurse?
2. What does it mean to be a new graduate nurse in an ICU in a NSW's hospital?
3. How do new graduate nurse experiences changes over time?

Answering these questions opens up the possibility for greater understanding of the experience of new graduate in the unique environment of the ICU. The outcome of the research may inform the development of orientation programs for newly graduated nurses, improve their job satisfaction and retention, and enhance professional relationships in the intensive care setting.

## **1.6 Research design**

Prior to commencing this study it was necessary to decide which research paradigm might assist to explore the questions posed in the most appropriate manner. The initial thought was to undertake an interpretive (Heideggerian) phenomenological study. However Heideggerian method would not have given a pure in-depth understanding of the unique life-world of new graduates practising nursing in ICU without the researcher's prejudgments or presuppositions (Heidegger, 1962). As Husserl (1936, trans. 1970) argues 'life- world' (Lebenswelt) is understood to be what individuals experience pre-reflectively, without restoring to interpretations.

Because I wished to explore the lived experiences of new graduate nurses in the ICU as they progressed to a proficiency over time, I came to the realisation early in the research process, that this topic would be better explored using a descriptive approach.

The study is underpinned by Husserlian phenomenological methodology. The phenomenon is the experience of being a new graduate nurse in the ICU. The aim is to



explore the experience of being a new graduate in an intensive care setting using the Husserlian phenomenology as a conceptual framework. Each individual's experience is compared using descriptive phenomenology across two phases of the study: (i) within the group of participants (Phase Two) and (ii) to their experience over two to four years (Phase Three). Upon further examination of the literature and reflection on nature of the study, I decided that the best approach to data analysis was Colaizzi's (1978) method. This method involves returning to the participants for validation of the data analysis. Due to unforeseen personal circumstances I had to take 2 years leave during my research. This study was conducted over a 10-year period (2003- 2013).

## **1.7 Participants**

The participants were organised into three groups: (1) eighteen new graduates nurses from different clinical areas, (2) ten new graduate nurses from ICU, and (3) five registered nurses with two to four years working experience (from group two). Each group was involved in one of the three phases of the study.

### **1.7.1 Group one - Phase One**

To gain an initial understanding of new graduate nurses perceptions regarding their first year in practice, I carried out a survey as a basis for developing questions in 2004. King and Horrocks (2010) suggest that, for qualitative interviewing, the researcher has an interview guide that outlines the main topics they would like to cover. One of the ways to form an interview guide is to carry out some informal preliminary work. Participants in this phase were eighteen new graduate nurses on their second placement within a NSW private hospital. They had completed six months of a 12-month New Graduate Nurse/Transition to Practice Program, and were from different clinical areas. This group was chosen in the belief that their answer to question, 'What does it mean to be a new graduate nurse?' would assist me to develop interview questions (Appendix 3).

I discussed the research project with new graduate nurses on a designated study day as part of the New Graduate Nurse/Transition to Practice Program. All new graduate nurses present on the day verbally consented to participate in the survey. The participants were then given 15 minutes to write on a blank sheet 'what being a new graduate meant to them'. The researcher collected the sheets and there was no further discussion at the time.

The participants were informed that they were not required to write their names or their clinical areas on the sheets. These responses became Phase One and informed the development of the interview questions for Phase Two.

### **1.7.2 Group two-Phase Two**

Between 2004 and 2009, ten new graduate nurses, who had ICU rotation as part of their new graduate nurse program placement, agreed to participate and answer the research question ‘What does it mean to be a new graduate nurse in an ICU in a NSW’s hospital?’. At the time of recruitment for this study, two to three new graduate nurses were employed annually in ICU.

### **1.7.3 Group three-Phase Three**

Five participants from the second phase, between 2008 and 2011, were re-interviewed to gain a longitudinal perspective. Two to four years had passed and participants now considered themselves to be proficient nurses. The reason for choosing these participants was to understand their experience of change over time. I revisited what these participants had discussed in Phase Two and posed the following questions: What kept you working in ICU? or Why did you leave ICU? What do you do as a nurse in ICU, that you did not do when you were a new graduate nurse? Can you describe a typical day in ICU? Have you ever been a preceptor for a new graduate since you finished your New Graduate Nurse /Transition to Practice Program? What attributes do you see in a new graduate nurse? How do you understand your role in ICU as a nurse who has completed a New Graduate /Transition to Practice Program?

The research project was thus divided into three phases and the aims of all three phases are discussed below.

## **1.8 The aims of the three phases**

The aim of the Phase One was to complete a pilot study to develop interview questions for Phase Two interviews. King and Horrocks (2010) suggest this is helpful in the development of interview questions. The aim of Phase Two was to discover the lived experience of new graduate nurses in the ICU. In the Longitudinal Study (Phase Three),

change in the experience of participants over time as they moved from novice to proficient nurses was explored.

## **1.9 Structure of the thesis**

In **Chapter One**, background information relating to the study as well as the need for the study are highlighted. This includes the reason for choosing a descriptive paradigm to explore the experience of new graduate nurses in ICU and the direction taken to accomplish the research.

In **Chapter Two** a review of the literature is commenced with a description of the new graduate nurse. The meaning of novice and issues of retention in nursing profession are explored as well as an overview of the ICU environment and interpersonal communication/interprofessional relationships. Literature about the experiences of new graduate nurses in ICU is reviewed. The final section focuses on the journey from novice to proficient nurse that takes place over time.

In **Chapter Three** the study's framework is discussed. Some common research paradigms are described. The use of descriptive phenomenology perspectives and the Colaizzi method of data analysis are discussed in order to develop an exhaustive description of the phenomenon.

In **Chapter Four** Phase Two is discussed. Questions for Phase Two were developed. Analysis and findings of Phase Two are discussed. The developed themes and their connections to existing literature are highlighted.

In **Chapter Five** the findings of Phase Three are analysed and discussed.

In **Chapter Six** a review of the study, notes the limitations of the study, conclusion, limitations and recommendations for practice, education and research are presented.

In summary, in this thesis the new graduate nurses' experience in ICU and changes in their experience as they pass through different levels of proficiency are explored. A qualitative descriptive methodology is discussed that identifies 'universal essences' of lived experience of being a new graduate in ICU and developing competency over the time. The outcomes from this study can significantly enhance the understanding of

important concepts and perceptions relevant to New Graduate Nurse/Transition to Practice Program in ICU and provide valuable insights for nursing administration and education.

# Chapter 2

## Literature review

*In this chapter the literature informing the study is described, critiqued and what is known and unknown about the topic is explored (Fulton & Krainovich-Miller, 2010).*

### 2.1 Introduction

Some qualitative researchers believe that a literature review prior to gathering data should not be very comprehensive as it might influence a researcher's perceptions of the findings (Polit & Beck, 2006b). For the purpose of this study, as I had chosen Colaizzi (1978) method of data analysis and due to significance of bracketing in this method, I undertook a brief literature review at the commencement of the research in 2003. A further literature review was completed after data analysis to compare findings with available information.

Different terms are used in the literature for new graduate nurses such as recent graduates, and new nurses. All of these terms identify nurses who have just graduated from university and are in their first year of practice. In in 2003, searching different databases including CINAHL, MEDLINE, HEALTH SOURCE, and OVID using the keyword, "new graduate nurse" for literature published in the previous ten years, 600 articles were found, and in 2012 more than 5000 articles were accessed. This demonstrates a focus on new graduate nurses and relevant issues over the last decade.

In part of my search, I focused on articles that captured new graduate nurses' experiences about their practice within adult nursing. Geographically, the search was limited to Australia so I collected data most in line with local nurses' experiences. I also limited the search to the last 10 years (2003-2013). This generated 42 articles of which 20 were rejected because they were not research articles.

In this chapter, existing knowledge of the new graduate nurse's experience is reviewed. The uniqueness of the ICU environment is also noted. The next issue discussed in this chapter is the literature relating to interprofessional relationships. Retention as the most significant factor in reducing staff shortage especially in critical care settings is also

discussed. Finally, the development of new graduate nurses in practice over two to four years after graduation is explored.

## 2.2 New graduate nurse

Available literature regarding new graduate nurses can be encapsulated under the following headings: transition to new role (Andersson & Edberg, 2010; Duchscher, 2008), emotions (Duchscher & Myrick, 2008; Malouf & West, 2011), patient safety (Berkow, Virkstis, Stewart, & Conway, 2009; Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2008; Johnstone, Kanitsaki, & Currie, 2008; Myers et al., 2010), communication (Dyess & Sherman, 2009; Manias, Aitken, & Dunning, 2005), orientation program (Lampe, Stratton, & Welsh, 2011; Muldowney & McKee, 2011; Ostini & Bonner, 2012), retention (Booth, 2011; Djukic, Pellico, Kovner, & Brewer, 2011; O’Kane, 2011), and since 2010 an increase in papers on the topic of new graduate nurses readiness for practice (Halcomb et al., 2011; B. Whitehead, 2011; Wolff, Regan, Pesut, & Black, 2010) (See diagram 2.1).



Figure 2.1 Literature review ~ Taxonomy

Whether or not reality shock as described by Kramer (1974), is still an issue, researchers have focused on different aspects of becoming a registered nurse and transition to the new role. Some like Andersson and Edberg (2010) call it transition from 'being a rookie' to 'becoming a genuine nurse' (p. 188). Duchscher (2008) suggests that new graduate nurses, during their first 12 months of practice, move through three stages (doing, knowing, and being) and need support during each stage. She presents a theory of transition to incorporate an evolutionary journey of becoming. The first stage of transition for a new graduate nurse is marked by emotions.

As part of the transition, and in the journey of becoming, new graduate nurses' emotions are discussed. According to Duchscher (2009) new graduate nurses in the initial weeks experience anxiety which is overwhelming and debilitating. Goh and Watt (2003) find that new graduate nurses feel too busy and stressed with competing work demands. They feel that they are only able to provide very basic care and struggle to achieve the goal of providing quality nursing care. Researchers argue that fear is a difficulty for new graduate nurses in their first year of practice (Fink, Krugman, Casey, & Goode, 2008). Other feelings reported by new graduate nurses include vulnerability, and powerlessness (Mooney, 2007b). In a qualitative study by Wangenstein, Johansson, and Nordstrom (2008) feelings of uncertainty are illuminated among twelve new graduate nurses in a hospital setting and home care in Norway.

Achieving competence will optimise the outcomes of new graduate nurses clinical practice (Reddish & Kaplan, 2007). It is widely recognised that concern regarding patient safety has grown. Due to nurses close involvement with the care of patients, they have a significant role in improving patient safety. Some researchers assess the ability of new graduate nurses to practice in a safe manner. For example, Fero et al (2008) in a retrospective analysis of 1211 new graduate nurses' critical thinking abilities during the first 2 weeks of employment in United States of America, reported that 29.6% of them did not meet assessment expectations. They required education in the differentiation of urgency, and initiating independent nursing interventions. In addition, they were not able to detect clinical problems, or to prioritise care. In response to these issues strategies were implemented to ensure new graduate nurses learn and employ national patient safety goals (Kaplan & Pilcher, 2013).

Readiness for practice involving the knowledge, skills, and judgment required for role performance and to provide optimum care to patients is another area of concern; numerous studies have explored this issue (Wolff et al., 2010). A review of the literature from 1974 to 2010 by Whitehead (2011), focusing on research articles regarding preparedness of new graduate nurses in the United Kingdom, identified a significant gap between theory and practice. He concluded that new graduate nurses do not feel adequately prepared for their role in practice.

An Australian study showed that a university based - clinical school model could address some issues regarding graduate preparedness for practice. In this model a university School of Nursing and Midwifery established several clinical schools within some hospitals in Melbourne. The majority of clinical and theoretical programs for the final year students were run in these schools. As a result, a close relationship between the university and hospitals developed. This study involved 10 new graduate nurses who completed their nursing degree from clinical schools. Using a descriptive interpretive methodology, the analysis of data identified that participants felt that being situated in a hospital gave them the opportunity to immerse themselves in hospital culture. They felt that the real world was brought to their classroom. The participants also felt being situated in a clinical school facilitated their engagement with practice (Watt & Pascoe, 2013).

Newton and McKenna (2009), using Carper's (1978) ways of knowing as a framework, explored the development of new graduate nurses knowledge and skills during the first 18 months after graduation. Analysis of focus group data collected at six monthly intervals from 25 new graduate nurses identified four ways of knowing: knowing self (thinking/learning about self); empirical knowing (making connections/recognising gaps); personal knowing (sense of being there for their patients which developed at the end of 14 months); and ethical knowing (questioning their obligations and actions). Aesthetic knowing (art of nursing), as Carper proposed, did not develop in participants in this study. Pressures of socialisation into the workplace and organisational barriers had negative influences on graduates' ability to consolidate their knowledge and skills as a nurse and being engaged in the art of nursing. This study illustrated current educational models do not always adequately prepare the students for transition to their professional role.



In another Australian study, readiness for practice was identified as to be more than work competencies. This qualitative study included 46 nursing and medical graduates at a regional public hospital in Victoria. Communication skills, knowledge regarding ward and hospital policies, maturity, and life experience, personality traits were defined as factors important in graduate nurse work readiness (Walker et al., 2013).

In a qualitative research study involving 81 new graduate nurses in diverse practice settings in United States of America, Dyess and Sherman (2009) found that communications between new graduate nurses and other interdisciplinary team members, especially doctors was not ideal. Some studies that examined new graduate- nurse relationships, found that developing effective nurse- patient relationships were considered to be difficult (Belcher & Jones, 2009; Newton & McKenna, 2007 ). Conversely, other studies report that new graduate nurses perceive patients as individuals with particular needs and develop close bonds with them (Oliver, 2008). Malouf and West's (2011) study of Australian new graduate nurses fitting into an acute care setting highlighted the desire among participants to establish a secure social bond with ward staff. This was so important to them that they perceived they would not be able to function in the ward if they did not achieve some degree of connection with their colleagues. Communication skill is an important element which when woven into the content of New Graduate/Transition to Practice Program, was found to facilitate new graduate integration, improve confidence, increase clinical productivity and readiness for practice (Ferguson & Day, 2007). When communication starts to fail, new graduate nurses stop asking questions and leaves them feeling unsafe and unsupported (Hippeli, 2009).

According to Johnstone, Kanitsaki and Currie (2008) 'Support is fundamentally a process that aids, encourages, and strengthens and thereby gives courage and confidence to a new graduate nurse or a group of new graduates to practice competently, safely, and effectively in the levels and areas they have been educationally prepared to work' (p. 52). Concurring with this definition, support for new graduate nurses could be provided in various ways. For example, other nursing staff are considered a source of support for new graduate nurses. Ostini and Bonner (2012) report that the orientation program was not the only source of support for new graduate nurses in a regional acute care setting in Western NSW. New graduate nurses also received assistance from other nursing staff regarding

time management, and with clinical issues. The participants also thought material supports such as study days assisted them.

Other support structures identified in the literature included: adequate staffing levels in the wards; accessibility to learning and expertise; supernumerary days; allocation of a designated preceptor; and the preceptor and preceptee being rostered on the same shifts (Fox, Henderson, & Malko-Nyhan, 2005).

In addition, undertaking orientation programs has shown to be a positive experience for new graduate nurses and to improve retention and competency (Atherton & Alliston, 2011; Carraher, 2012). A 12-month state-wide transition to practice program in Queensland, Australia is another example. This program specific to intensive care has been sustained since 1999. Over 12 years, 824 new graduate nurses completed this program. The outcomes include achieving practice standards, and facilitating career progression for new graduate nurses (Juers, Wheeler, Pascoe, Gregory, & Steers, 2012). It is interesting to note that ten years prior to this study only 51% nurses in public and 52% nurses in the private sector, perceived that the support offered to new graduate nurses during transition period in Queensland, was appropriate and adequate (Parker, Plank, & Hegney, 2003).

Between June 2006 and December 2009, a national evaluation of 'Nursing Entry to Practice' program was carried out in New Zealand. In this project, lessons learnt and factors influencing success were identified. This three-year longitudinal study showed that the program provided a supported environment for new graduate nurses new skills and knowledge acquisition. In addition it had a positive effect on retention of new graduate nurses into New Zealand Health system. Other key findings were an inconsistency in applying the preceptorship model, the need for improvement in leading preceptorship programs such as policies, preceptor preparation, and monitoring performance (Haggerty, McEldowney, Wilson, & Holloway, 2010). This was also identified in an Australian study by Smedley(2008). In her study, she pointed that many registered nurses perceive they do not have skills required as a preceptor. Furthermore, Evans, Boxer and Sanber (2008) investigated transitional programs at seven hospitals in Sydney, Australia. They used a descriptive design and interviewed nine new graduate nurses and 13 experienced nurses. They identified programs weaknesses: the times that

new graduates spent without support (such as being in-charge of a ward); the bullying and horizontal violence; unrealistic high expectations of a new graduate; and rotation in different clinical areas. Except for unsupported time and rotation, which are directly linked to the transition programs, the other weaknesses identified by authors are issues that existed long before transition programs were implemented. It could be claimed that the weaknesses of transition programs are not being able to address these issues or empower new graduate nurses to deal with these situations.

Despite numerous studies regarding support programs for new graduate nurses, an integrative review of literature by Rush et al (2013) showed that due to variability in research designs, a conclusion cannot be drawn as to which transition programs are the best for new graduate nurses, yet New Graduate/Transition to Practice Programs have a positive effect on retention.

There is variation in the literature regarding what affects new graduate nurses' retention. In a survey of 1933 new graduate nurses across United States of America factors affecting the decision to remain in the same workplace were organisation commitment, and job satisfaction. Findings of this study showed that patient load, mandatory overtime, shift, type of clinical area, income, and age had significant effects on the decision to stay (Kovner, Brewer, Greene, & Fairchild, 2009). Another study, involving 1152 new graduate nurses in United States of America, highlighted that new graduate nurses preferred a job that provides holistic patient care. They liked autonomy and collaboration in their practice. New graduate nurses prefer a job that gives them the opportunity to use diverse knowledge and skills and to be able to affect patient outcomes. In addition receiving recognition, having a secure and stimulating job, are also important factors (Djukic et al., 2011).

Few studies were found concerning the lived experience of what new graduate nurses deem important about entering and remaining in the work force for few years, especially in ICU.

### **2.3 New graduate nurse and ICU**

There are elements which make ICU a unique environment compared to other clinical areas. The acuity of patients and the technology required for stabilising them make

nursing in the intensive care setting more complex and dynamic (British Association of Critical Care Nurses, 2010).

Some studies indicate that ICU is a particularly stressful work environment (Mealer, Shelton, Berg, Rothbaum, & Moss, 2007; Poncet et al., 2007). Some even have considered the stress in caring for critically ill, young or dying patients in ICU as a barrier to care (Wilkin & Slevin, 2004). In contrast, other studies indicate that ICU nurses do not significantly experience higher levels of stress compared to the nurses working in other wards (Burgess, Irvine, & Wallymahmed, 2010).

Regardless of whether nursing in ICU is more stressful than nursing in general wards, caring for critically ill patients in ICU would create high stress levels. The patients in ICU are vulnerable; they are experiencing medical complications or even life threatening illness. Other factors, such as, the intense pace of work, decision making, prioritising, problem solving, and frequent interruptions, are identified as causes of stress in ICU (Shimizu, Couto, & Merchan-Hamann, 2011). Stress, specially during medical crises when immediate interventions of multiple ICU team members is required, could affect performance (Piquette, Reeves, & LeBlanc, 2009).

In addition, studies show that registered nurses' knowledge and clinical assessment skills are correlated with perceived stress. As nursing in ICU occurs in a highly technological environment, the importance of the nurse's knowledge, skills and competence in the intensive care area is acknowledged (Australian Health Workforce Advisory Committee, 2002; British Association of Critical Care Nurses, 2010; The Workforce Advisory Panel Australian College of Critical Care Nurse, 2003; Williams, Schmollgruber, & Alberto, 2006). In a study of 320 nurses in Australian public hospitals where various workplace stressors were examined, inadequate preparedness was a source of stress among nurses (E. M. Chang et al., 2006). This was also revealed in a cross sectional cohort study related to critical care nurses in an inner city teaching hospital in Northwest England. The researchers noted a correlation between perceived stress and lack of confidence and competence. Also a significant negative correlation was identified between the number of years of nursing experience in ICU and stress related to dealing with patients and relatives (Burgess et al., 2010).

In a descriptive qualitative study, Wilkin and Slevin (2004) highlighted the importance of prioritising care in ICU nursing. In order to be able to prioritise care and provide effective and high-quality intensive care, critical care nurses must possess the relevant specialist nursing knowledge and skills to deal with all aspects of patient management, especially in recognising and responding to changes in the patient's physical condition. They acknowledged that the years of nursing experience in ICU would affect one's ability to perform these necessary tasks. Rischbieth (2006) concurred with this in her paper highlighting the need for reconfiguring the concept of nursing skill mix in ICU. She linked risk of adverse events and poor outcomes for acutely ill patients to the nurse years of experience.

The ICU environment and requirements for practice as a nurse in ICU become more significant when one discovers that ICU is a popular workplace among new graduate nurses. A few studies (Halcomb et al., 2011; Happell, 1999) have indicated that working in health care settings with high levels of technology, such as critical/intensive care, is significantly desirable to student nurses. The attraction of ICU for new graduate nurses is possibly linked to their undergraduate clinical experiences. Shih and Chuang (2008) showed a strong relationship between areas of practice as student and the willingness to work after graduation, among 326 nursing students in Taiwan. Critical care was the second area of choice for these nursing students for their future careers. These findings differ from a Norwegian study in which 323 undergraduate nursing students at the end of their education program listed critical care nursing as their sixth preference for future work, medical /surgical and midwifery were at the top of the list (Kloster, Hoie, & Skar, 2007). Although career preference seems different in the population of Norwegian students compared to Taiwanese or Australians, data in all these studies shows that experiences from practice influence students' choice of work area. Also students' career choice may be related to the amount of theoretical and clinical experience in the field, suggesting that the more theory and clinical subjects in an area may affect students' choices (McCann et al., 2010).

In a recent longitudinal study by Stevens (2011) career preferences of 150 nursing students within NSW, Australia were measured at commencement, midway and at the last lecture of final semester. For the students immediately prior to completion of a Bachelor of Nursing degree, intensive care was the second most popular choice after surgical areas.

McCann et al (2010) also examined the career preferences of over 80 Bachelor of Nursing students in Victoria, Australia in their first, second and third years of study. Acute care of adults was the most popular career choice. Indeed ICU has proven to be one of the most frequently requested specialities chosen in the New Graduate /Transition to Practice Program. It therefore, becomes important to explore their experiences in such a 'desirable' area.

There is little research into the experiences of new graduate nurses in ICU. Issues such as confidence with care of critically ill patients, advanced medical technology, time management, acceptance into the social structure of the unit poses a burden to the new graduate experience in ICU. These issues are discussed below.

O'Kane (2011) using a comparative qualitative study investigated the experience of eight new graduate nurses commencing their profession in a 13-bed general ICU in United Kingdom. She found that new graduate nurses face challenges regarding completing tasks within specific time frames, as a result, they feel anxious. Feeling accountable as a registered nurse adds to this challenge. In addition, they are challenged by being accepted as an ICU team member. The topic of time management for new graduate nurses has also been discussed in a paper by Litchfield and Chater (2008) who explored the lived experience of time management for new graduate nurses in a neonatal unit in a public hospital in Australia. The new graduates were unable to manage their time due to lack of knowledge and skills, and as a result, felt anxious.

Farnell and Dawson (2006) in a longitudinal qualitative study, explored the experience of fourteen new nurses in a Critical Care Unit in the United Kingdom. The participants had between one to 10 years experience in other clinical areas. Several themes were apparent in the participants' descriptions of their experience: support, knowledge and skills, socialisation and moving on. For new nurses, competency based orientation program, support, preceptors, ability to socialise to the critical care environment, were key factors influencing their experience. Only two of participants had less than one-year clinical experience post registration, this study, therefore might not reflect the experience of new graduate nurses.

Mori, Nakagawa, and Whitaker (2005) in a descriptive study in Brazil identified the main difficulties experienced by recently graduated nurses in ICU. These included equipment, technical skills, interpersonal relationships, and theoretical knowledge. The sample size for this survey was small- from 175 questionnaires sent out only 25 new graduates responded (14.28% response rate).

Based on existing research it may be concluded that new graduate nurses with lower competency and skills will experience the highest stress level in caring for acutely ill patients. Studies suggest that ICU nurses are engaged in constant high levels of physical activity and diverse care with their patients which causes physical distress, emotional exhaustion and depersonalisation (Shimizu et al., 2011). Although case exemplars of new graduate nurses experience in general wards are frequently reported in the literature, there is a paucity of descriptions of their experience in ICU.

## **2.4 New graduate nurse and interpersonal communication/interprofessional relationships in ICU**

Interpersonal communication can be described as the process of creating or sharing meaning between two or more people. The essential element- according to the Tubbs Communication Model - are the sender or receiver, message, context, channel, interference and feedback. The message is transmitted verbally and/or nonverbally (Tubbs, 2010). Skilled communication is one of the standards for establishing and sustaining healthy work environments. Nurses must be as proficient in communication skills as they are with clinical skills (The American Association of Critical-Care Nurses, 2005).

In a hospital setting, communication occurs between health care provider, patient, and families as well as among health care providers. Interprofessional relationships or communication across the professions is a significant contributing factor to the provision of safe healthcare. Studies in this area generally indicate that poor relationships, together with conflict and aggression in the workplace, causes job dissatisfaction and compromises patient outcomes (B. McKenna, Smith, Poole, & Coverdale, 2003).

One of the special topics of discussion in health care systems is the nurse-doctor relationship. The earliest article on this topic was titled the 'Dr-Nurse Game' (Stein,

1967). Stein described how the nurse could only suggest changes in patients care plans indirectly and in specific circumstances. The enhancement of nurses' education, changes in the female role in society and the complexity of patients, this relationship started to change (Wagner et al., 2011). The articles highlight concerns regarding the nurse- doctor relationship. In the early 2000s researchers still report that only 33% of nurses think they experience a collaborative relationship with doctors (Thomas, Sexton, & Helmreich, 2003). In recent years, the quality of interprofessional relationships has improved. In a literature review by Schmalenberg and Kramer (2009) revealed how the nurse-doctor relationship has improved since 1990s. In a qualitative study in New Zealand, nurses and doctors in a primary care setting reported that effective interprofessional relationships between individual doctors and nurses did exist (Pullon, 2008).

It is not only nurse- doctor relationship which cause concern. In a study by Moore, Leahy, Sublett, and Lanig (2013), involving 82 registered nurses from an acute care facility in United States of America using mixed method, 21% of participants reported considering leaving the profession due to poor nurse to nurse relationships. The authors did not identify the years of experience of the nurses in this study.

Clearly, in an ICU where treatment decisions are complex, effective communication is even more vital to successful care (Gauntlett & Laws, 2008; Scheunemann, McDevitt, & Carson, 2011). The delivery of care in ICU demands a team effort and without the support and collaboration of the full ICU team little can be achieved (Vincent, 2006). Communication in the ICU is conducted between and within health care teams, patient and family and may occur verbally and nonverbally. Good communication is clearly fundamental in a critical care setting and affects patient and family outcomes. Poor communication on the other hand may lead to adverse events.

A systematic review of 180 clinical trials showed that improvement in communication reduced family stress, length of stay and treatment intensity (Scheunemann et al., 2011). Communication among ICU health care members, team work, mutual support and interprofessional collaboration are considered as important factors in dealing with the ICU clinical situation and improved outcomes for critically ill patients (Rose, 2011; Wilkin & Slevin, 2004). Without effective communication important current information regarding to the patient may be overlooked, delayed, or missed.



Unfortunately, poor communication has been noted in ICUs in several studies. A study by Reader et al (2007) on interprofessional collaboration among ICU nurses and doctors in four United Kingdom hospitals, showed that members of ICU teams had different perceptions of their communications with one another. For example in a survey scale of ‘communication openness between nurses and doctors’, nurses reported significantly lower scores compared to doctors. Additional research in the United States of America also has indicated that ICU team members have divergent perceptions of their communication behaviours, with more nurses than doctors reporting difficulties in speaking-up about problems with patient care, and fewer nurses reporting that teamwork between nurses and doctors is well coordinated (Nathanson et al., 2011; Thomas et al., 2003).

There is considerable discussion in the literature about the nurse-doctor relationship, nurse-patient relationship, nurse-nurse relationship, and communication skills in ICU (Belcher & Jones, 2009; Dyess & Sherman, 2009; Kelly & Ahern, 2008; Manojlovich, 2009; Schmalenberg & Kramer, 2009; Ulrich et al., 2006). Conversely, there is little information available that provides insight into new graduate nurses’ experience and perception relating to the interactions with other members of the critical care team and critically ill patients and their families.

It is vitally important that new graduate nurses have positive and effective communication experiences, and recognition of their expectations. Studies reported in the literature on issue indicate that new graduate nurses are expected to reach prescribed milestones within a very short timeframe. Some of the milestones that need to be achieved, especially in the first six months of the New Graduate/Transition to Practice Program are: establishing oneself as a healthcare team member; acclimatising to the new job and organisation; developing confidence and competence in clinical skills; and making sense of the role of a nurse relative to other healthcare professionals (Duchscher, 2008; Halfer, 2007). This is also identified by Cleary and her colleagues in Sydney, Australia. Their study investigated the experiences of 10 registered nurses during the first 2 years of mental health employment. The study showed that new graduate nurses need to enhance their communication skills to suit specific patients and professionals and various workplace events (Cleary, Horsfall, Mannix, O’Hara-Aarons, & Jackson, 2011).

Casey, Fink, Krugman, & Propst (2004) identify that the new graduate nurse may feel unaccepted by their peers and experience difficulty as a new members of the team communicating, especially with doctors, in an acute care setting. McKenna and Newton (2007) conducted a study, involving 21 new graduate nurses from four hospitals in Victoria, Australia. In this study, it was recognised that only after completing the New Graduate /Transition to Practice Program, did new graduate nurses feel a sense of belonging to a particular clinical setting.

Kelly and Ahern (2008), in a phenomenological study in Australia, noted that the different personalities and attitudes among doctors and senior nurses overwhelmed new graduate nurses, and in general, they found communication with doctors relatively uncomfortable. The lack of respect from the experienced nurses toward new graduate nurses is often cited in the literature as a major challenge (Casey, Fink, Krugman, & Propst, 2004; Dyess & Sherman, 2009; Kelly & Ahern, 2008; B. McKenna et al., 2003).

Transition from the student role to the registered nurse role is difficult; the new graduate's lower level of skill and expertise causes other health care team members such as other nurses, medical staff, and physiotherapists, to be critical of them (Hippeli, 2009; Mangone, King, Croft, & Church, 2005). Also, an Australian study of 57 graduate nurses, found that new graduate nurses feel that they do not have the fundamental preparation to support them in their interactions with families (Gough, Johnson, Waldron, Tyler, & Donath, 2009).

There is sufficient support in the literature to identify that trust is a crucial element in establishing an effective nurse-patient interaction (College of Nurses of Ontario, 2006; Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009; Lotzkar & Bottorff, 2001; Mok & Chiu, 2004; Sellman, 2007). The importance of previous nursing experience in developing trust between the new graduate nurse and patients is described by Belcher and Jones (2009) in a qualitative study involving new graduate nurses in a Melbourne metropolitan hospital, in Australia. They explore the new graduate nurses' experience of developing trust in nurse-patient relationships and find that developing rapport is the first step to building a trusting relationship with a patient. In order to develop rapport, new graduates identified previous nursing experience as a major theme. There is a paucity of

research regarding new graduate nurses' perceptions about developing a trusting nurse-patient relationship (Belcher & Jones, 2009).

The ways in which graduate nurses communicate in ICU with health professionals, patients and relatives have rarely been addressed in the literature. In past research, investigators detailed nurses' communication processes during their first year post graduation but less frequently in critical care settings. The question therefore needs to be asked: Would new graduate nurses see themselves as members of a team in a sharing and contributing relationship?

## **2.5 New graduate nurse retention in ICU**

Although it seems that the issue of nurse shortage, at least for the Australian metropolitan areas until the next decade is solved, shortage of experienced nurses both in Australia and internationally is still an issue. However; acute-care wards are affected by the nursing shortage with heavy workloads and job dissatisfaction resulting in increased turnover rates (Marcum, 2004). In Australia by 2016, 115,549 registered nurses will be available to the workforce and demand will be 119,506, demonstrating a negative gap of 1,342 registered nurses (Health Workforce Australia, 2012b).

There are multiple factors to consider in maintaining the balance of supply and demand. Australia's population is ageing. One impact of this demographic change includes increasing losses from the health workforce as the current health workforce ages. For example, from 2004 to 2009, the proportion of nurses aged 55 and over and working increased from 15% to 20 %. This means more nurses are getting close to retirement age, (Health Workforce Australia, 2012b). The exit of nurses from the workforce, due to retirement, will affect supply. An exit is described as nurses leaving the workforce either to work in other occupations, or to leave the labour force entirely. The estimated exit rates for nurses and midwives, based on the Household, Income, and Labour Dynamics in Australia (HILDA) survey data for 2009, showed a range from 5.2% to 12.8% (Scott et al., 2012). Exacerbating this issue is the increase in number of patients requiring an ICU bed.

Looking at supply of workforce, findings of United States of America Census Bureau's Current Population Survey and American Community Survey, showed that between 2002

and 2009, the number of full-time equivalent registered nurses ages 23–26 increased steadily by 62 % (Auerbach, Buerhaus, & Staiger, 2011). Similarly, there has been growth in the number of registered nurse graduates over the period from 2006 to 2010 in Australia (Health Workforce Australia, 2012a). In 2011, there were more new graduate nurses than suitable graduate positions available in public hospitals in Australia. This was not due to a higher number of supply to demand but related to new graduate nurses not willing to work in aged care or in rural areas (Health Workforce Australia, 2012a).

The Australian Department of Education, Employment and Workplace Relations Skill Shortages Summary 2011-12 revealed that in the occupations of nursing and midwifery, employers were only able to fill 75% of their vacancies and only attracted 1.4 suitable applicants per vacancy (Department of Education Employment and Workplace Relations, 2012). The latest data regarding Critical Care Nurse Workforce in Australia identified the vacancy rate for critical care nurses averages 6.87% to 11.07% in public and private sector ICUs (Australian Health Workforce Advisory Committee, 2002). The Western Australia (WA) Adult Critical Care Nursing Workforce Steering Committee 2010 report stated that to meet demands of ICUs staffing by 2014 in WA, approximately 580 additional educated critical care nurses would be required and would be supplemented by overseas nurses' employment.

Moreover, Australia is not alone in grappling with this problem. According to a 2011 KPMG survey, at general and surgical United States of America hospitals the annual registered nurse attrition rate is about 14% (The KPMG Healthcare & Pharmaceutical Institute, 2011). Estimated nurse turnover costs for 2007 financial year in United States of America ranged from \$7,875,000 to \$8,449,000 (Jones, 2008). The report from The American Organisation of Nurse Executives (AONE) noted that 53% of critical care facilities, relying on temporary staff or travelling nurses (Larson, 2002).

Nursing shortages in critical care are likely to be due to an increased rate of attrition. For instance, new graduate nurses, as primary source of staffing in health care facilities are especially drawn to critical care areas, although they might not remain in ICU after completion of their New Graduate/Transition to Practice Program (Australian Health Workforce Advisory Committee, 2002). Unfortunately there is a paucity of literature to clarify nurses' career choices and movements especially in intensive care settings to be

able to shed some light on this issue (Gaynor, Gallasch, Yorkston, & Stewart, 2006; Halcomb et al., 2011; McCann et al., 2010). This is confirmed by Australian Health Workforce Advisory Committee (2002) analysis of the critical care nurse workforce 2001-2011. The Committee identified that lack of recent consistent, reliable, and longitudinal data to describe the critical care nurse workforce was a major limiting factor for this report.

In response to the lack of longitudinal data regarding new graduates and registered nurses workforce in general, a cohort study was established by University of Queensland, Australia, Massey University, University of Auckland, and AUT University from New Zealand. The aim was to collect demographic and workforce data regarding graduates from these universities. In the first survey, 111 university graduates participated. Seven percent of Australian graduates were not employed as nurses. Among Australian graduates 11.8% intended to work in the United Kingdom or Ireland in the next 12 months. Only 2% of Australian graduates worked in adult critical care. The survey reported that 15% of Australian university graduates were employed in paediatric/NICU speciality (second highest number of distribution after perioperative/ surgical speciality). As 79.4% of participants stated that they were employed in their preferred clinical speciality, it may be concluded that among the participants in this study, paediatric/NICU was the second choice area of employment (Huntington, Gilmour, Neville, Kellett, & Turner, 2012). This article did not clarify the participants' level of experience, although as the survey was sent to graduates of 2008 and the article was published in 2012, the maximum number of years of experience would not be more than three years. In addition, turnover since graduation was not investigated.

Bowles and Candela (2005), in a survey of 352 nurses in United States of America, noted that the main reasons for turnover in the first year of practice included: stress associated with the acuity of patients; unacceptable nurse-to-patient ratios; feeling of patient being unsafe; lack of support; too much responsibility; location move; salary; schedule and benefits. Most of the participants worked in urban settings. The authors did not specify the participants' work area. On the other hand, Atherton and Alliston (2011) after implementing a 15-week orientation in a tertiary ICU in Auckland, noted that safe support networks and a supportive environment were principal factors in retaining new graduate nurses. This was confirmed in a study in United States of America when by implementing

a mentoring program for new graduate nurses the turnover rate dropped from 20% to 7% (Faron & Poeltler, 2007).

Future demand for critical care services and critical care nurses is expected to increase with population growth and ageing. As well as expanded services (in terms of bed numbers), increased productivity of critical care nurses is expected, as the flow of patients in critical care services increases (due to technological advances). New graduate nurses are assets for the future of nursing. The question needs to be asked: How may new graduate nurses be retained in ICUs, job satisfaction created and empowerment improved? This question cannot be satisfactorily answered without being acquainted with their needs.

## **2.6 New graduate nurse career progression**

Despite the number of studies into the graduate year, few authors have explored how graduates progress in their profession following the completion of the initial year (Table 2.1).

In order to understand nurses' perception of their work environment and their needs in the first years of practice, Pellico et al (2010) completed a national cohort study of 229 registered nurses who had graduated from New York University and the University of Buffalo. The participants had various levels of postgraduate degrees. The first survey was undertaken initially 6 to 18 months after graduation and the second was completed a year later by the same nurse. Exploring two experiences within two and a half years of their graduation demonstrated that the working environment affects registered nurses' satisfaction. In addition, factors associated with dissatisfaction were identified. These included lack of leadership at the clinical level, verbal abuse, high patient to nurse ratios and labour work involved with bedside nursing. The authors did not identify participants' specific areas of employment however, they did mention that 77% worked in inpatient hospital settings. Pellico and her colleagues showed that the focus of nurses' frustration changed. In the first time period new graduates focus on their own inadequacy regarding clinical skills. In the second time period they were frustrated with workplace inefficiencies. The authors suggest an education program based on the nurses needs in year two or three after graduation. The Pellico et al. study was a survey; participants received the questions in written format. Carrying out a face-to-face interview would have

provided a greater opportunity to complete a deeper exploration of their experience. In addition, this study did not investigate reasons for remaining in their workplace.

Maben, Latter, and Clark (2007) concurred with Pellico et al.'s (2010) findings regarding frustration among nurses two years after graduation. Maben and her colleagues explored new graduate nurses' experiences of implementing their ideals and values in contemporary nursing practice, followed by a further investigation three years after graduation. Using an interpretive research design, they identified that new graduate nurses entered clinical practice holding ideals and values around delivering high quality, patient-centred, holistic, and evidence-based care. However, once in practice, professional and organisational constraints influenced their ability to implement these ideals and values. In practice, they had to find a way to accommodate their ideals and survive or find other ways to adjust their expectations. After two years in practice participants were categorised into three groups: 'sustained idealists'; 'compromised idealists'; and 'crushed idealists' according to how they adjusted their expectations (Maben et al., 2007, p. 107). Sustained idealists were able to implement and retain their ideals in practice. Compromised idealists were frustrated nurses who could only implement part of their ideals. The majority of participants belonged to this group. Crushed idealists were defined as nurses who perceived their ideals as impossible to implement. The authors concluded that there is a need to reformulate the nursing mandate in a way that is more realistic and sustainable.

Using a grounded theory method a study in the United States of America, Deppoliti (2008) reported that in the first 3 years after graduation new graduate nurses progress through various stages to construct their professional identity. Within all of these stages, elements of relationships, responsibility, continual learning, and perfection were crucial for successful transition. Deppoliti identified stages as: 'finding a niche', 'orientation', 'the conflict of caring', 'taking the licensure examination', 'becoming a charge nurse' and 'moving on' (p. 258). This study involved 16 participants. As they had different levels of experience (from one to three years) and the study was not a longitudinal or comparative design, participants were not followed in their journey of professional identity. In Deppoliti research 'moving on' is described as a point of development when the nurse experiences comfort and competence and wants to learn more and develop new skills. This was not achieved until they had just about 3 years of experience.

Grochow (2008), in California, followed seven new graduate nurses for two to three years with a view to evaluate their level of proficiency and progress during the time. An evaluation tool with clear expectations for each level was used. Grochow claimed it takes two to three years of experience for nurses post-graduation to reach a competent stage. She did not explore new graduate nurses' experience during this time.

McKenna and Newton (2008), using phenomenology approach, examine how nine nurses from regional and metropolitan hospitals (public and private) in Victoria, Australia developed knowledge and skill in the six months following completion of their New Graduate /Transition to Practice Program year; that is, when support from a structured support program no longer exists. The main theme that emerged was 'moving on'. They reflected on their experiences as graduates and now saw themselves as providing education and support for their colleagues. 'Moving on' brought further career progression; a number of the nurses had already begun postgraduate studies to move their careers into the next phase. The authors recommended further work to explore the period beyond the graduate year in the development of the registered nurses.

In the final study of four qualitative studies on new graduate nurses' transition by Duchscher (2007), she explores the transition journey of 15 newly graduated nurses over 18 months, although there is no publication of her study findings regarding 12 to 18 months after graduation.

One study conducted by Halfer and Graf (2006) suggests that graduates undergo a grieving process as they move away from their academic environment and enter the work environment. These authors found that graduates are dissatisfied with their work environment in the first 12 months but that this is resolved by the 18-month period.

'Finding a niche' and 'moving on' when the registered nurse finds comfort and competence in clinical work are common themes in the literature, explore different aspects of new graduate nurses' development from graduation to at least 18 months after graduation.



Table 2-1 New graduate nurse career progression.  
Few authors have explored how graduates progress in their profession following the completion of the initial year.

Author	Year	Country	Design	Participants	Aim	Findings	Comments
Pellico et al	2010	US	National cohort study	229 registered nurses Phase one: 6-18 months after graduation, Phase two: within 2.5 yrs after graduation	To identify nurses perception of their work environment and their needs in the first years of practice	Working environment of RNs impacts both nurses' satisfaction and their dissatisfaction	<ul style="list-style-type: none"> <li>• Survey not interview</li> <li>• Did not investigate reasons for remaining in their workplace</li> </ul>
Maben, Latter, & Clark	2007	UK	Interpretive research design	Phase one: 72 Final-year student nurses, Phase two: 26 registered nurses 4-6 months post qualification and again at 11-15 months	To explore new graduate nurses experiences of implementing their ideals and values in contemporary nursing practice	On qualification nurses emerged with a coherent and strong set of espoused ideals around delivering high quality, patient-centred, holistic and evidence-based care. The majority experienced frustration and some level of 'burnout' as a consequence of their ideals and values being thwarted within 2 years in practice	No comparison of responses in 4-6 months with 11-15 months post qualifications.
Deppoliti	2008	US	Grounded theory	16 participants	To describe and explore the experiences that contribute to the construction of professional identity in hospital nurses 1 to 3 years after graduation.	In the first 3 yrs after graduation new graduate nurses progress through various stages to construct their professional identity: Finding a niche, Orientation, The conflict of caring, Taking the licensure examination, Becoming a charge nurse, and Moving on.	Participants were not follows in their journey of professional identity. Participants had different levels of experience (from 1 to 3 yrs).
Grochow	2008	US	A pilot study, design not described	7 new graduate nurses	To evaluate level of proficiency and progress of new graduate nurses within 2 -3 yrs	Takes 2-3 yrs of experience for nurses post-graduation to reach a competent stage	Did not explore new graduate nurses' experience during this time.
McKenna & Newton	2008	VIC, AU	Phenomenology	9 new graduate nurses	To examine how new graduate nurses develop knowledge & skill in the 6 months following completion of new graduate nurse program	Main theme: 'moving on'	Did not explore effects of work environment on NGN development.

Author	Year	Country	Design	Participants	Aim	Findings	Comments
Duchscher	2007	Canada	PhD by publication - Grounded theory	14 new graduate nurses	To explore both the process and substance of the 18 months journey taken by new graduate nurses making the role transition to professional practice	Transition Shock model & transition conceptual framework	No publication regarding 12-18months after graduation
Halfer & Graf	2006	US	Survey	122 responded	To study perceptions of the work environment and job satisfaction for NGNs in first 18 months of employment	Graduates in the first 12 months undergo a grieving process but this is resolved by the 18-month period.	<ul style="list-style-type: none"> <li>•Conducted at a children's hospital.</li> <li>•Survey not interview</li> </ul>

## **2.7 Summary**

In this chapter, literature was reviewed to develop a foundation for this present study. Gaps in understanding the lived experiences of new graduate nurses, specifically in ICU, and after completion of New Graduate/Transition to Practice Programs were identified.

The difficulty for the novice nurse in transitioning from educational institutions into health care settings was revealed in the literature. The impact of psychosocial support and empathy from other staff on new graduates' experiences was also identified. The increasing acuity of patients and technological environment of ICUs were found to be factors that escalate the anxiety felt by novice nurses. Limited studies explored the experience of new graduate nurses in their new role and in the complex environment of ICU.

As the literature in the last decade shows, limited research has been conducted to study the lived experiences of new graduate nurses specifically in adult ICUs (Farnell & Dawson, 2006; Mori et al., 2005; O'Kane, 2011). Considering that one's lived experience is the sedimentation of all their previous experiences, each phenomenological study is unique (Munhall, 2012b). Therefore, further exploration of new graduate nurses' experiences, specifically in ICUs with its different environment, is considered valuable.

The following chapter, Chapter 3, explains the methodology in detail and how the inquiry has been carried out. It includes comments about qualitative research, particularly phenomenology as the chosen method for the study. In addition, it covers the plan for conducting and organising the study.

# Chapter 3

## The study framework

*In this study, a descriptive phenomenological approach is used to explore the lived experience of new graduate nurses during their placement in ICU and their understanding of the experience after a few years in practice. In this chapter qualitative research, descriptive phenomenology Colaizzi's approach and its criticisms are discussed.*

### 3.1 Introduction

A paradigm guides the researcher in the choice of method and the study's fundamental construction. The elements of such paradigm include ontology, epistemology, and methodology (see table 3.1). The research methodology identifies one or more research methods that the researcher plans to use. The research methodology governs and limits the range of choices for data collection, data analysis, and the nature of the conclusions drawn (Park & Mauch, 2003).

In this chapter the philosophical foundation of the research method used to guide this study is discussed, and as such is defined as: '... a body of knowledge and insights, a history of lives of thinkers and authors, which constitutes both a source and a methodological ground for present human science research practices...' (Van Manen, 1997, p. 30). Therefore, in order to obtain a sense of how knowledge is produced by research, then evaluated, and used, it is important to unpack the conceptual perspective of the study. This knowledge is generated by answering research questions. The theoretical assumptions underlying the choice of methods in qualitative research, used in generating a particular form of knowledge, are based on philosophical traditions including: Grounded theory, Phenomenology, Historical research, Ethnography, Action research, Feminist research, Interpretive interactionism, and Critical ethnography (Taylor, 2006b).

Increasingly, over the past years, qualitative research methods are being embraced by nurse researchers, due to its applicability to nursing. Qualitative research is more congruent with the discipline of nursing which is based on a holistic and interactive

philosophy and knowledge gained from human experience (Holloway, 2005) . It enables the researcher to explain qualitative phenomena where they have not been able to quantify the questions asked (Ball, McLoughlin, & Darvill, 2011). For this current study, phenomenology is the method of choice. In this chapter, implementation of descriptive phenomenology as a qualitative paradigm is outlined and a number of issues surrounding qualitative research are explicated.

**Table 3.1: Paradigm of research-**

To clarify the researcher's structure of inquiry an exploration of the paradigm adopted for the study needs to be discussed

Concept	Question	Description
Ontology	What is the form and nature of reality? (Christian Apologetics & Research Ministry, 2005)?	Ontology provides acknowledgment of the existence of multiple realities, such as different feelings and perspectives toward the same phenomena from different people (researchers and every single participant in research) (D. Jackson, Daly, & Chang, 2003).
Epistemology	What is the nature of the relationship between the researcher and knowledge, and how do individuals verify what is true? (Coventry University, 2000; D. Whitehead, 2007)	Participants in qualitative research are viewed as the source of knowledge. The researcher is the one who is 'unknowing' and should be open to the experience. The researcher goes to the people involved in the experience and lets them speak. The qualitative research starts with a phenomenon or experience (Munhall, 2012a).
Methodology	How can the inquirer go about finding out whatever they believe can be known?	The way to structure the study and develop the knowledge and depends on the question being asked. The desire to gain knowledge and understand the social, cultural, and experiential aspects of a particular aspect of human existence is the origin of asking question (D. Jackson et al., 2003).

### 3.2 Qualitative research and its critics

Qualitative research is, 'the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design' (Polit & Beck, 2012d, p. 739). It is exploratory and involves a naturalistic approach. Munhall (2012c) stated, 'Qualitative research methods have much to offer as a research paradigm that is congruent with nursing's larger worldview, paradigm, or model. These methods offer ways to approach individuals in experiences, to encourage them to give voice to their experiencing and to care enough to search for meaning within the experience' (p. 61).

Characteristic methods of data collection include interviews, questionnaires, observation logs, journals, and participant observation as well as a variety of other techniques used to generate rich and meaningful data (Ammon-Gaberson & Piantanida, 1988). Charmaz (2003) have noted that qualitative interviewing provides an open-ended, in depth exploration of an aspect of life about which the interviewee has substantial experience, often combined with considerable insight.

Qualitative researchers usually study in a single setting or have a small number of participants or sites. A widely held view, especially among quantitative researchers, is that qualitative research lacks probability sampling and as a result is not considered high quality research (Light, Singer, & Willett, 1990). Maxwell (2005) argues that qualitative research uses purposeful sampling where particular sites and individuals are selected deliberately to provide the information needed to answer research question, as this information cannot be obtained from other sources.

Some authors believe qualitative research lacks external validity and generalisability (David & Sutton, 2011). Lipscomb (2012) and Sandelowski (1997) questioned the use-value of qualitative research. If qualitative research findings cannot be generalised then there is little or no usefulness in understanding the findings of studies in other situations, groups, or experiences. As a result, the use-value of qualitative research findings to nurses in practice would be under question. If the findings of qualitative research are limited to a particular time, place and sample then such findings would not generate recommendations for other times, places, and population (Newell & Burnard, 2006, p.

112). Despite this argument, qualitative research continues to have substantial implications for practice.

In response, Polit and Beck argue that qualitative research addresses this issue by considering the models of generalisation proposed by Firestone (1993). The framework of generalisation used by Firestone for quantitative and qualitative research includes classic statistical generalisation, analytical generalisation, and case-to-case transfer (transferability). In statistical generalisation, one infers that what is true of a sample is true of an entire population. This is valid only to the extent that the sample is representative of the population. Quantitative researchers begin studies by identifying a population. In analytical generalisation, generalisation is not inferred to the population sampled but to a construct or theory that may have much wider applicability than the particular case studied. Hence, the researcher strives to generalise the findings in support of a theory. Transferability means that the findings of a study may be applied within different groups of people or in different settings. It is the decision of the readers and consumers of the research to transfer the findings and apply them to new sites or situations (Polit & Beck, 2010a).

To increase the broad applicability of qualitative research findings, most writers suggest providing rich, or as noted by Gibert Ryle (1971, p. 474) 'thick' description (Firestone, 1993; Geertz, 1993; Lincoln & Guba, 1985b; Ponterotto, 2006). Thick description refers to extracting the meanings, actions, and feelings of the people or phenomena studied (Denzin, 2001). High quality, descriptive and critical information, enables readers of the research to understand the study's context and participants. This results in making an appropriate decision about the similarity of study contexts and their own environment (Polit & Beck, 2010a).

The major contribution of qualitative research is the extensive and detailed description of a point of view, a social world which gives the reader an understanding of a participant's world (Munhall, 2012d). The goal or purpose of quantitative approach is also to gain understanding but it requires structuring research questions in a way that can be observed, analysed and measured by numbers, percentages, and statistics. The focus of this study is to explore the experience of the journey from new graduate to proficient nurse. This



experience cannot be examined or measured with a quantitative paradigm (Taylor & Roberts, 2006).

### **3.3 Some common research paradigms in qualitative research**

Qualitative studies have their theoretical underpinnings in anthropology, psychology, and sociology (Polit & Beck, 2012f). Common designs include Ethnography, Grounded theory and the paradigm used in this study, Phenomenology.

According to Spradley (1980, p. 3), 'Ethnography is the work of describing culture'. The aim is to understand the activities and behaviours of a social group within its culture by observation, collecting data, and using multiple methods and hypotheses to form a picture of the social whole (Tham, 2003). Ethnography requires the researcher to spend long periods of time working directly with members of the cultural group. As a result rich and holistic descriptions of standard behavioural and social patterns emerge which describe the culture (Streubert, 2011b).

Grounded theory with a theoretical concept from sociology, inquires into key social psychological and structural processes within human interactions. The focus of Grounded theory is to develop theory about dominant social processes rather than to describe a particular phenomenon (Polit & Beck, 2012f).

Phenomenology, both a philosophy and a methodology, focuses on revealing meaning that makes social understanding possible and enriches our understanding of everyday life (Van Manen, 1997). There are two approaches, interpretive and descriptive. Descriptive (eidetic) phenomenology brings out the essential components of the lived experiences specific to a group of people (Flood, 2010). The purpose of descriptive phenomenology is to describe the human experience as it is lived (D. Carpenter, 2011a).

The approach taken in this study is descriptive phenomenology to answer the question 'What does it mean to be a new graduate nurse?'. This type of inquiry was considered the most appropriate to explore the experience of the journey from new graduate to proficient nurse in ICU. Since this is the paradigm used to guide the study, it is necessary to describe phenomenology in depth.

### 3.4 Phenomenology

The word 'phenomenology' originated from two Greek words: 'phainomenon' and 'logos.' Phainomenon, the participle of the middle-passive verb 'phainesthai,' derives from 'phiano', 'to show,' so it means 'which shows itself' (Nicholson, 2006). Phenomenology as a qualitative form of research focuses on phenomena as they appear. Phenomenology literally means the study of phenomena such as events, situations, experiences, or concepts. It describes something that exists as part of the world in which we live (Hancock, 2002). The questions in the phenomenology tradition include, 'What was it like to...? How did you feel when...? What did you think about...? How did you live through...?' Phenomenology is based on the belief that human beings are naturally self-interpreting and capable of reflective description of their perceptions (D. Carpenter, 2011a).

Phenomenology has been practised for many centuries. German philosopher, Immanuel Kant (1724-1804) in 1764, first described phenomenology. Kant believed that the mind had a complex set of functions. One of its crucial functions is the process and application of concepts to sensory inputs; as result knowledge is generated. This ability of mind is called synthesis, which is central to cognition. Kant's epistemological model generally states that the mind actively interprets information thus raw materials are organised into experiences. In his epistemology when he states that nature is not independent of thought and what is observed is not the only reality, he is practising phenomenology (Brook, 2013; Streubert, 2011c). Phenomenology as a moving and dynamic philosophy has been developed and branched out over the last century.

There has been a series of phenomenological movements namely the Preparatory, German, and French phases. The Preparatory phase was dominated by the German philosopher Franz Brentano (1838-1917) and his student Carl Stumpf. Brentano reintroduced the concept of 'intentionality' - the principal subject of phenomenology - into modern philosophy. Intentionality is a characteristic of the mind and means being aware or conscious of something. It is the information about something and the attitude toward something, 'the assumption that the life world is not an objective environment or a subjective consciousness or a set of beliefs; rather it is what we perceive and experience to be' (C. Carpenter, 2010, p. 127).

The German phase was led by the German philosopher Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976). The concepts of essences, intuiting, and phenomenological reduction were developed during this phase. Essences are the basic units of common understanding of any phenomenon. Intuiting is an accurate interpretation of what is meant in the description of the phenomenon under investigation. Reduction is identifying any preconceived ideas about the phenomenon under investigation. Husserl believed that phenomenology should be recognised as science and should be the foundation of all philosophy because phenomenology assists in deep understanding of the human experience (D. Carpenter, 2011a).

The third phase of phenomenological movement is French phase. The leaders of this phase were Gabriel Marcel (1889-1973), Jean Paul Sartre (1905-1980), and Maurice Merleau- Ponty (1905-1980). Concepts developed during this phase included 'embodiment' and 'being in the world'. As Munhall (1989) stated, 'Embodiment explains that through consciousness one is aware of being in the world and it is through the body that one gains access to this world' (p. 24). French philosophers argue that all actions arise from the perception of the phenomena. The individual cannot exist outside of the world they live in; they cannot be separated, and each influences the other. Furthermore, each person's lived experience is different from another person's lived experience (D. Carpenter, 2011a).

Phenomenology was adopted by nursing in the 1980s and 1990s (Embree, 2000). It has continued to inform much nursing research and researchers undertake various approaches to phenomenology (Banonis, 1989; D. Carpenter & Narsavage, 2004; Jiang, Chou, & Tsai, 2012; Kosowski, 1995). Phenomenology and nursing reflect the same values and beliefs relating to individuals and their relationship to the environment. They both value the holistic perspective of human experience. Phenomenological design is used to pose questions important to nursing, such as experiences of phenomena relating to health and illness, and treatment and care from the perspective of caretaker and giver. Understanding human experience is essential in nursing (D. Carpenter, 2011b). Phenomenological research gives nursing a new way to interpret the nature of consciousness and the involvement of individuals in the world (Beck, 1994). Thus people experiencing the phenomena describe their experience, and the researcher abstracts their words into common themes (Annells, 1999).

Phenomenological methods differ according to the theoretical assumptions that underpin them. Two main theoretical phenomenological perspectives are descriptive (eidetic) and interpretive (hermeneutic) (Cohen & Omery, 1994). They differ in how findings are generated and used to augment professional knowledge. Certainly, the methodological approach of any study, including the way in which data are analysed, should be compatible with the chosen theoretical framework. When a framework is properly utilised it is interwoven into all parts of the study. Lopez and Willis (2004) encourage nurse researchers to identify whether phenomenological studies are descriptive or interpretive in nature to clarify philosophical linkages and methodologies.

Husserl (1936, trans. 1970) argued that 'life- world' (Lebenswelt) is understood to be what individuals experience pre-reflectively, without resorting to interpretations. In developing a phenomenological framework to support an exploration of individuals' perceptions of what it is like to be a new graduate and then a proficient nurse in ICU, I believe that descriptive (Husserlian) rather than interpretive (Heideggerian) phenomenology best suits my purpose. Both approaches support the development of an understanding of what the experience means to persons. Interpretive phenomenology calls for the interpretation of a person's prejudgments or presuppositions in view of the text (Heidegger, 1962). Descriptive phenomenology calls for the suspension, or bracketing, of one's own presuppositions of reality to understand the reality of others (Husserl, 1913, trans. 2012). I believe that the descriptive approach best supports the development of an understanding of the unique life -world of new graduates nursing in ICU and how this changes over time.

### **3.5 Descriptive phenomenology**

Edmund Husserl (1859-1938) is credited as the father of descriptive phenomenology. His interest was the epistemological question: How do we know about the man? The goal of his phenomenology is the description of the lived world. Examples of philosophical traditions that inform descriptive phenomenology include Van Kaam's (1966), Colaizzi's (1978), and Giorgi's (1979) approaches (Beck, 2006; Todres & Holloway, 2010). Husserl's assumption is that subjective information, such as the human lived experience, perceived by human consciousness, should be important to scientists because it helps them to understand human actions in particular events or situations. Another assumption

underlying Husserl's approach to the study of human consciousness is that human lived experiences share the same phenomenon, a 'universal essence', the true nature of the phenomenon being studied. The third assumption of Husserl phenomenology, radical autonomy, articulates that humans are free individuals who influence their environment and culture. Conversely the impact of culture, society and politics on the individual's freedom to choose are not essential to Husserl's thought (Flood, 2010; Lopez & Willis, 2004).

Descriptive phenomenology involves three steps- intuiting, analysing, and describing. The first step, intuiting, is a direct exploration that transforms the researcher into a research instrument to interview and know the phenomenon as described by study participants. The researcher without the application of opinion or previous knowledge focuses on the phenomenon as described by the participants. Next, the researcher examines the data to determine the participants meaning of the phenomenon. The second step, analysis, involves identifying the essence of the investigated phenomenon. The goal of analysis is to develop a pure and accurate description. The third step, describing, involves grouping elements of phenomenon and finalizing with a written description of phenomenon (D. Carpenter, 2011a).

A key epistemological strategy of descriptive phenomenology is the concept of reduction or 'bracketing' to eliminate prejudgement or presupposition on the part of the researcher (Husserl, 1913, trans. 2012). Researchers put aside their personal beliefs as well as previous knowledge and personal experience or background about the phenomenon, in order to bring an unbiased approach to the study and try to see the real phenomenon (D. Carpenter, 2011a). Therefore, researchers clarify their biases in documentation that includes their own comments on experiences, prejudices, and perspectives that may influence the study. Thus, the researcher works with the study participants and uses the bracketing technique to attempt to capture the details of the human experience in an unfiltered way.

This study was informed by a descriptive phenomenology approach that provided insight into the life-world of new graduate nurses, and their journey. The human existence of new graduate nurses holds meaning. Connecting with the life-world of new graduate nurses and their journey towards becoming proficient nurses provides an opportunity to increase

understanding of the changes that occur in new graduate nurses' thoughts and needs over time. Using in-depth interviews, participants in this study were able to share their perceptions, feelings and lived experiences.

### **3.6 Criticisms of descriptive phenomenology**

There are criticisms regarding descriptive phenomenology itself and criticisms regarding descriptive phenomenology as used by nurse researchers.

Heideggerians think that interpretation in phenomenology is inevitable hence there is no such thing as descriptive phenomenology, 'The meaning of phenomenological description as a method lies in interpretation' (Heidegger, 1962, p. 37). This is a debate between descriptive phenomenologists informed by Husserl, and hermeneutic phenomenologists informed by Heidegger (Todres, 2005). Another criticism articulated by interpretive phenomenologists is that bracketing, as an important component of Husserlian phenomenology is impossible. The researcher's mind cannot be freed of the background of understandings that underpins the phenomenon under study.

Crotty (1996) criticised phenomenological research conducted by nurses. He commented that the qualitative research methods used in these studies were not pure phenomenology as founded by European phenomenological philosophers. He identified this as 'new' phenomenology, as descriptive, subjective and lacks critique. Paley (1997) indicated that nurse researchers misunderstand key concepts of Husserlian phenomenology and that their research is not consistent with the original philosophy of Husserl.

It is because of these issues, cited above, that Norlyk and Harder (2010) stress the need to clearly articulate a study's approach, philosophical underpinnings, phenomenon under study, bracketing or reduction, and how the knowledge produced by the study could be evaluated, trusted and utilised. Some of the methodological processes that can help to overcome the major criticisms are discussed below.

### **3.7 Criticisms addressed**

In response to the criticisms of descriptive phenomenology regarding impossibility of reduction or the necessity of interpretation, some scholars, such as Finlay (2009), consider

a description and interpretation as a continuum where a research could be more or less interpretive. This means even descriptive method include elements of both interpretive and descriptive phenomenology.

Furthermore in response to the impossibility of reduction, Dahlberg (2006) suggests that even if reduction is considered by some as impossible, being reflective and aware of intentionality would assist the researcher in a better understanding of phenomena. By restraining their personal beliefs, theories, and other assumptions, the researcher prevents being misled and gains a clear understanding of the meaning of the phenomenon. The researcher uses an understanding that not only takes care of particular pre-understandings, but the understanding as a whole. Thus, 'they do not understand too quick, too careless, or slovenly' (Dahlberg, 2006, p. 16). Colaizzi gives similar advice and indicates that if the researcher uncovers their presuppositions about the phenomenon under study, they will discover their beliefs and attitudes. Researcher can use presuppositions to develop research questions (Colaizzi, 1978). He also suggests returning to each participant and asking them about the findings to compare the researcher descriptive results with participant experience to validate the themes emerged from the research.

In response to Crotty's criticism, Todres (2005) argues that changes in the Husserlian philosophical project over time are leading to productive findings. Giorgi clarifies that modifications were made to phenomenology as a philosophy to make it relevant to scientific work of nursing research. He states that Crotty and Paley have failed to make a distinction between philosophical and scientific phenomenology (Giorgi, 2000a, 2000b).

In choosing descriptive phenomenology as the methodological process for this thesis, I followed the above advice. I chose to expose my presuppositions about new graduate nurses in ICU. I reflected on my presuppositions, and discovered certain beliefs and attitudes. This reflective process is discussed later in the chapter. The listed presuppositions and the findings of Phase One were a preliminary basis for formulating interview questions (Appendix 3). To address the risk of personal bias, assumptions and presuppositions, and to obtain the purest description of being a new graduate nurse in ICU, I chose to return to participants and ask them about the findings as advocated by Colaizzi (1978).

Although adopting phenomenology as a framework for conducting nursing research is challenging, it has gained respect as a valid approach in nursing research. Phenomenology offers a means to study human phenomena or lived experiences strongly relevant in the health care arena (Flood, 2010). Applying descriptive phenomenological approach in research: ‘may ‘humanize’ health- and social-care, not just by representing the ‘voices’ and views of patients, users and professionals, but by accessing descriptions of experiences that carry the intelligible meanings and textures of what it is like to be there’ (Todres, 2005, p. 117).

### **3.8 The research methodology**

The research methodology, used in this study is descriptive phenomenology. This approach is discussed below. Descriptive phenomenology is inductive and descriptive. The researcher aims to understand the human experience as it is lived with no preconceived expectations. This includes the cognitive, subjective perspective of the person who has experienced the phenomenon (Omery, 1983). Descriptive phenomenology follows a set of methodological steps: bracketing, intuiting, analysing, and describing. There are several procedural interpretations of phenomenological method used as guidelines for the practice of descriptive phenomenology in human science research. I sought a method that calls for validation of the results of data analysis from the participants in a situation. I believe validation in this way is important if the study results are to capture the essence and complexity of the participants’ experiences (Lincoln & Guba, 1985a). I favored Colaizzi’s (1978) *Procedural Steps of Data Analysis* because neither Giorgi (1979) nor Van Kaam (1966) call for validation of the findings by those living within the situation. Polit and Beck (2012e) categorise Colaizzi’s approach as a descriptive phenomenological method, however, Beck and Watson (2008) indicate that Colaizzi has tendencies towards both descriptive and interpretive phenomenology. Colaizzi’s method provides a structure for data analysis. This method involves seven steps: 1) acquiring feeling for the participants’ descriptions, 2) extracting significant statements, 3) formulating meaning, 4) organising clusters of themes, 5) validating themes, 6) integrating to exhaustive description, 7) formulating exhaustive description, and final validation (D. Carpenter, 2011a; Colaizzi, 1978; Taylor, 2006b).



### 3.8.1 Bracketing

Descriptive phenomenology focuses on bracketing, which is the cognitive process of a qualitative researcher to free themselves of bias or presumptions (D. Carpenter, 2011a). As I have practised in ICU for many years bracketing is helpful in narrowing my attention in such a way as to be able to discover rational principles underlying the phenomenon of the new graduate nurse journey in ICU (Taylor, 2006b). Furthermore, to ensure adherence to the principle of bracketing, only a brief literature review was conducted at the beginning of the research. The main review of literature occurred after data analysis so that a pure description of lived experience of new graduate nurses in ICU was achieved. Hence, my biases did not influence the research. The bracketing process was used in all three phases of study.

According to Gearing (2004), bracketing comprises three phases:

- (a) Abstract formulation with elements of the researchers' epistemological position, ontological perspective, and the theoretical framework.
- (b) Research praxis consists of the foundation and focus of the bracketing strategy, researcher (internal) and phenomenon (external) supposition, temporal structure (delineating the start point, duration and end point of bracketing), and parenthesis composition.
- (c) Reintegration focusing on unbracketing and reinvestment of the bracketed data into the larger investigation.

Gearing (2004) outlines six typologies of bracketing: ideal (philosophical), descriptive (eidetic), existential, analytic, reflexive (cultural), and pragmatic. The difference in each type of bracketing is based on a researcher's theoretical orientation, questions, focus, and emphasis. In this study, I followed descriptive or eidetic bracketing because it provides bracketing guidelines for descriptive phenomenology. The use of bracketing in the present study is described in three phases, as presented below.

### **3.8.1.1 Abstract Formulation Phase**

The abstract formulation phase of bracketing in a qualitative study includes creating an orientation standpoint and a theoretical framework (Gearing, 2004).

*Orientation standpoint* is divided into two components: epistemology and ontology (Gearing, 2004). From epistemology perspective, post-positivists claim there is a reality to be known but it is unlikely that this reality will be perceived perfectly (Denzin & Lincoln, 2011). While developing and conducting this study, I found myself close to a post-positivist stance because I believe observation may be imperfect and has errors and that all theory is revisable. The goal of science is to find the truth because all measurement could have error; the post-positivist emphasises the importance of multiple measures and observations to obtain the truth. To address this issue the data analysis process was closely observed by my supervisors and final findings were returned to the participants to ensure the truth essence of experience was obtained.

Two ontological perspectives are involved in descriptive bracketing: critical realism and relativism (Gearing, 2004). Post-positivists hold to critical realism, which claims that reality exists beyond the human mind. The scientific method does not perfectly grasp the truth because the scientific method contains errors from human bias (Lincoln, Lynham, & Guba, 2011). Therefore, truth is never perfectly captured. I believe nothing absolutely uncovers the truth perfectly because truth is involved with our perceptions and understanding. However, using phenomenology helps reveal the truth of a phenomenon. Therefore, throughout this study, I considered myself a critical realist.

As mentioned previously the *Theoretical framework* that guided the study was descriptive phenomenology, a methodology used to describe the experience of new graduate nurses journey.

### **3.8.1.2 Research Praxis Phase**

The research praxis phase of bracketing in a qualitative study involves five components: Foundational focus, internal or researcher supposition, external (phenomenon) supposition, temporal structure, and parenthesis (boundaries) (Gearing, 2004). Each component and its creation in the study is described below.

***Foundational Focus*** in bracketing consists of three foci: First, bracketing is defined as the process of setting aside presuppositions. Second, bracketing is defined as a process to discover the essence and structure of a phenomenon to either illustrate the immediate phenomenon or understand the fundamental universal essences of that phenomenon. Third, bracketing is defined as a combination of the first and second foundational foci, setting aside presuppositions, and finding the essence and structure of a phenomenon. The foundational focus of the bracketing in this study was the first foci.

***Internal or researcher suppositions*** are a set of the researcher's personal knowledge, history, culture, beliefs, expectations, values, viewpoints, and academic background. Therefore, in descriptive bracketing, the researcher brackets out their suppositions and assumptions. For this study, I clarified my biases in documentation that included comments on my experiences, prejudices, and orientations that might influence the study. My bias was experience and knowledge related to new graduate nurses. I discussed my suppositions with my supervisors. I was open to the idea that, throughout the course of study, I might uncover personal biases that I was not aware of prior to the study. Thus, I updated my list of biases and assumptions throughout the course of study. Details of my biases and assumptions are described in the following paragraphs.

Before collecting the data, I documented my previous knowledge of critical care nursing, personal background, judgements, assumptions, and perceptions. These assumption and preconceptions are derived from my own experience. The assumptions and preconceptions are listed below:

- The ICU is not an appropriate learning environment for new graduate nurses.
- Most new graduate nurses face being underestimated by their senior colleagues.
- New graduate nurses are not ready for the ICU environment.
- Patients would not wish to be cared by a new graduate nurse.

I also recorded in my journal what I knew about ICU staff members and the environment at the private hospital where this study was conducted.

I undertook a program similar to the New Graduate Nurse/Transition to Practice Program after my graduation overseas in 1994. The program was mainly developed to ensure that after graduation from university nurses would become part of health care workforce. The

program did not provide the support required for new graduate nurses and this situation continued until I left my homeland in 2000. Hence, I did not have any experience with the New Graduate Nurse/Transition to Practice Program as seen in Australia. However I have always experienced working with new graduate nurses since I was a new graduate. English is my second language and I used English to conduct my interviews. I did not have any difficulty during the interview process and the participants were able to understand me. However, if a participant did not understand me, clarification was sought during the conversation.

During data collection and before each interview, I took time to read about the bracketing procedures for qualitative research in order to maintain this guideline. In addition, I wrote notes about how the study participants reacted to the conversation and expressed their feelings during the interview. I attempted to minimise bias by listening carefully to what each participant said and what each participant experienced. I used clarification techniques when a participant mentioned unclear situations concerning things that were significant to their experience during placement in ICU as a new graduate nurse.

Wall, Glenn, Mitchinson, and Poole (2004) discussed developing a reflective diary, based on the framework of Schon (1987 ) and Johns (1994). This strategy supports the concepts of reflecting ‘on’ and ‘in’ actions and identifying specific learning, which has taken place. The reflective diary helps direct the researcher to have more understanding and critical thinking during the use of bracketing. After finishing each interview, I recorded details of the interview situation and evaluated the achievement of bracketing in each interview. I recorded what I knew about the participant and what my perception was of the participant’s experience during the placement in ICU. After finishing the interview with each participant, some of the participants’ stories influenced my personal feelings. I put myself in their shoes and remembered my own experience when I started to work in ICU 18 years ago although I reminded myself to maintain my role as the researcher. Furthermore, I noted what was learned from each interview and how to improve bracketing for other situations during interviews with further participants. Therefore, I bracketed out my suppositions and assumptions before, during, and after data collection.

***External (phenomenon) supposition*** are divided into three components: the examination of phenomenon being studied (e.g. history, values, or beliefs); the study of the

world/environment (e.g. large social and cultural elements); and the combination of both of the first two components. In this study the phenomenon being investigated was the experience of new graduate nurses in ICU and the changes in participants' experience over time.

*Temporal structure.* The researcher defines the time line for bracketing, including the start, duration, and end points. In this study, descriptive bracketing started when the methodology was chosen and ended after completing data analysis.

*Parenthesis (boundaries)* described as ideal, natural, or designed. In descriptive bracketing, the boundary composition involves the researcher's natural attitude. In this study, I suspended my natural attitude by writing in the journal and using the reflective diary from the period prior to collecting data until finishing the data analysis.

### **3.8.1.3 Reintegration Phase/Unbracketing and investment**

If one considers bracketing in qualitative research as being similar to brackets in mathematical equations, within brackets is the phenomenon under investigation, and outside brackets are the researcher's suppositions. In a mathematical equation, after achieving the data derived from within the brackets, the data are reintegrated in to the equation. Similarly, in the last stage of bracketing the researcher emerges the bracketed data back into the research (Gearing, 2004). In this study, I started bracketing when I selected the methodology, and I ended bracketing at the presentation of findings.

In summary, bracketing helps participants describe their experiences without the researcher influencing their thoughts. This strategy is important when applying the descriptive phenomenological approach because bracketing reduces the researcher's biases and presumptions while conducting the study. Therefore, the study findings demonstrate as close as possible the actual experience of the investigated phenomenon.

### **3.8.2 Intuiting**

In this step, the description of phenomenon as it is experienced by the participants is obtained. The researcher acts as 'instrument' or tool for data collection. The primary method of data collection is the interview where the researcher listens to individual

descriptions of phenomenon. In this step the researcher becomes totally immersed in the phenomenon under investigation (D. Carpenter, 2011a). I conducted semi-structured interviews to make sure that a specific set of topics were covered. At the same time, participants were free to provide as much detail as they wished.

### **3.8.3 Analysing**

Different procedural interpretations of phenomenological method can be used as guidelines in analysing the data. The aim is to identify the essence of the phenomenon under investigation which involves putting segments together into a meaningful conceptual pattern (D. Carpenter, 2011a). To facilitate the analysis, narratives are transcribed and the collected data are organised. This can be achieved manually or by computer programs (Polit & Beck, 2012e). In this study, I used a manual method in Excel format. Coloured highlight markers were used to code the content of narrative materials. For example, if I was analysing the responses to a question about being a new graduate nurse in ICU, a green highlighter was used for text relating to challenges, a blue highlighter for text on expectations, a teal highlighter for text relating to the ICU environment, and so on. All codes and data relating to codes were consolidated into a single Excel workbook. An ID number was assigned to each quote and coding (Hahn, 2008). Using Colaizzi's (1978) approach the significant statements pertaining to the phenomenon were extracted from transcripts. Meanings were formulated and organised into themes, which were then clustered into comprehensive categories.

### **3.8.9 Describing**

In this step, the researcher defines the phenomenon of interest. This means the researcher must describe the distinct and critical elements of the phenomenon in a written description. Hence, findings as isolated themes must be explicitly interrelated. Furthermore, the researcher must make sure bracketing is maintained throughout the analysis (D. Carpenter, 2011a; Polit & Beck, 2012f). According to Colaizzi (1978), the researcher should return to participants and ask about the findings to establish whether descriptive results compare with their experiences or some aspects of their experience have been omitted. I developed an exhaustive description of the phenomenon which was

integrated and formulated from the analysis of results. Participants in this study reviewed the findings and did not make any suggestions for change.

### **3.9 Summary**

Qualitative and quantitative research approaches are used to answer questions or solve problems. Because many nursing questions involve human experience a qualitative approach is appropriate to address many of these questions (Polit & Beck, 2012c). During the last two decades, qualitative nursing research has changed. New research has been pioneered by qualitative nursing researchers rather than sociologists and psychologists. Qualitative research has secured a highly regarded place over the last decade (Streubert, 2011c).

Phenomenology is a unique, scientific methodology and philosophy. The structure of this study is summarised in Figure 3.1. The thesis reflects my account of the description and in-depth understanding of being a new graduate nurse in ICU and their journey, using descriptive phenomenology and the seven steps of Colaizzi's data analysis. In the next chapter, the application of descriptive phenomenology in this study is presented.

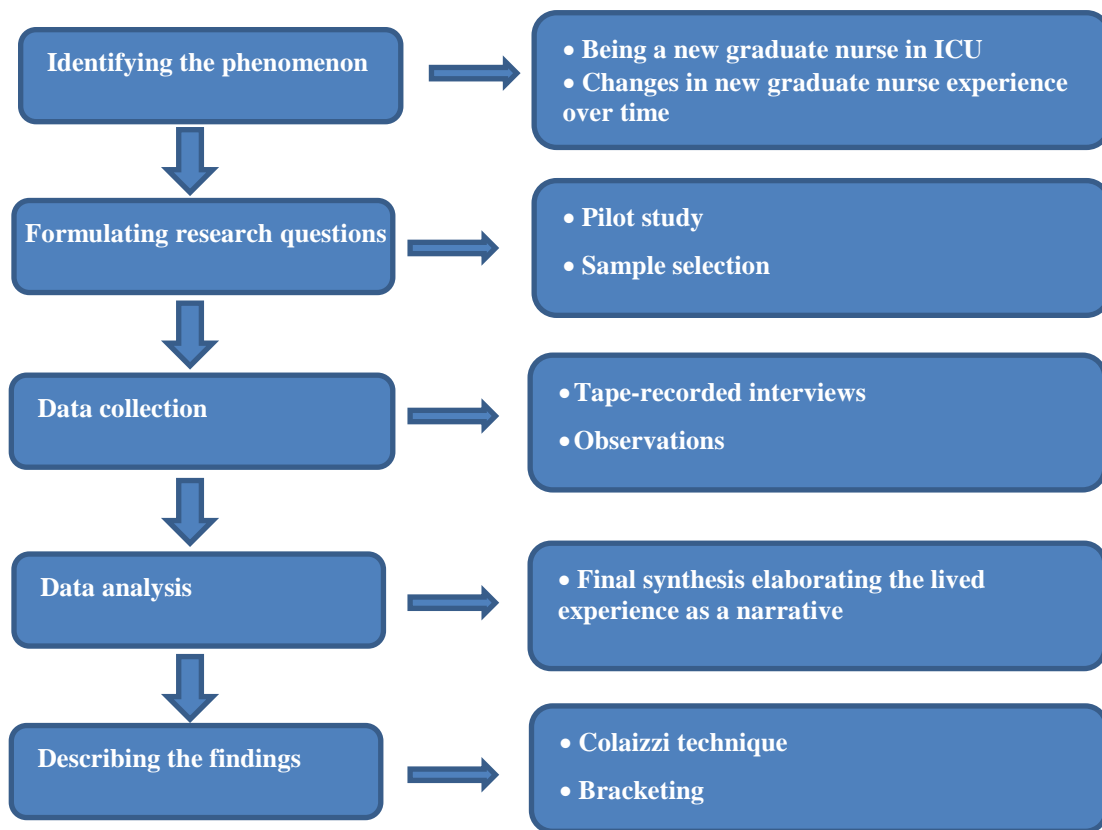


Figure 3.1 Phenomenological and longitudinal approach



## **Chapter 4**

### **The research parameters, the conduct, and findings of Phase Two**

*In this chapter, the research question and design for Phase Two are discussed. Participants selection, data collection, ethical considerations, and analysis strategies are described. In addition, rigor, trustworthiness, values, and biases of the study are discussed.*

#### **4.1 Introduction**

All research begins with asking a question and outlining the objectives for a study. Based on the research question, an appropriate method is chosen. In qualitative research, emphasis is on the holistic understanding of complex human experience. To explore this, participants are purposefully enrolled based on their familiarity with the phenomenon to be studied. Data are generally collected via interviews, then analysed inductively via specific, rigorous techniques, and then organised in a manner that best answers the research questions (Beck, 2009). In this chapter the research parameters (question and objectives), the conduct of Phase Two of study, and the findings are described and discussed. The presentation of findings is consistent with Colaizzi's approach where significant statements are extracted from the narratives. More holistic construction of rich, complete textual accounts of the phenomenon of interest, as presented by the participants, in a narrative style are contextualised in appendix 9- 'Examples of Colaizzi steps Phase Two' (pp 172-180).

#### **4.2 The research question and the research objectives**

The research question for Phase Two is 'What does it mean to be a new graduate nurse in an ICU in a NSW's hospital?' The objectives are to:

1. Describe new graduate nurses' experiences in ICU during the first year after graduation.
2. Identify the factors that perceived to affect new graduate nurses experience.

3. Explore new graduate nurses preparedness are for practising in ICU.

### **4.3 Design, implementation and choice of data collection method**

Descriptive phenomenology and Colaizzi's data analysis approach are used to uncover the meaning of being a new graduate nurse in ICU among participants at the beginning of their journey.

### **4.4 Ethical considerations**

Approval was obtained from both the University's and the hospital Human Research Ethics Committees (Appendix 2). All participants were informed that narrative research can cause participants to reflect and re-experience feelings related to sharing their stories. Polit and Beck (2012b) recommend using debriefing sessions for participants who experience distress related to reliving experiences. The participants were provided with access to a counsellor if needed. None of the participants experienced any stress from the interview process.

Participants gave informed consent to join this study (Appendix 5 & 6). They had the opportunity to discuss the research and to withdraw at any time. Confidentiality of the participants was assured. Names of participants do not appear on any study material except for the consent form. Each participant was assigned a code and a pseudonym.

I discussed the need for audio recording with all the participants during initial contact and everyone consented to be audio-recorded. The audio-records and all written research materials, including interview transcripts are securely stored in a locked filing cabinet and will be destroyed after five years after completion of this study in accordance with the Joint Australian Government National Health and Medical Research Council / Australian Vice Chancellors' Committee Statement and Guidelines on Research Practice (May 1997).

### **4.5 Criteria for sampling**

I used a purposive sampling method with a homogenous strategy. In purposive sampling the rationale for selecting is based on an individual's particular knowledge of the

phenomenon to be investigated, in this instance, 'meaning of being a new graduate nurse in ICU' (Creswell, 2013). By adopting an homogenous strategy in purposive sampling, variation can be deliberately reduced (Polit & Beck, 2006a). For example, participants are individuals who belong to the same subculture or have similar characteristics. In this study, the sample was homogenous with respect to the variables of RN, less than one-year experience in practice, employment in a NSW private hospital's ICU, and rotation through a New Graduate /Transition to Practice Program. These criteria for inclusion in the study or variables were established before the sampling commenced.

#### **4.6 Recruitment of participants**

It was convenient to canvas the potential pool of new graduate participants from my own work place. Participants were recruited through an invitation (Appendix 4) posted on the noticeboard in the ICU tearoom. Between 2004 and 2009, ten new graduate nurses who had an ICU rotation as part of their new graduate nurse program agreed to participate. Recruitment occurred while the new graduates were undertaking rotation through the ICU. To avoid any concerns of unequal or dependent relationships being developed with me, interviews only commenced when the participant had completed the rotation in ICU.

#### **4.7 Sampling size**

Generally, when conducting qualitative research, small samples sizes are common. Furthermore there is no actual guideline for sample size in qualitative studies (Barroso, 2010; Holloway & Wheeler, 2010). Therefore, commonly data saturation determines sample size. This occurs when no new information is obtained from the participants. In the current study data saturation was reached with ten interviews for Phase Two (Holloway & Wheeler, 2010; Polit & Beck, 2012g). Saturation is characterised by the following factors: i) scope of the research question, ii) data quality, iii) duration of research, iv) type of sampling strategy, and v) type of qualitative inquiry. In this study, six to eight participants were seen as sufficient. The participants were good informants who were able to reflect on their experiences and communicate effectively. In addition, because in Phase Three longitudinal data was to be collected, which provided a greater amount of information, fewer participants were needed. Furthermore, due to the type of

inquiry (phenomenology), small samples of participants are sufficient (Morse, 2000; Polit & Beck, 2010b).

#### **4.8 Study site and setting**

The primary study site was a private hospital's ICU in Sydney. Participants included ten graduates from five different Australian universities with a Bachelor of Nursing degree. I conducted five interviews in the participants' homes and five in the hospital.

Polit and Beck (2012a) argue that the interview setting can influence the way people respond during the interviews and requires a quiet, private, and comfortable environment. I interviewed participants at mutually agreed locations including the tutorial room in ICU, participants' homes, and over the phone for one participant in Phase Three who was overseas. A quiet environment facilitated all the interviews. Interviews were audio-recorded.

#### **4.9 Data collection**

The data collection occurred at least 3 months after the participant's placement in ICU. Prior to conducting the interviews, I explained the purpose of the study and asked each participant to sign an informed consent, and complete the demographic data tool (Appendix 7).

The interviews were audio-recorded because an accurate and reliable record is achieved when both the questions and answers are recorded. Audio recording allowed me to focus on developing rapport with participants and listening attentively. Also recording the raw data allowed for the material to be available for further in-depth analysis (Minichiello, Aroni, & Hays, 2008).

In depth, face-to-face, semi-structured interviews began after I had created an atmosphere of comfort and security to prevent distractions, noise, and interruptions. I used predetermined questions to guide the interviews (Appendix 8) in order to maintain the same general direction for each interview while responses from the participants prompted 'Follow-up questions or probes designed to elicit more detailed information' (Polit & Beck, 2012a, p. 537). I asked the participants to share their thoughts and feelings relating

to being a new graduate nurse in ICU until topic exhaustion occurred. I provided time for reflection during the interview process and focused on listening and observing the participants.

Colaizzi (1978) advises that the researcher should listen 'with more than just his ears: he must listen with the totality of his being and with the entirety of his personality' (p. 64) thereby becoming a research instrument to facilitate the interview process.

Two important lessons were learned in this process. The first was to step out of the role of mentor senior nurse into the role of researcher. The second, perhaps more important, was the need to develop mastery of open-ended interviewing. For this purpose, I had to consider a few points. I was seeking understanding from the participant's point of view, not vice versa hence I tried not to substantiate my own beliefs in questions. In addition I was following the mood of interviewees and aware of the participant's body, posture, and intonation of words (Munhall, 2012e).

Audio-recorded interviews were completed with all of the ten participants. Since I am not an expert transcriber, a transcriber was employed and audio-recorded interviews were transcribed into a word document.

I listened to each audio-recorded interview and reviewed each transcript in order to assure accuracy, then rigorously analysed the transcriptions. The length of interviews was between 1 to 1 1/2 hours.

#### **4.10 Technical difficulties**

I encountered a small number of technical difficulties. Taking note of whether the tape recorder was recording with a good quality of sound was important as well as taking note of when it was time to turn the tape over. A problem with the speed of tape-recorder hampered the audiotape quality of the first interview tape. Another issue was that, on some occasions, the interview was conducted before the participant commenced their shift, so I had to watch the time closely during the interview to make sure the interview would finish on time.

## 4.11 Phase Two

The interviews consisted of semi-structured, open-ended questions (Appendix 8). I invited the participants to describe what it was like to be a new graduate nurse in ICU in an attempt to gain an understanding of their experience of working in ICU.

The method of analysis described by Colaizzi (1978) was utilised to provide a rich description of the essential structure of the phenomenon. Colaizzi outlined the following steps (Colaizzi, 1978):

*Step.1 Acquiring a sense of each transcript*, in the phase of being a new graduate nurse, I conducted each of the interviews personally, which helped me to gain a sense of the whole experience for each participant. Colaizzi (1978) believes that researchers should read participants' narratives to acquire a feeling for their ideas in order to understand them.

To gain a sense of each participant's description of their lived experience of being a new graduate, I initially listened to each audio-record several times and read each transcript three times or more.

*Step .2 Extracting significant statements*, as Colaizzi (1978) suggests significant phrases and statements should be extracted from the transcripts. I read and analysed each transcript to identify and highlight the statements that told each participant's story of their lived experience of being a new graduate. To organise the collected data I used a manual method. I used a table of codes and a table of contents to categorise and group the data in a word document. This was completed by creating a table with numbered rows from each interview. Hence, I could clearly highlight and locate statements in one column. After highlighting each statement with a different colour, I re-read the data to identify early themes that were emerging in the data then entered the data in Excel sheets (Hahn, 2008).

*Step.3 Formulation of meanings*, Colaizzi (1978) recommends that the researcher attempts to formulate more general meanings for each significant statement distilled from the text. Each significant statement relating to the description and experience of being a new graduate was studied very carefully to determine a sense of its meaning. The fundamental questions I asked myself were 'what is the meaning of being a new

graduate?’ and ‘what does this tell me about new graduates in ICU?’ Hence formulated meanings were developed, taking into account the statement preceding and following each significant statement, to ensure that contextual meaning was not lost (Appendix 9).

*Step.4 Organising formulated meanings into clusters of themes*, similar formulated meanings were placed together in a separate Excel sheet. These formulated meanings were examined then organised into theme clusters (Appendix 9).

*Step.5 Exhaustively describing being a new graduate nurse*, an exhaustive description was created by reviewing all of the significant statements, formulated meanings and resulting theme clusters (Appendix 9).

*Step.6 Describing the fundamental structure of being a new graduate nurse in an ICU*, a comprehensive description of the lived experience of new graduate nurses in ICU was generated.

*Step.7 Returning to the participants*, as a final validation step after data from the last participants were collected and analysed, I returned to five participants to have them read the exhaustive description to ensure credibility of the study findings. The purpose of this final step was to determine if findings compared with their own experiences of the phenomenon being studied and they validated it as true to their experience. Because not all the participants remained in ICU, some moved away to another city and overseas (between 2004 and 2011), by the time that data were analysed (2009) I could access just five of the new graduate nurses. These participants reviewed the exhaustive description and stated that they felt that it was true to their experience.

## **4.12 Rigour**

Rigour in qualitative research refers to trustworthiness of the research findings. Streubert (2011a) asserted, ‘The goal of rigour in qualitative research is to accurately represent study participants experiences’ (p. 48). The most common technique used by Husserlian researchers to ensure that rigor is not compromised due to researcher bias is to ‘identify and articulate assumptions prior to data collection and analysis’ (Cohen & Omery, 1994, p. 148). I listed and reflected upon my own beliefs about the new graduate nurse’s experience in ICU. These assumptions are listed in Chapter 3 p 52 -53. Lincoln and Guba

(1985a) proposed explicit criteria for trustworthiness of qualitative research: credibility, dependability, transferability, and confirmability of the research.

To establish credibility in this study, I utilised selected techniques recommended by Lincoln and Guba (1985b). Firstly, I employed prolonged engagement; interviews lasted from 60 to 90 minutes and focused on the lived experience of participants. Interviews concluded when the participant had no further information to share. For assessing credibility of research, Lincoln and Guba (1985b) recommend performing participant checks, which correspond to validating findings required in the Colaizzi (1978) method. During this process I summarised the interviews with participants to check the accuracy of the description of the phenomenon.

I ensured dependability with an inquiry audit. According to Lincoln and Guba (1985b), the auditor examines the authenticity of the research findings as well as inspecting the research product. My supervisors assessed all research documents to confirm the research findings (Polit & Beck, 2012h).

Transferability refers to the generalisability of data. Qualitative research is not considered generalisable. Lincoln and Guba (1985b) best describe transferability in qualitative research by claiming that the researcher ‘can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility’ (p. 316). I enhanced transferability by providing a rich and thorough description of the phenomenon hence, any person who wishes to ‘transfer’ the findings to a different context is responsible for judging how sensible the transfer is.

Confirmability refers to consistency and repeatability of the data collection and data analysis. This was assured by the audit trail and manual coding method with Excel to organise the data (Figure 4.1). Field notes (about the process of data collection), theoretical notes (developing ideas during analysis), or method notes (regarding approaches to categorising or organising the data), were used to assist with consistency. Manual coding using Excel assisted me to examine and organise the data efficiently around the identified themes (Hahn, 2008; Lincoln & Guba, 1985b; Rebar, Gersch, Macnee, & McCabe, 2011).



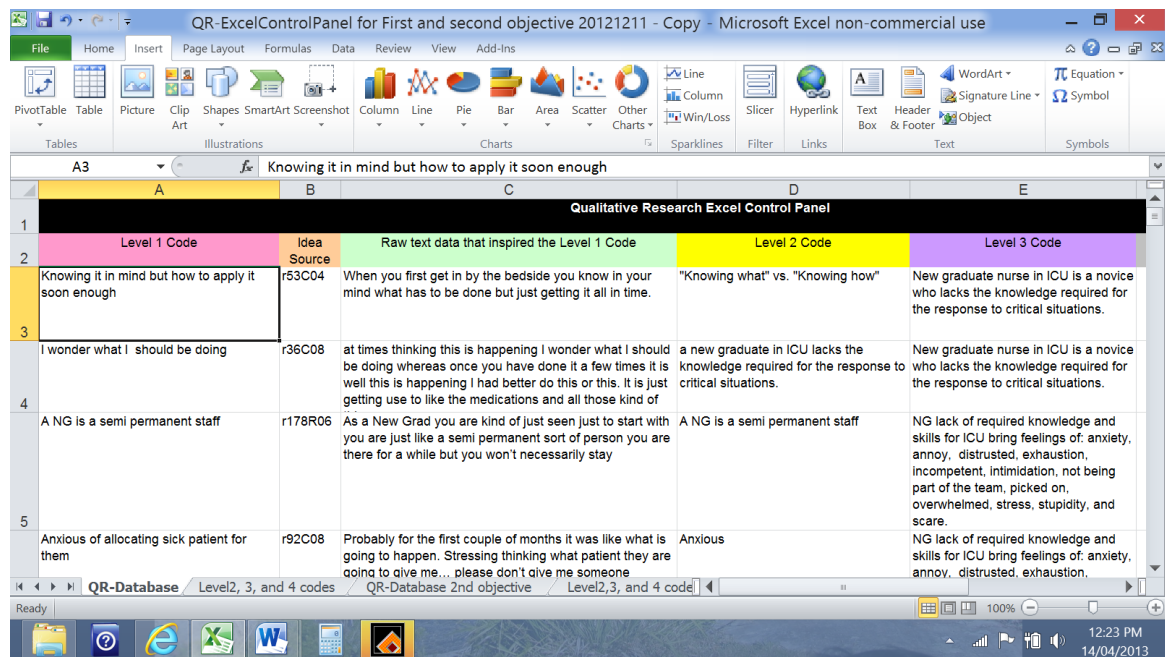


Figure 4.1 A visual overview of using Excel to organise the data

An easy and clear way to locate statements in transcriptions (by looking at source of data column) and high light three levels of coding.

### 4.13 Introducing the participants

Ten new graduate nurses volunteered to participate in this study. Nine of the participants were female and one was a male. Eight of the participants were between the ages of 21 and 30, one between 31 and 40, and one between 41 and 50. Participants graduated with a Bachelor of Nursing from five different universities and three different states. Having the participants from different age groups and university backgrounds helped to explore the diversity of individual experiences in the context of the shared experience. All of the participants received 2 weeks orientation. Participants had worked as a RN in ICU from 3 to 6 months at the time of interviews. Nine participants had spent 6 months in medical/surgical clinical areas as their New Graduate/Transition to Practice Program placement. One participant was a direct entry to ICU on her first rotation (this was a new strategy undertaken after 2009 to employ new graduates in ICU as their first rotation). All participants were Australian born. Two of the participants were able to speak another language besides English. I provided participants with a pseudonym to facilitate the telling of their stories. Pseudonyms were assigned so that there was no resemblance to the real names of the participants. Table 4.1 depicts demographic data of the participants.

Participants engaged in honest, open dialogues with me, which enhanced the quality of the interviews and richness of the data obtained.

Participant	Pseudonym	Age	Gender	Experience in ICU	Past work history in clinical areas	University	Other qualifications
1	Adam	20-30	M	5 months	Nil	University of Tasmania	Nil
2	Caroline	41-50	F	6 months	Nil	Southern Cross	Nil
3	Kate	20-30	F	3 months	Nil	University of Sydney	Nil
4	Kylie	20-30	F	6 months	AIN ( Nursing home) 2 yrs	University of Sydney	EN
5	Lily	20-30	F	6 months	EN 4 yrs	Not specified	EN
6	Linda	20-30	F	6 months	AIN ( Nursing home) 3 yrs	University of Western Sydney	Nil
7	Lucy	20-30	F	3.5 months	AIN ( Nursing home) 6 yrs	Not specified	Bachelor of Business, Bachelor of Law
8	Mary	20-30	F	4 months	Nil	University of Queensland	Bachelor of Science
9	Rose	20-30	F	6 months	Nil	University of Tasmania	Nil
10	Sophie	30-40	F	6 months	Nil	Not specified	Nil

Table 4.1- Characteristics of new graduate nurses in Phase Two

#### 4.14 Theme Clusters in Phase Two

This section describes the study's theme clusters, which were extracted from the transcripts. Examples from the transcripts are provided to illustrate the participants' lived experience during their New Graduate /Transition to Practice Program placement in ICU. Analysis of data proceeded through the Colaizzi stages outlined in Figure 4.2.

The six themes were uncovered: (a) Perception of ICU: unique environment; (b) Feelings; (c) Expectations of performance; (d) Interaction with others; and (e) Journey of novice

nurse. The following paragraphs address each theme cluster and provide descriptive findings of the participants' lived experiences as new graduate nurses in ICU.

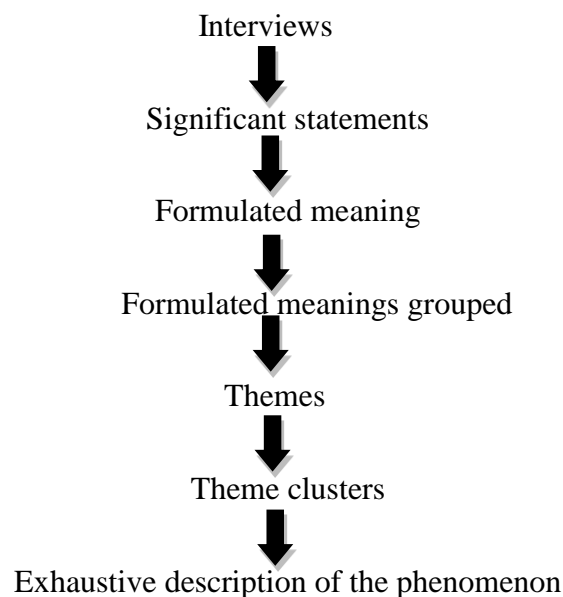


Figure 4.2 - Summary of data analysis

#### **4.14.1 Theme cluster one: Perception of ICU: unique environment**

The first theme cluster - perception of ICU- was defined as participants' understanding of ICU. These experiences were important because they distinguished, for participants the characteristics of ICU which made it a different environment to other clinical areas. These experiences were discussed and organised into three subthemes: attraction, challenges, and requirements.

##### **Attraction**

Attraction is defined as what caused the participants to choose ICU as preferred placement in their New Graduate /Transition to Practice Program. McCann, Clark, and Lu (2010) report that adult acute care nursing was one of the two most popular career choices among third year Australian Bachelor of Nursing students between 2005 and 2007. The ICU attraction in this study included: nursing critically ill patients, high responsibility, fast pace, different atmosphere to the ward, patient-nurse ratio, getting to know your patient, closer patient observation, and the opportunity of utilising broad clinical skills and knowledge in practice.

One major factor influencing the choice of New Graduate /Transition to Practice Program placement for participants in this research was the type of patients admitted to the ICU. Choosing the work place because of type of patients is consistent with studies reported in the literature (Palese, Tosatto, Borghi, & Maura, 2007). The participants took advantage of ICU rotation to try taking on the responsibility of looking after acutely ill patients, where patients and families are at the most vulnerable times of their lives. Because of the intense nature of the nursing care given to patients, specialised and comprehensive nursing knowledge is needed.

*I think it is the critical stages that the patients are in. I don't know... it sort of seems like...Intensive Care to me is like... the clinical sort.....what a nurse can achieve in terms of how much responsibility you have. You have to be very knowledgeable as well. I think it is more the critical ...how unstable the patients are that we do get is the major attraction. [Adam]*

Participants' responses reflect the new graduate nurse's perception that the ICU environment is different from the general ward area. The nature of critical care nursing is lifesaving and highly technical, matching patients' severity of illness and clinical needs. The glamorous and technological nature of acute care being attributable to the new graduate nurse placement preference is consistent with the literature on career choices (Happell, 1999; McCann et al., 2010; Rognstad & Aasland, 2007). Participants also highlighted patient to nurse ratios as a reason for wanting to work in ICU.

*Just the variety of the patients we are getting, the pace that is in ICU. Just the whole atmosphere in ICU that is completely different to ward nursing. The concept that you have one nurse for a ventilated patient two to three for unventilated... I like that kind of nursing... that you actually get to know your patient instead of running in and out of rooms like you would on the ward. I find that really interesting that you can sort of see all your clinical skills in Intensive Care it is just there and just really interesting. [Linda]*

*... I am quite a fastidious person so I find it really hard looking after six or seven people. I find it very frustrating, because I want to do everything for everyone and I was always leaving work an hour late. So ICU I felt was a good place for me because I could do*

*everything for everyone because the time is there, because you only have one or two patients... [Sophie]*

Some participants highlighted that gaining clinical experience in critical care, as a new graduate nurse, when support throughout the New Graduate /Transition to Practice Program is available, was the reason for wanting to work in ICU. This further supported the work of Farnell and Dowson (2006) who suggests that nurses come to critical care for knowledge and skills acquisition. Furthermore, using descriptive quantitative survey in five ICUs in Ireland, Muldowney and McKee (2011) identified that nurses new to ICU, perceived the environment as conducive to clinical learning. The majority of participants had 2-5 years' experience as a nurse. This could have resulted in different findings if new graduate nurses were recruited in the survey.

*It [ICU] was something completely different from ... say the surgical area that I had done prac at Uni, and I had done a tiny bit of experience in High Dependency placement at the end of my practical in third year, so I was interested in seeing that kind of area because I had limited experiences and I just thought this would be a good year to see with the support whether it was an area that I wanted to go into or not.[Linda]*

*The learning experience it is not an opportunity you get all the time [Mary]*

Participants mentioned one of the reasons to choose ICU, was the importance of working in ICU. They expressed the belief that ICU was the most important clinical area where they could use their clinical skills and knowledge gained at the university. A person's willingness to enter the nursing profession or to remain within it, has also been linked to professional public image of nurses and the profession's relative status (Reiskin & Haussler, 1994; Takase, Maude, & Manias, 2006). Furthermore, a perceived degree of social prestige in choosing critical care as a career choice has also been suggested by Ganz and Kahana (2006). They found that one of the factors affecting nursing students' perceptions towards clinical specialities is social belief in value of technology.

*... so it was trying to prove that I could make something of what I have done and work in the highest kind of area that I thought was the most important sort of thing and prove that I can mix it up there with the best of my workforce.[Rose]*

*The type of patients they had in ICU I knew it was a high acuity area for patient care that you were maintaining basic life support with them so that was something that was important in all areas. [Caroline]*

One participant found the nurse's autonomy the reason for wanting to work in ICU. She believed nurses in ICU are able to make clinical judgements and decisions and act on these decisions. A survey by Reiskin & Haussler (1994) identified that high school students did not perceive nursing as a career with the power to make decisions. If nursing students have the same perception, it is not surprising then when they enter the workforce that they prefer to make up for this shortfall. Palese et al (2007) acknowledges this sense of autonomy as an important factor for newly qualified nurses to choose their first work place.

*The other area that I really like is the autonomy of it [ICU]. not that I could go and do whatever I wanted to but I like the fact that if my patient is in pain I can give them more morphine. I like the fact that it is autonomies here you do have room to make a clinical judgment, you need to, and you need to do it very quickly. [Lucy]*

## **Challenges**

Challenges were defined as situations in ICU that participants found demanding or stimulating (mentally or emotionally). These include the move from theory to practice, the vast knowledge and skills required to nurse critically ill patients, and utilising various high technology equipment.

New graduate nurses considered university as more theoretical, and the transition process as application of theory to practice (Ostini & Bonner, 2012). The participants felt that they had acquired the essential clinical skills at university to enable them to function as qualified nurses although they did not possess appropriate clinical skills and knowledge to nurse critically ill patients.

*I like the challenges of ...like the actual knowledge challenge, the ability to have the amount of knowledge necessary to provide safe patient care ... because that is a real challenge there is always something new. [Sophie]*

*.... on the ward it is quite often specified, what you need to do for the patients whereas here [ICU] you need to monitor the patients and there are guidelines as to what to do.*  
[Mary]

In addition, participants found themselves confronted with situations when they had to give their full attention and alertness to the patient's condition. Being responsible for detecting minor changes in a patient's status, that could get aggravated in a very short time, was also named as one of ICU challenges. Participants did not always have the scope of knowledge to recognise acutely sick patients confidently, and this could adversely affect patient care and cause dangerous situations that would otherwise be preventable. The issue of detection and management of deteriorating patients is not just a challenging topic for new graduate nurses; it has been one of the hot topics in NSW Health Department and Clinical Excellence Commission over the last few years. According to incident management in the NSW Public Health System (IIMS) March 2007, data from 178 case reviews in 2006, listed the reasons for inadequate patient management leading to harm to patients included: knowledge, skills, competence issues and clinician failure to properly diagnose the deterioration. One of the areas NSW Health has invested in is education and training. The education program focuses on detecting warning signs of deterioration and ensures that patients receive appropriate care in a timely manner (Clinical Excellence Commission, 2008). The participants just confirmed that knowledge and skill obtained by training and experience could address the issue of recognising and responding to deteriorating patients.

*You are dealing with one or two patients who are very ill or have the potential to go downhill very quickly so it has an added level of extra vigilance and I think the responsibility in some respects is a bit more.* [Sophie]

*I think the challenge is the critical state of the patients...the way that they can deteriorate so quickly and the way you need to react very quickly. You don't have time to sit there and go well maybe I could do this, maybe I could do that.* [Lucy]

Participants felt challenged by the amount of equipment they were supposed to know and work with. This has been also explored by Feng and Tsai (2012) in a study of the socialisation of new graduate nurses in Taiwan. They revealed that new graduate nurses

experienced so many stimuli that they felt overwhelmed. This is further supported by a descriptive qualitative study regarding lived experience of new nurses in a hospital in United State of America. It highlights that complicated equipment and advanced technology added to challenges new graduate nurses faced (Clark & Springer, 2012).

*There are so many machines... you are not just looking after the patient, there is everything else around you, gadgets and patients to look after... [Lily]*

*I think mainly the equipment that we tend to use we don't see on the ward like the dialyses and that sort of thing. Just becoming confident with the adjustments you need to make and things like that. [Mary]*

## **Requirements**

Most ICU patients require close monitoring and life support devices such as ventilation, inotropic therapy, renal replacement therapy to name a few. Participants believed that to work in an ICU environment some criteria are essential. The World Federation of Critical Care Nurses supports this:

*'A critical care nurse is a registered practitioner who enhances the delivery of comprehensive patient centred care, for acutely ill patients who require complex interventions in a highly technical environment; bringing to the patient care team a unique combination of knowledge and skills. The roles of critical care nurses are essential to the multidisciplinary team who are needed to provide their expertise when caring for patients and their relatives' (World Federation of Critical Care Nurses, 2005).*

It is vital for critical care nurses to be able to use the highly technical equipment confidently. This is also mentioned in the literature. Even a few decades ago when technology was not as sophisticated, in a survey of ICU nurses in the North of England, Stones (1986) ascertained that new equipment was a challenge for nursing staff. Furthermore, it is known that perceptions of technology differ between (Swenson, 2008). Participants in this study comprised two generations: two from generation X (born between 1965 and 1979) and eight from generation Y (born between 1980 and 1994) (McCrinkle, 2007). Generation Y is known to be technologically sophisticated as they have been exposed to technology from infancy (Hart, 2006). Even so, in this study, they



felt challenged by the number and different types of equipment in ICU. One participant described:

*So I think you just have to be really keen to learn and just push yourself to learn. Stand up and talk to people. You have to be a bit outgoing you can't be reserved...there is so much out there in Intensive Care you have to be keen you can't be one of these people who wants to just sit back and watch you have to be keen you have to be jumping in and saying I want to know... I want to learn. You have to be enthusiastic about learning.*

[Linda]

The Australian Critical Care Nursing Education Advisory Committee describes a critical care nurse as one who not only requires knowledge and skills in clinical decision-making, and critical thinking, but also in problem-solving, reflective practice, leadership, and teamwork (Williams et al., 2006, p. 400). The need for critical thinking and rapid response was highlighted in this study as Caroline said: “*You have to really act and move fairly quickly.*” Being organised, having confidence, remaining calm in critical situations and being able to work under pressure were also highlighted by participants as requirements for working in ICU:

*I just think the most important thing about your shift is that you have to be prepared for anything that goes wrong. You have to have good time management skills and I think you really have to be organised. Like you have to have all of your drugs there you have to have ....you have just got to be really organised* [Lily]

*I think you need the confidence to show the patient that you're fine. You can't flap around in front of a patient that is not well... think okay how the family is feeling, how is the patient feeling and if I start flapping around here in a panic they are only going to panic. It is only going to make the situation worse.* [Caroline]

The skills and knowledge of an ICU nurse are applied across the domains of early recognition and intervention, risk management, recovery and rehabilitation in the care of critically ill patients (Critical Care Nurse Training Standards Task Group, 2005; World Federation of Critical Care Nurses, 2005). Participants indicated one important ‘must’ for working in ICU is to be equipped with all the knowledge and skills required to care for critically ill patients. They described how much they had to learn and some likened it to a

network with many detailed branches. This is consistent with Wilkins and Slevin's study (2004) which showed appropriate skills and knowledge are essential factors in delivering effective and compassionate care to critically ill patient.

*Yes there was just so much more to learn, and then you would learn one thing and then you find out there is even more detail that you have to go into. It's just like a network of...you just branched off into so much more detail. I can't explain it. You would be doing a chest x-ray and you would think yes... yes I have got it I understand one thing and then you find out there are ten other things that you should know about ... [Kate]*

*I really needed to have a good medical knowledge because I look at the nurses here... the high level nurses here... they are the most unbelievable. Their anatomy and physiology, even their chemistry, their knowledge is just unbelievable. I never even thought it would be as in-depth as what it is. [Lucy]*

One issue for new graduate nurses, highlighted throughout the literature, is the time management (Andersson & Edberg, 2010; Myers et al., 2010). Participants felt that time management was quite important and they considered this skill as natural skill in some new graduate nurses. O'Kane's (2011) study of new graduate nurses in ICU found that time management was one of the main challenges for them. In my study, participants did not consider time management as the main challenge but as a requirement for working in ICU.

*Some [new graduate nurses] just really battle... in your basic ward work, in your time management. Some [new grads] wouldn't be able to work under the pressure in ICU.... you can't flap around as much in ICU... there is just some that you just think they just don't seem to have the skills or ability. [Caroline]*

As suggested in the literature a foundational characteristic of new graduate readiness for practice is the application of practical knowledge. There is a sense that foundational clinical skills can be practised and advanced clinical skills can be developed in general wards (Wolff et al., 2010). This perception was also expressed in this study when participants stated that they could benefit from working in general wards for a longer period before entering ICU as they could transfer the basic nursing skills acquired in the ward area.

*You do need pre knowledge; my opinion is you need a year or two before going into ICU not the first six months of nursing ever. University doesn't count as nursing experience... coming straight out of reading text books going onto the ward for six months and then going straight into ICU just didn't seem to be enough time. [Kate]*

#### **4.14.2 Theme Cluster Two: Feelings**

The second theme cluster- Feelings- was defined as emotions experienced by participants in this study. Feelings varied from unpleasant and difficult to pleasant and divided into two subthemes: Negative feelings and Satisfaction.

##### **Negative feelings**

Negative feelings in this study referred to unpleasant emotions, which according to participants, included anxiety, annoyance, exhaustion, incompetence, intimidation, not being part of the team, being picked on, feeling overwhelmed, stressed, and stupid. Participants found their lack of required knowledge and skills for safe practice in ICU caused negative feelings.

Studies have shown that the negative feelings of graduate nurses such as being overwhelmed or fearful of making mistakes are generated from situations in which they are not able to perform the care they feel is the most appropriate, through lack of experience (Ellerton & Gregor, 2003; Watt & Pascoe, 2013). Furthermore Li and Lambert (2008) found that anxiety related to insufficient knowledge led to extreme stress. In the current study, anxiety experienced by participants was associated with lack of confidence and feelings of inadequacy to deal with very ill patients, and unexpected events requiring fast action. This further supports the work of Casey, Fink, Krugman, and Probst (2004) who suggest that feelings of lack of confidence and feelings of inadequacy were common sources of stress for graduate nurses.

*Well starting out anyway, I was a bit anxious... I think it was mostly lack of confidence about myself, that was mostly it. [Kate]*

*Probably for the first couple of months it was like what is going to happen. Stressing thinking what patient they are going to give me... please don't give me someone difficult.*  
[Caroline]

At the beginning of their placement, participants felt that the ICU environment was intimidating and overwhelming. They even considered being a new graduate in ICU as a “scary” experience. Kylie described it “*It was very intimidating and a bit scary at first... at times it does feel overwhelming*”. The participants did not have the knowledge required to cope with technology and the level of patient dependency in ICU. This led to participants feeling overwhelmed, scared and out of their depth.

*I had a [post op] heart [surgery] coming back. Someone had done the set up for me and I should have checked it but I didn't and then the heart came back, it turned out that everything had been set up except the air and the oxygen so that was totally my own fault. They came in and the ventilator was alarming... we got that sorted because a few people were helping me out but then as the patient was all set up, the blood pressure was going up and down and I was hanging the Gelo[fusion] and titrating drugs and running from one side of the bed to the other..... It was all too much and then the final thing was the burette fell off the bag....and the bag burst all over the floor and that was the end of it. I burst into tears. It was just one shift where everything went wrong. I wanted to quit nursing.* [Kate]

*You walk in there on your first day and you don't know what any of the equipment is and it is all very overwhelming and you know you don't know how the ventilator works and you don't know how the monitor works. There are all these machines it is a totally scary environment.* [Sophie]

*I think because I have never worked with patients that were so ill and I wasn't quite sure what to expect... like I knew having a heart patient what things I needed to look out for, but it is... just knowing how much time you have to intervene.* [Mary]

Participants also highlighted feeling mentally exhausted at the end of their shifts. There is a considerable amount of research regarding exhaustion and burn out (Azoulay & Herridge, 2011; Mealer et al., 2009; Spence Laschinger, Grau, Finegan, & Wilk, 2012). Exhaustion develops as part of burnout and is due to taxing work situations, and time

pressure. Excessive job demand is considered to drive people into a spiral of expending valuable personal resources (such as effort, and energy) (Shirom, 2011). During the first three years of practice, every fifth nurse is at some point burned out (Rudman & Gustavsson, 2011).

*Over a more period of time it's getting less than when I first started I use to go home and I was just exhausted mentally exhausted, whereas now I am sort of more content I can go home and I can separate it more [Linda].*

Participants experienced feelings of not being part of the ICU team; they even highlighted feelings of being worthless or being belittled. Ostini and Bonner (2012), in an Australian study focusing on the experience of newly graduated nurses working in a rural acute care facility, identified similar findings. They described that in some clinical areas, it took a while for new graduate nurses to feel included and be part of the team.

*Still not having a permanent place in the team and not being accepted all that sort of thing [Rose]*

*Only at first, they wouldn't really ask me they would ask the senior staff the questions. [Kylie]*

*You sort of feel quite worthless and feel like nothing [Lily]*

*Initially I thought such and such is making me feel about one inch big... maybe I am crap... maybe I am doing the wrong thing. [Mary]*

Participants described that due to lack of knowledge they experienced stress and anxiety. Sometimes they felt by the end of the shift they had enough. Lack of knowledge, clinical judgment, and decision-making skills are well-researched causes of stress and one of the most influential variables that affects new graduate nurses decisions to quit their jobs (Booth, 2011). Bowles and Candela (2005) in a survey of 353 new graduate nurses in United State of America reported that the vast majority of new graduates in their study believed that the working environment was stressful. The most frequent reasons for leaving their first positions was related to stress associated with the acuity of patients and the feeling that patient care was unsafe. In the current study two of the participants

mentioned that they even thought of leaving nursing due to the emotional challenges, and the kind of patients they nursed.

*You have some days where you get over it....and you have had enough.* [Adam]

*I had a tubed patient on dialysis.... and I had never had a patient on dialysis. They withdrew treatment from this lady, and they had to tell her daughter. I started crying and it was just really sad and it was just horrible. I just didn't expect it and I didn't really know what I was doing because I think looking after a tube patient on dialyses is quite difficult especially for a New Grad and I had no idea what I was doing let alone withdrawing treatment.* [Lily]

*I did question if I had made the right choice coming to ICU on my first shift just simply because it was such a stressful time for me and I thought...how am I going to survive my six months.* [Mary]

Above extracts describe occasions when participants felt most stressed, challenged and reflect a possible reality, that of leaving nursing in ICU.

### **Satisfaction**

Satisfaction was described as the contentment participants felt when they fulfilled their own expectations regarding caring for an ICU patient and taking part in a patient's recovery. They described their feelings as 'good', 'content', 'satisfied', and 'rewarded'.

*Usually pretty content that I have done my little bit with the patient.* [Mary]

The participants were beginner nurses in their first year of work. When they were able to deal effectively with situations, they felt a great deal of self-esteem and self-worth. This is supported by Jackson (2005) who focused on newly qualified nurses' experience of a good day. She highlighted that satisfaction could be gained from developing competency. For participants in her study one of the essential components of a good day was 'to be able to perform competently'. In the present study several participants commented that feelings of satisfaction came with being able to detect early signs of a patient's deterioration and making a clinical decision.

*Yes and it does boost your confidence in what you are doing then ...I made a difference.*  
[Mary]

*Being in a clinical situation where I now have enough knowledge in the background to go and pick up on something early, or make an early diagnosis, or alert the doctors to something that they haven't seen, or someone else hasn't seen, and you have managed to prevent something... or you have managed to stabilise the patient before something else goes wrong. Being able to intervene before that feels good ...that feels good, yes. You go "Wow I actually know something and I feel good".* [Rose]

Feelings of satisfaction were strongly linked to the rewarding aspect of having a primary responsibility for patient care. The nurse- patient ratio of 1:1 or 1:2 in ICU, due to the serious nature of patients' illnesses, gave the participants the opportunity to provide acceptable quality of care to their patient. For some patients the process of recovery was slow however, this gradual progress was rewarding for participants. Jackson (2005) described the sense of satisfaction among newly qualified nurses achieved when the nurses were able to spend time with the patients, giving one to one care and being able to make sure all their needs are met.

*Even just to see long term patients... you have had dealing with care and different stuff... you can see that every day that they are getting better and might be with them for so many days out of their whole stay in Intensive Care but you can see that... like yours and everybody else's work... they progress. And I find that really rewarding.* [Linda]

#### **4.14.3 Theme Cluster Three: Interaction with others**

The third theme cluster - Interaction with others - was defined as communication between participants and others in ICU including patients, relatives, nurses, medical team and allied health personnel. Related subthemes were Interaction with patients, Interaction with other members of ICU team.

##### **Interaction with patients**

Interaction with patients referred to the communication between a participant and patient in ICU and the influence of the communication on the participant.

There is sufficient support in the literature to identify that trust is a crucial element in establishing an effective nurse-patient interaction (College of Nurses of Ontario, 2006; Fleischer et al., 2009; Lotzkar & Bottorff, 2001; Mok & Chiu, 2004; Sellman, 2007). Participants understood the importance of trust and feeling safe in nurse-patient interactions, and they believed it could influence a patient's acceptance of care. Some of participants expressed how they tried to hide their level of inexperience in ICU from their patients and their families as they felt this lack of experience would influence the level of trust the patient might have in their ability to carry out their care. Two examples are as follows:

*They would probably think "Oh... my god! You're not very experienced" or they might lose a bit of faith in you. And I probably would too if someone was looking after me and they said actually this is my first year out I would be like okay... it would be like what are they doing now .... No, I don't usually let on and if some just say directly how long have you been nursing ....Oh well I just avoid it. So no, I don't let them know. [Caroline]*

*...I was looking after a patient who had had major heart surgery and here I am looking after this person and the family says, "Have you been working here for long?" ...I just get around it and say I have been working here for a while instead of saying I am just learning everything and just get around it in a way to change the conversation and stuff. I change it by saying everyone here is very experienced and everyone has done other qualifications after their nursing degree. [Linda]*

Previous work by Andersson and Edberg (2010) also identified this attitude among new graduate nurses of conveying confidence to patients as a sign of becoming a genuine nurse. They described that new graduate nurses focus their energy on getting acceptance from patients. In the current study, some participants used different ways to hide the fact that they have limited experience in ICU. They avoided answering questions such as 'how much experience do you have', and even tried to camouflage their appearance, which labelled them as junior staff. Sophie believed if she wore a darker coloured uniform, the patient and families would think she was senior and they would trust her more.

*I would never ever wear the light colour shirt because if I wore the light colour shirt they would always ask me how long I had been out of uni[versity]. ...But if I wore the dark*



*colour, they would always think that I had been out for a certain amount of time. For some reason they had in their head the dark uniform means that you are more senior and patients would trust things that you say and families would trust things that you said... it would just make things easier. It's really bad, it's pitiful.* [Sophie]

Druchscher (2008) reported that the endeavour to disguise feelings of inadequacy by new graduates is a normal behaviour. The importance of previous nursing experience in developing trust between the new graduate nurse and patient has been described by Belcher and Jones (2009) in a qualitative research study involving new graduate nurses in a Melbourne metropolitan hospital, in Australia. They explored the new graduate nurses' experience of developing trust in nurse-patient relationships and found that developing rapport was the first step to building a trusting relationship with the patient. In order to develop rapport, new graduates identified previous nursing experience as a major theme (Belcher & Jones, 2009).

### **Interaction with other members of ICU team**

Interaction with other members of ICU team refers to communication with doctors and nursing staff in ICU and its effect on them. Participants in this study agreed that interprofessional relationships between nursing and medical staff in ICU is more equitable than in a general ward.

*At first coming from the ward, it is really different.... the doctor situation... it is a lot easier to talk to the doctors in Intensive Care, because you work in a tight [relationship] .....you have to be communicating well with the doctors in Intensive Care where as on the wards it wasn't really like that... nobody spoke to the doctors.* [Kylie]

Most participants revealed that they find support in interactions with doctors and named it as a good experience, *"I think their (doctors) communication with us is quite good"* Lily claimed. Participants indicated that as soon as doctors knew they were new graduate nurses they would patiently explain different clinical matters to them. The importance of support for new graduate nurses as they enter the work force is well documented in the literature (Johnson, 2003; Rush et al., 2013). The following quotes illustrate participants' experience of communication with doctors as being supportive and understanding:

*... Doctors were actually quite good I thought. Generally, I think most of them, if they knew you were new ...You were introduced as soon as you came onto the unit as being a New Grad and someone new... so I found that that was quite good because they knew that you were new.... they had no issue with explaining things . [Sophie]*

*Most of them (doctors) if they know you are a New Grad; they tend to explain things a bit more. [Mary]*

Three participants claimed that the different personalities of doctors would affect how approachable they were, especially at the beginning of their rotation. They found interacting with doctors challenging and intimidating. This finding is confirmed in the literature. For example Gough, Johnson, Waldron, Tyler, and Donath (2009) in an Australian study, report that graduate nurses find that asking questions of doctors is challenging. Kelly and Ahern (2008), in a phenomenological study in Australia, noted that the different personalities and attitudes among doctors and senior nurses overwhelmed new graduate nurses, and in general, they find communicating with doctors relatively uncomfortable.

*I think first out... yes, I was very intimidated by the doctors, I didn't know how to approach them and sort of things like that, whereas if you are a more senior level you know how to communicate to the doctors and you can get things done a lot faster. [Linda]*

These contrasting perceptions of interactions with doctors could be due to the different interpersonal skills and personalities of participants. It is recognised in the literature, that lack of interpersonal skills is a contributor to bullying at work (Croft & Cash, 2012). In addition, the personal characteristic of new graduate nurses affects how well they fit in (Moore et al., 2013).

The participants identified having other new graduate peers available to talk to and share clinical experiences was a relief. This is consistent with Ostini and Bonner (2012), and Dyess and Sherman (2009) who identified that debriefing with other new graduates is a good source of support.

*I think sometimes when you are a New Grad, not specifically in ICU but other places as well, they don't expect you to be there that long and sometimes they don't get to know you and things like that. [Mary]*

One of the factors that participants believed affected their interactions with the nursing staff was that they did not know them. On occasions participants believed that because of the temporary nature of their employment as new graduate nurses, the permanent staff did not consider them members of the team. One of the participants found that some senior nurses interact with new graduate nurses in a different way compared to other staff:

*...one of them, a CNS when I see how he interacts with other nurses that are above me I think there is hope for me, he is just testing me and making me do stuff and maybe in 6 months, 9 months everything will be fine . [Lucy]*

Participants also spoke of their commitment and determination to 'do their best' as new graduate nurses. Participants stated that they felt the need to prove themselves as competent nurses to be part of the team and accepted by their colleagues, as can be seen from the followings:

*I think it is only to prove myself and I think there will be a time when I will have proved myself, not to be the perfect nurse but to be a competent nurse ...not that I am incompetent but I am not quite at that stage yet. [Lucy]*

The importance for new graduate nurses to feel that they are part of the team in ICU is highlighted in the literature. A variety of authors have investigated the issue of new graduate nurses socialisation and being part of the team in ICU. For example, Malouf and West (2011) studied new graduate nurses 'fitting in' with an already established social group in clinical area. They indicated 'fitting in' was about feeling one's self to be part of a social group and this was important to new graduate nurses. Similarly Andersson and Edberg (2010), found that nurses during their first year after graduation wanted to feel the acceptance and sense of belonging to the staff and the unit. None of these studies specifically identified the temporary nature of new graduate nurses employment as a factor that prevents other staff trying to get to know them.

*It was good... it was good to have another New Grad with you, so you weren't floundering around on your own...somebody else was floundering around next to you too.*  
[Caroline]

Participants reported that the nursing staff were not aware of their level of knowledge and skills. Hence, sometimes they would explain the simplest nursing clinical tasks. Sophie said, *"It can be difficult sometimes interacting with staff because they don't really know you and they don't know how much you know"*. It is interesting that when Moore, Leahy, and Lanig (2013) studied nurse to nurse interaction from experienced nurses' perspective, and reported that new graduates who had a know-it-all attitude were likely to have difficulty establishing positive relations with experienced nurses.

Some other participants reported frustration in dealing with the feeling that they were being watched by their colleagues. However, they understood the position of other nurses in terms of maintaining safe clinical practice. This re-iterated the findings of Myers, Reidy, French, McHale, Chisholm, and Griffin's study that preceptors believed nurses new to practice are not able to identify what they do not know and preceptors considered this as a safety concern (Myers et al., 2010).

*They are very vigilant and looking over your shoulder which you understand but it can be frustrating because sometimes you feel like they can't even trust me to do the most basic of things but you understand why .* [Sophie]

Few studies have examined the role of personal resources (self-efficacy, self-esteem, and optimism) in lowering emotional exhaustion (Spence Laschinger et al., 2012). In the current study, it seems that participants with different personal resources have different perceptions of the criticisms from their colleagues and they respond in different ways. Reactions to criticism, as manifested by participants, were accepting of it, or negatively exaggerating it. Some participants accepted the perceived criticism from their colleagues, as they were aware of their own lack of skills and knowledge. Adam, Rose, and Sophie shared their experiences:

*I don't take the critique in a bad sense. It's good. Essentially that is what we need... it is necessary. For myself I have only been in Intensive Care for five months so of course people tell me this is a better way of doing that or not to do it that way.* [Adam]

*If someone new came into the environment, you do need to the first thing rate them.*

[Rose]

*The person that is watching you they don't know that you have done this thing like heaps of times in the last three weeks. You can take an arterial blood gas for example because they haven't worked for two weeks so they are watching to make sure but I understand why so it is frustrating but you still understand it. It is such an environment it can potentially be quite dangerous so you have to have that supervision there and that is fine.*

[Sophie]

Participants identified that some of nursing staff were easy to approach. After trying different colleagues, they would know with whom they could ask their questions or approach for help. Most of the time the person chosen for support was the lowest in the hierarchy. Johnstone et al (2008) carried out an investigation on exploring the concept of support as a process critical to facilitating graduate nurse transition and integration into a hospital's local systems. Findings of their study suggest that new graduates actively seek out staff that they think will support them the most. Supportive staff tend to be identified by their manner and the way they make them feel.

*It is good in a way because it makes it quite clear, as who the best people are to ask for advice ... on different levels. For example, if I needed advice on a technical nursing matter, I would go to someone who was maybe a CNS or close to being a CNS. Whereas if I needed some more personal advice like: I am finding this really hard, and I didn't feel comfortable discussing that with someone that was sort of close to the top of that chain of hierarchy. I might go to someone that was maybe a couple of years in.... that maybe hadn't done their Post Grad yet, who maybe would be able to empathise more where I was coming from, and be able to feel more comfortable communicating that information with them.* [Lucy]

*You sort of find out who you can ask and who you can't and those more willing to help you and you keep going back to those people and asking.* [Linda]

When asked to share their experiences of communicating as new graduate nurses in ICU, the participants reported how the positive feedback from their colleagues or patients boosted their confidence. Jackson's (2005) phenomenological research into the

experience of a good day by newly qualified RNs mirrors the current study. The participants were looking for confirmation that they were performing to an acceptable level. Caroline described her experience as “*It just took the pressure off and I thought well maybe I am not that useless*”. Another participant shared the feeling of satisfaction she experienced from positive feedback she received for her role in a patient’s recovery:

*I have had a couple of patients that have said “You are a really good nurse keep going this way, don’t change, make sure you stay in nursing so that other people have the same experience that I have”; and you come out and you feel really good; and you think like “Wow..... I really made a difference to someone, and maybe I did make the right decision by being a nurse”. [Rose]*

Formal appraisal was important to participants going through their placement in ICU. The participants believed that feedback from the manager was as an opportunity to evaluate their progress and achievements during the New Graduate /Transition to Practice Program:

*I think they [senior nurses] need to say “Yes you have had a bad day but you did well we will see you tomorrow”; just a bit of positive feedback would do wonders... Like I think, I had a chat with one of the other New Grads and that was probably one of the most important things that we said we were never told that we were doing well. You can’t judge how well you are doing unless you get feedback; unless you are getting negative criticism all the time, which you seem like you are when you are a New Grad, there is no obvious sign that you are doing really bad [Rose].*

According to Kanter (1993) feedback is a support structure which enables employees to accomplish their work in meaningful ways. In addition, studies show that new graduate nurses, as newcomers to healthcare teams and complex work settings, understand the importance of constructive feedback (Laschinger & Smith, 2013). Five new graduate nurses stated that they reflected on the feedback. One participant expressed:

*I do thrive on feedback, I find that really important just so I can take it on and improve my skills. Sometimes I will ask people and go “Am I doing the right thing?” and different stuff, because I like to get feedback off people about doing stuff. [Linda]*

#### 4.14.4 Theme Cluster Four: Expectations of performance

The fourth theme cluster- Expectations of performance- was defined as the performance level considered reasonable for a new graduate nurse in clinical practice. This included what participants perceived to be their colleagues' expectations and their own expectations of themselves. Nurses, by graduation, expect to have the necessary skills to perform nursing and to be a nurse; however, in this study the exact level of performance required was vague. It is also interesting to note the differing expectations between generations (Calhoun & Strasser, 2005; Hart, 2006; Swenson, 2008). Between 2004-2009, when Phase Two was conducted, for the first time in many hospitals, three to four generations of nurses were working together. Different generations often have quite different expectations of their work (Greene, 2005).

Some participants reported high self-expectations, which contributed to their motivation to do their best, and at the same time, it was overwhelming. Farnell & Dawson (2006) and Newton & McKenna (2007) reflect similar findings reporting that graduate nurses have high self-expectations and their tendency for self-criticism cause stress.

*I think I expected too much of myself... like the NUM said she could see that I was not happy. [Kate]*

Ostini and Bonner (2012) found that being newly graduated did not lessen feelings of responsibility among new graduate nurses. This concurs with this study, that participants felt a sense of responsibility to maintain their professional standards.

*I have very high expectations of myself as well... so I would push myself even more. I have very high expectations of myself in doing a lot of stuff... I am pretty self-conscious and conscientious person. [Linda]*

All participants stated that there was inconsistency between their own clinical performance expectations and others' expectations of them. Some participants regarded the levels of expectation in their clinical performance by their colleagues as high. This is consistent with studies by Johnstone & Kanitsaki (2008) and Millwater et al (2006). They identified that new graduates were frequently expected to perform at levels more consistent with those of an experienced nurse. Also a previous study by Hatler, Stoffers,

Kelly, Redding, and Carr (2011), indicated that inappropriate expectations of new graduate nurse handling a patient load resulted in significant stress and feelings of inadequacy.

*I think it is so daunting because people just think you know how to use this or that. I would definitely say people expect you to know more... but there are some things you have to come back to square one and just say I don't know what I am doing can you explain it. And if you don't ask and you don't explain to people they will just expect that you know. [Lily]*

*... In the very beginning, I felt that they expected me to be better than what I was in this environment. Occasionally you would come across someone... a couple of staff... who would think .... "You should know this. You should know this by now". It's like... we have been here now two weeks, how could I know everything by now and they said Oh well I thought you would be quicker at this by now. .... I thought you would have picked up more on this by now... [Caroline]*

*...some people really do expect a lot of you and you think... oh my God... I am a new grad[uate], give me a break. [Rose]*

Conversely, some participants believed ICU staff were underestimating the level of knowledge and/or skill of new graduate nurses. McKenna et al. (2003) reported similar findings; their study demonstrated that most graduate nurses felt undervalued by other nurses. They also reflected on horizontal violence experienced by Registered Nurses in their first year of practice.

*Sometimes you find that they do underestimate what you do know. I think just one day someone was explaining to me just how to do a simple dressing and that is something you learn in your first year. [Mary]*

*... then some other people you kind of get put on a back foot because it's like ... "Oh they are just New Grads" [Rose]*

*... as in New Grads in particular they just think you are this clueless student who doesn't know what they are doing.... and you just feel too old for it to have all these people talk*



*down to you and have to explain things slowly to you.... and everyone sort of sees you as the inexperienced one [Kate]*

*Because I think people generally, look down on a New Grad. But that is not just any New Grad... that is just New Grads in general... because they don't have the experience that other people around you have. People constantly give you advice which I think is so good but sometimes I think ....you know.... people pick on you or just think that because you are a New Grad then, you are just a New Grad. [Lily]*

Undervaluing the capabilities of new graduate nurses or holding unrealistically high levels of expectation indicates a lack of consensus among nurses as to the performance of new graduates. Lofmark et al. (2006) reported that nurses with 5 or more years' experience years tended to rate new graduates' competence more harshly than nurses with less than five years' experiences.

#### **4.14.5 Theme Cluster Five: Journey of novice nurse**

The fifth theme cluster - Journey of a novice nurse - was defined as the process of gaining knowledge and skills over the period of time from when participant start the placements in ICU until they feel confident to practice independently. Through this journey of learning, they experienced challenges. Participants started their journey at the lowest level of the profession and as they proved themselves, they became confident.

As described by Benner (2001) skill acquisition in clinical nursing practice starts with the novice level when an individual does not have any (or minimum) previous experience in the clinical situation. Novice refers to the new graduate nurse who is new to the ICU environment and the type of patients and has no previous experience as a RN in ICU. They lack the knowledge required to respond to critical situations. The participants were afraid they would not know what was going on with each patient.

*I don't know what I am doing... I've got these patients and I don't know what I am doing. [Caroline]*

*I just got myself in a situation where the patient was really sick and I hadn't been in that situation before and not knowing what the next step to do and needing to do the step*

*faster and then having to intervene... I would probably get there but it would take time.*

[Rose]

*.... If the patient was on a ventilator, there should be time to start weaning them off and heading towards extubation. I wouldn't know the best time to do that and it wasn't the best care for the patient. I wasn't helping them quickly along to the road to recovery.*

[Kate]

Dreyfus & Dreyfus (1980) distinguish between the level of skilled performance that can be achieved through principles and theory, learned in a classroom, and the context-dependent judgements and skill that can only be acquired through actual practice. Participants agreed that at the commencement of their placement in ICU they had the foundational knowledge of a clinical situation although they could not make the connection between their knowledge and a patient's needs. Participants indicated that, as novice nurses, they were focused on the acquisition of knowledge and skills.

*You have only had three years of uni you don't have the experience... not even close*

[Lily]

*What you learn in your degree is sort of like the basics.... that is what I see it, as the three years only covers the basics, it sets you up for learning more through other courses that you apply for yourself through the other organisations.* [Linda]

*You learn your basics but they cover all your nursing, so you have got your mental health and your this and your that... maybe if there was some subject that covered your acute care... you have your basic acute care.* [Caroline]

*Because I think when you have finished studying you are not always competent in regards to drawing a bridge between the practical and the theory.* [Sophie]

Some participants felt incompetent for practice in the ICU setting. They worked in the present without a full grasp of clinical implications. Duchscher (2009) has provided ample evidence in her study that during the first three to four months of practice, new graduate nurses felt that being 'exposed' as clinically incompetent is one of their primary fears.

*...like I was basically incompetent I had no idea what I was doing.* [Caroline]

*Well I don't think we get enough prac in the university course to be prepared for what we do when we come out. A lot of the things you don't learn until you are actually out working.* [Mary]

Confirming what Mary said, previous studies indicate that new graduate nurses often feel unprepared for the challenges in intense practice environments (Dyess & Sherman, 2009; Pellico et al., 2009).

As discussed in the literature, new graduate nurses move away from the novice stage through a transition process (Duchscher, 2008; Goh & Watt, 2003). Transition has been defined in Webster's Dictionary as 'passage or movement from one state, stage, subject, or place to another' (transition, 2013). In this study transition referred to moving from the role of being a novice in ICU to the next level. Repeatedly, participants shared the meaning of being a new graduate nurse as moving from the education environment by completing a nursing degree to the service environment where they had to learn to be a nurse.

*I look at being a New Grad as part of finishing my degree and it is like an extra year and then I am feeling more qualified now, I feel like I have done a degree in nursing that I am sort of starting to become a nurse.* [Linda]

Similarly the theory of transition presented by Duchscher (2008) incorporates a journey of becoming, where new graduate nurses progress through the stages of 'doing', 'being', and 'knowing'. A Swedish qualitative study of newly qualified nurses' experiences during their first year in the new professional role also showed similar findings. It illustrated that the new graduate nurses' experience of becoming a nurse was a process that started with striving for acceptance and respect from their colleagues, and ended with actually feeling like a registered nurse (Andersson & Edberg, 2010).

Similarly to what Duchscher (2008) has described, participants in this study initially experienced feelings of being unprepared for the responsibility and the functional workload of the new role. They had limited knowledge and skills of critical care nursing. Participants lacked the skill of critical thinking and subsequently of making clinical judgments. However, by the end of six months in ICU, participants had developed considerable skills with practice.

*I had to put in a catheter a few weeks ago... I have done it on a dummy but I have never done it on a person before and I never got to do it as a student simply because you are a student and most people, they, don't want a student putting in a catheter which is fair enough... [Mary]*

*One of my patient's blood pressure was dropping... "Do I do this?", "Do I do that?", "At what point do I call the doctor?" Or their urine output has been very low for the last couple of hours perhaps they need a little bit more fluid... even something as simple as "Should I alter the height of the bed or maybe I should get them back into bed?" [Lucy]*

Similarly in a qualitative research conducted in community-based care facilities in Florida, Dyess and Sherman (2009) reported that new graduates often feel unprepared for the challenges of complicated environments requiring critical thinking.

Over time, participants felt a consistent and rapid advance in their thinking, knowledge level, and skills competency. They became increasingly comfortable with their roles and responsibilities as nurses. If participants used to seek validation for their decision-making and clinical judgments from colleagues before, they began to examine the underlying rationale for nursing and medical interventions and their appropriateness and effectiveness.

*Well initially when I started if something like that happened ...say if you have got infusions running you would be unsure what you would put it to and then you would shout out to the doctor ... "What do you think?", whereas now I would have no sort of hesitation. I'm adjusting the infusions and that to what I believed would be more beneficial to them. Then of course, if it does continue to worsen you need more advice. [Adam]*

*When I had just started, just doing arterial lines and CVPs and all these gizmos and gadgets, I had never heard about and how to just do stuff , whereas now to sort of just tube and set up and things, I find just so easy now. It is just part of the day. I don't have to think about it so much. That is just basically built in now. You can do a setup so easy whereas when I first started, they would say are you okay such and such coming back. you would have to remember how many tapes you had to put out, have to put out the Keflin, have to put out the GTN, make sure you have got your potassium, make sure you*

*have got all your lines. Whereas now it is just like... it all flows, and I get it up really quickly whereas it use to take me ages to remember where everything goes. [Linda]*

Participants gained knowledge and skills over time, and felt more accepted and trusted by the staff, found they were more confident and progressed to the next level. As a result, participants felt satisfied and more comfortable. Similarly Malouf and West (2011) reported that new graduates did not want to appear 'stupid' to other staff members and other people's perceptions of them were very important in determining their ability to fit in.

*You know I feel better than I did few months ago because I know more. I think that people are more accepting of us and more comfortable with us working around them because they feel that they can trust us a bit more now which is important.... I feel more comfortable. [Rose]*

*Slowly as you gain confidence, they would sort of back off a bit. [Kylie]*

*When you get through a shift that might have been a difficult a shift... maybe an acutely unwell patient... and it has just flown because you have been so busy you look back and you think, "Wow, I did that." You know it just boosts your self-confidence too. [Caroline]*

*It does give me satisfaction that I can get everything setup and I can have my patient come in nice and smooth and get all that done even if my patient has anything going wrong with him that I am on the ball that I can pick it up quick. [Linda]*

It is important to consider that new graduate nurses experience two transitions: the transition from being a student to being a new graduate nurse, and the transition from being a novice to becoming an advanced level beginner and then progressing to the next levels as they gain experience. It seems that at the beginning of the New Graduate /Transition to Practice Program these transitions overlap. The initial transition from student into the professional role is a unique stage in a new graduate journey. As new graduates gain experience and acquire knowledge and skills, they move forward from novice level practitioners to the advanced beginner level when the second transition is completed.

#### **4.15 Exhaustive description**

According to Colaizzi (1978), providing an exhaustive description of the investigated phenomenon is the fifth of a seven step phenomenological data analysis method. In the exhaustive description, the researcher integrates the results of study. In the present study, the findings were organised into five theme clusters (Figure 4.2). Therefore, the exhaustive description is composed of the findings of the phenomenon being studied - the experience of new graduate nurses in an ICU.

For new graduate nurse, ICU was an unknown segregated clinical area, a unique environment with challenges. New graduate nurses in ICU experienced challenges such as trying to be part of the team, the vast knowledge and skills required to nurse critically ill patients, perceived high expectations from other staff, and utilising high technology equipment, responsibilities, intensity, and time management. At the same time, the challenges brought learning opportunities, which made ICU an attractive place to work. Although, to go through these challenges smoothly, new graduate nurses believe they needed to have enthusiasm for learning, in depth knowledge, and time management skills.

New graduate nurses' perception of ICU brought a range of feelings from satisfaction to annoyance. Negative feelings such as anxiety, annoyance, distrust, exhaustion, incompetence, intimidation, not being part of the team, picked on, overwhelmed, stress, stupidity, and being scared occurred. The root of these negative feelings came from a lack of required knowledge and skills for ICU.

In the unique environment of ICU, new graduates interacted with other nursing/medical staff, patients, and their families. New graduate nurses responded in different ways to their perceptions of their interaction with others: understanding, accepting, doing the best possible, exaggerating negatively, or getting frustrated. In interaction with staff, they benefited from positive feedback. Interaction with other members of ICU team was supportive and in occasions challenging. New graduate nurses were able to identify which members of the ICU team were approachable. In communication with patients, they try to hide the fact that they are graduate nurses. New graduate nurses perceived that other staff either had high expectations of them or underestimated their abilities, although they usually had high expectations of themselves.

In transition from being a novice to the next level, new graduate nurses undertook a journey. When they started in ICU, they did not have the knowledge or skills required to work in ICU. They required constant prompting. They experienced challenges as learning opportunities. New graduate nurses entered a hierarchical system in which, they went up from lowest rank to higher level as they proved themselves. They gained confidence they felt more accepted and trusted by other staff.

#### **4.16 Fundamental structure**

Colaizzi's (1978) next step is to take the exhaustive description and write a clear statement of identification of the fundamental structure of the phenomenon. I developed the following statement of identification of being a new graduate nurse in ICU from the research findings.

Participants articulated that being a new graduate nurse in ICU implied being a novice on a journey to become a confident nurse, experiencing different challenges, feelings, thoughts, and perceptions on the way. The main challenge for new graduate nurse was their lack of knowledge and skills required for the work in ICU. New graduate nurses, according to their own personalities and coping mechanisms, found different ways to confront their feelings, thoughts, and perceptions. New graduate nurses had different experiences in communicating with others (patients and their families, nurses, doctors and allied health). The interaction experience was either overwhelming and frustrating, or quite pleasant and supportive. New graduate nurses also experienced disparity in the skill levels expected of them. As time passed and the new graduate nurses learnt more, they were able to feel more trusted by others, found themselves to be part of the team, and felt more satisfied.

#### **4.17 Summary**

In this chapter, the findings of the data analysis of interviews with 10 new graduate nurses were presented, interviews focused on participants' day-to-day experiences in ICU. Colaizzi's (1978) method was utilised to conduct the data analysis. Five major themes emerged from the data. Participants, in their journey as novice nurses in ICU, experienced various feelings and emotions. They found ICU a unique environment with challenges and attractions, where practitioners require specific levels of knowledge and skills to

practice at an appropriate level. In addition, interactions with others including patients, doctors, and nursing staff, were described by participants. Participants had different perceptions of others' behaviour in their interactions. In chapter 5, issues relevant to changes in participants' experience after few years in practice (Phase Three) are explored.



## **Chapter 5**

### **The conduct and findings of Phase Three**

*In this chapter the research question and design for Phase Three is discussed. Participants' selection, data collection, ethical considerations, and analysis strategies are described.*

#### **5.1 Introduction**

In the previous chapter an exhaustive description of being a new graduate nurse was developed. In this chapter, the original group of participants were revisited to explore their lived experience as registered nurses with two to four years of experience, and to understand the changes in this experience over time. This chapter describes the research question and aim, demonstrates the design and implementation, and data collection. In addition, participants' recruitment, characteristic and ethical issues are outlined. Finally, descriptive phenomenology and Colaizzi's approach applied in this study are illustrated.

The presentation of findings is consistent with Colaizzi's approach where significant statements are extracted from the narratives. More holistic construction of rich, complete textual accounts of the phenomenon of interest, as presented by the participants, in a narrative style are contextualised in appendix 11- 'Examples of Colaizzi's (1978) step-Phase Three'(pp 181-188).

#### **5.2 Phase Three**

After completion of Phase Two, I was curious to know how the participants in the study had changed in their career and whether they had different views and perceptions in this journey. Looking for an answer, I commenced Phase Three.

##### **5.2.1 Ethical approval**

Ethical approval was renewed annually by completing annual reports to the university and the research committee of the hospital. A new application was not required as there were no changes in the way participants were approached nor to the interventions

implemented. Because in Phase Three the same participants from Phase Two, who had already been given an information sheet and completed consent forms, were involved, and there were no changes in nature of the study, a separate information sheet was not given nor was a consent form obtained. In order to maintain anonymity, participants' names were changed to the corresponding codes and the same pseudonyms from Phase Two to facilitate the telling of their stories. The pseudonyms had no resemblances to the real names of the participants. The findings were not discussed outside the student-supervisor relationship.

The structure of the study is revisited in Figure 5.1 (see Figure 1.1 p. 3).

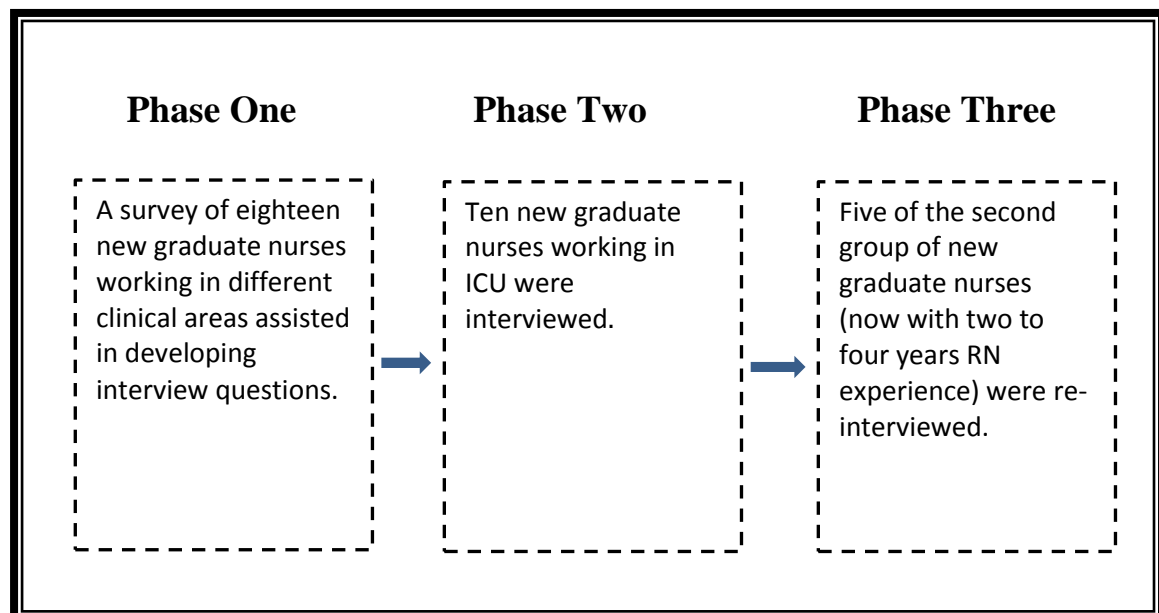


Figure 5.1 Structure of the study as it progressed through three consecutive phases, each phase related to the previous one

### 5.2.2 The research question and the research process

Five of the original ten participants were re-interviewed. Two to four years had passed and these new graduate nurses were now registered nurses with two to four years' experience. A further in-depth interview was completed (see Appendix 10). The research question for Phase Three was 'How did the new graduate nurse experience change after few years in practice?' The objectives were to:

1. Explore changes in their experience of working in ICU that they perceived to be relevant to their work experience.

2. Identify the factors that led them to remain in ICU.
3. Explore how they view newcomers now.

Common themes among the participants in Phase Three were extracted. I repeated two of interview questions from Phase Two. As a result, I could compare participants' responses to the same question over a period of time (i.e. as the journey of a novice nurse).

### 5.2.3 Participant recruitment

Five of the original participants agreed to be re-interviewed. Three of the five participants were still working in the same ICU, one had joined the ambulance services and practised as a paramedic nurse, and one was living overseas and not practising in ICU. The purpose of the study was explained to the participants. They were quite excited to know how far I had progressed with my research. Interviews were arranged at times to suit the participants. The participant who was living overseas was interviewed over the phone. I therefore completed five interviews to see how they might be able to inform the study about their experience as registered nurses after few years in practice. Table 5.1 depicts demographic data of the participants.

Participant	Pseudonym	Age	Gender	Experience in ICU	Comments
1	Adam	20-30	M	2.5 yrs	Still working at the same place
6	Linda	20-30	F	4 yrs	Moved to UK
7	Lucy	20-30	F	2.5 yrs	Still working at the same place
8	Mary	20-30	F	2.5 yrs	Still working at the same place
10	Sophie	30-40	F	2.5 yrs	Joined ambulance services

Table 5.1- Characteristics of registered nurses in Phase Three

In summary, participants in this longitudinal part of the study were interviewed twice, once in the Phase Two and then in Phase Three when they were considered to be proficient nurses. The other five participants from Phase Two were not available for further interview for different reasons. Caroline and Kylie left ICU and I could not contact them. Kate stated that she did not want to continue in ICU and had started a career in Paediatrics. Lily, who continued working in ICU, was not willing to participate in Phase Two. Rose left nursing after a year and started a different career.

### 5.3 The organisation of the findings

The themes for the lived experience of registered nurse in ICU are described under the same headings as those in the Phase Two: (a) Perception of ICU; (b) Feelings; (c) Interaction with others; (d) Expectations of performance.

The longitudinal study also compared participants' responses to two questions in interviews in Phase Two and Phase Three: 'Can you describe a typical day in ICU?' and 'What motivated you to choose working/ remaining in ICU?'.

### 5.4 The Longitudinal Study- Phase Three- experience of registered nurses in ICU

The longitudinal phase of the study comprised the five participants interviewed in Phase Two. In this section theme clusters, extracted from the transcripts, are described. Examples from the transcripts are provided to illustrate how the experience of the participants changed as registered nurses with two to four years of experience working in ICU (Appendix 11).

Analysis of data proceeded through the Colaizzi stages outlined in Figure 5.2. In following paragraphs, each theme cluster is addressed and descriptive findings of the changes in experiences of participants as registered nurses in ICU are reported.

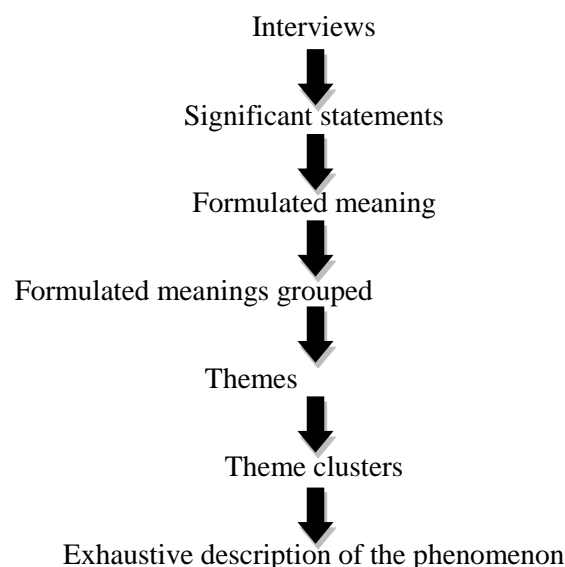


Figure 5.2 - Summary of data analysis

### 5.4.1 Theme Cluster one: Perception of ICU- attraction

The literature, over that last 10 years, reveals that much is known about why people decide to qualify as nurses (Cho, Jung, & Jang, 2010; Hickey, Harrison, & Sumsion, 2012; Neilson & McNally, 2013). Similarly a number of studies have investigated nurses' reasons for leaving the profession (Fitzpatrick, Campo, Graham, & Lavandero, 2010; Stone et al., 2006). Less is known about the factors that influence career decisions within nursing. In a review of literature by Gaynor et al (2006), they found no studies that examined retention of new graduates and they recommended tracking new graduates to understand attrition, retention and workforce choices within the nursing profession. In 2008, Robinson et al (2008) in United Kingdom, carried out a national study regarding career movement of 1596 nurses qualified in England. Their research only focused on demographic factors influencing retention, such as, participants' age and family conditions. In a similar study across Queensland, Australia and New Zealand, graduates from four universities were invited to participate in a graduate e-cohort study. The focus of this research was gathering demographic information. The researchers concluded that their participants were younger nurses and single which increases the likelihood of moving or travelling overseas and quitting their jobs (Huntington et al., 2012). They did not examine other themes such as new graduate nurse retention after completing the New Graduate Nurse/ Transition to Practice Program, and themes related to the reasons nurses choose to remain in a workplace.

In the current study, in Phase Two, participants perceived ICU as a different environment compared to other clinical areas. Over the two to four years there were no changes in participants' perception of ICU. In Phase Three, participants still considered ICU a desirable workplace. The attractions of ICU included challenges, learning opportunities, life-saving environment, findings very similar to Phase Two.

One major factor influencing the choice to remain in ICU was the challenges in ICU; this was the same in Phase Two. A participant in Phase Three said, "*I am enjoying the challenges*". Although a few years had passed and the participants now had experience in ICU, critically ill patients and unexpected events could still be challenging:

*I like the intellectual challenge of ICU nursing the fact that it keeps me thinking and it keeps me on my toes [Lucy].*

Lobo, Fisher, Baumann, and Akhtar-Danesh (2012) in a Q- Method study involving 40 ICU nurses in Ontario, Canada, explored what critical care nurses perceived as effective retention strategies. They found different views among the participants, which correlated with their age and years of experience. Nurses, with the average age of 40 and with 14 years' experience, identified challenging and innovative roles as influencing factors in retention. Younger nurses believed workplace luxuries such as onsite fitness facility as being the most effective factor in retention. For them challenging and innovative roles were least effective retaining factors. Conversely, in my study, for the participants, who were mostly in their 20s with two to four years' experience, challenge was a significant factor for their retention.

Concerning the participants' work environment, perceived knowledge and skills development opportunities appeared to be strongly related to their intention to stay. This finding is supported by previous research showing that learning opportunities are characteristics that motivate and improve retention in ICU (Cartledge, 2001; Van Dam, Meewis, & Van Der Heijden, 2012). In the past, the participants as new graduate nurses stated that learning opportunities were a strong drive and attraction for choosing ICU as their work place. Similarly, Pavlish and Hunt's (2012) study revealed that learning focused environments impact nurse's perceptions of meaningful work.

*We [nurses in ICU] are always seeing something different. I feel like I have got the ability to learn something new....like nearly every shift I feel like I learn something new from different situations [Lucy].*

As Lucy explained, learning opportunities in ICU are due to exposure to variety of patients and specialities.

*I think we [nurses in ICU] do have the benefit of being exposed to huge areas of different types of nursing and different types of medicine. [Lucy]*

Certainly, in this study it was important to the participants that in ICU they had the opportunity to nurse a variety of patients. Little is known about whether the type of

patients influences nurses' career choice. The variety in the amount of procedures nurses undertook was a positive factor, as illustrated in a qualitative study involving nurses working in surgical areas (Mackintosh, 2007). Most of the research regarding career choice and type of patient has focused on nursing students or just before graduation. Halcomb et al. (2011) asked final year nursing students why they would choose critical care nursing as their future employment and they found the most common reason given was the varied and challenging work.

In a study involving 55 nursing students in the United State of America, Fenush and Hupcey (2008) identified factors that influence the choice of working in critical care units after graduation. One reason for choosing critical care was the perception of making a great difference in the care of patients. Adam described his choice of staying in ICU based on the opportunity to be part of medical emergency team:

*There was sort of the medical response team to any of the code blue calls in the hospital as well. So they were quite big aspects that drew me back to the unit.*

The attraction to ICU was a factor impacting staff retention in this study. A review of studies regarding nurse retention reveals some workplace practices positively correlated with intention to stay, these include: safety climate and teamwork (Abu Al Rub, Gharaibeh, & Bashayreh, 2012; Hinson & Spatz, 2011; Liu et al., 2012); engaging staff and providing opportunities for professional development (Hinson & Spatz, 2011; Kooker & Kamikawa, 2009); perceived empowerment (Hauck, Quinn Griffin, & Fitzpatrick, 2011); support for new staff to become productive members of staff, employee rounding, and recognition (Hinson & Spatz, 2011). Price's (2001) theory on staff turnover speculates that distributive justice (when rewards and punishments at work are related to job performance), promotional chances, and supervisor support, influence staff intention to stay at the job. Although in my study participants did not identify any of these factors as contributing to their intention to stay in ICU.

#### **5.4.2 Theme cluster two: Feelings**

The second theme cluster - Feelings was defined as emotions experienced by participants as registered nurses in ICU in Phase Three. Some of them indicated that their feelings had

changed since Phase Two. They were presently experiencing positive feelings and described themselves as being comfortable, confident, and at ease.

In the context of the transition from novice to a higher levels of expertise, learning takes multiple paths; with the expansion and enhancement of knowledge and skills, the development of a personal identity, including emotional and self-control are achieved (Boshuizen, Bromme, & Gruber, 2004). Hence, learning is not only about cognition, it needs to be recognised that emotions have an important role (Simons & Ruijters, 2004). This concept is supported in the current study when participants experienced confidence:

*I think by the end of my 6 months I only started to feel comfortable with what I was doing.... And then before you know it you are years down the track. [Mary]*

Participants achieved work competencies by learning from practice; as a result, they experienced feeling confident. All of the participants had completed postgraduate courses, expanding their theoretical knowledge and insights, thus they experienced feeling proficient. As professionals these participants contributed to the development of newcomers, therefore, they experienced feeling of satisfaction. As Sophie described:

*You get to a certain point when you no longer worry about asking silly questions... because you know these people don't care if you ask something that is silly. Whereas before I used to think "Am I asking silly questions?" and "Should I ask that?" ....you don't care if you don't know something you just ask someone or you look it up... there is no silliness... there is none of that... it is a totally different way of working... it's really good... its way better. I would hate to go back to being a New Grad.*

The participants described feeling at ease after six months in the New Graduate/Transition to Practice Program. This is consistent with studies in the literature that suggests that nurses in one to three years post-graduation find a 'niche'. For example, Deppoliti (2008) in her work exploring the professional identity of registered nurses in hospital settings, identified that nurses develop a sense of comfort in their work environment after one to three years post-graduation.

In Phase Two, participants as new graduate nurses, adopted self-protection attitudes. They felt vulnerable and sometimes during interactions with their colleagues, they experienced



not being trusted, being watched, and criticised, which resulted in avoidance behaviours. In Phase Three, participants had developed competence in clinical practice, which led to confidence and the ability to anticipate problems. They felt that their capabilities or skills were compatible with those required for practice.

### **5.4.3 Theme cluster three: Interaction with others**

The third theme cluster - Interaction with others - was defined as communication between the participants and their colleagues or patients; related subthemes were support, and trustworthiness.

#### **Support**

Support was a crucial factor influencing the perspectives of participants in their interactions with others. Participants indicated that they experienced a supportive work environment although the nature of support had changed from when they were new graduate nurses. Initially they received the support as novice nurses to ease the transition. Currently participants demonstrated support towards newcomers mainly by sharing their knowledge and experiences. Australian College of Critical Care nurses (2002) competency standards for specialist critical care nurses states that experienced intensive care nurses are expected to act as mentors and supervisors for other staff members. This is implemented by identifying their learning needs and assisting them to meet them. In this study participants took on the role of preceptors. Preceptoring in this study is defined as a voluntary pairing of a participant with a less experienced/skilled nurse. Storesund and McMurray (2009) concur having found that experienced staff are considered to be a learning resource for other staff member. This cultivated an environment of teamwork among the participants and newcomers. In addition, McKenna and Newton (2008) described this as 'moving on' indicating that 18 months after graduation, nurses moved from being graduates to providers of education and support for others. In this study, Linda related that:

*I can use my experience and reflection as a tool for students and new nurses. I explain to them [that] it is important to find senior nurses you feel comfortable with, and express your feelings. I always advise them: "It is important if you are unsure about a situation or you make a mistake, speak up." [Linda]*

The participants found themselves re-exposed to the concept of novice while preceptoring new graduate nurses. It was familiar to them concept as they had been new graduates themselves a couple of years ago. There was consensus among participants that new graduate nurses were novices in ICU. In addition, participants all agreed on what to expect from new graduate nurses. They believed that new graduate nurses had no experience and required rules to guide their performance. The participants considered new graduate nurses in ICU as apprehensive learners. Sophie said:

*I try to remember the New Grads are really apprehensive, scared and worried and you know they are panicking. New Grads tend to worry about the most simplest things.*  
[Sophie]

Participants believed new graduate nurses were task-oriented and would usually miss even basic nursing care. This was the same view that participants had of themselves when they were new graduate nurses. In response to how they see new graduate nurses, Adam said, “*they [new graduate nurses] are still at the learning level*”. The participants believed new graduate nurses did not have the critical thinking skills to be able to consider the whole situation and think of relationships of what was happening. Lucy, one of participants with two years’ experience described her perceived characteristics of new graduate nurses:

*It is day one cardiac patient, I need to take the drains out, I need to get my patient out of bed and I need to do this...this...and this, forgetting what it is like .... Maybe your patient is extremely anxious and is not coping well with the whole thing.... or is in enormous amounts of pain...you need to pick up on the subtle sort of cues...*

In this study, there was no debate among participants regarding what to expect from new graduate nurses. All agreed that they consider new graduate nurses as novices who need support and assistance. Conversely, Wolff, Regan, Pesut, and Black (2010) in an exploratory study involving 159 Canadian nurses, identified disagreement among participants about what it was reasonable to expect from new graduates and their level of performance. Some participants expected new graduates after a month of orientation to be able to perform at the level of experienced nurses. Others expected them to be ready to provide care at the beginners’ level. The difference in the expected level of performance

is likely to be due to participants being from different clinical sectors where various levels of job specific capabilities, clinical and theoretical knowledge, are required.

In this study, there was a sense of understanding among participants about new graduate nurses. Observing new graduate nurses reminded them of their own experience. Gaining awareness of new graduate nurse transition has been considered as a first step to facilitating the integration of new graduate nurses (Ferguson & Day, 2007). For example, Mary said:

*It is kind of funny because you sort of think “That was me at some stage”... I do remember how I felt when I first started and I think you kind of feel sorry for them in a way because you think I know how much I hated it when I first started.*

The participants indicated that they helped new graduate nurses and students to deal with the uncertainty of the clinical setting (ICU) and to gain clinical skills. These novices could then perform and further learn required skills under their watchful eyes. Mooney (2007a) in a study of newly qualified Irish nurses also reflected that support, such as a period of preceptorship, could ease the transition from a supernumerary student to independent nurse. Whitehead (2010) recommended having a full time clinical supervisor available to new graduate nurses while on shift, such strategy could alleviate much of the anxiety felt by these nurses. A statement from Sophie depicting this role included, “*I have had a new grad that I have been watching ....like helping ... keeping an eye on things.*” The preceptor role description has been mentioned in the literature; the role comprises assessing new employees and monitoring their performance (Elmers, 2010). Participants in the current study did not have a formal role description, however, as Sophie mentioned it was expected of them.

*You kind of have to watch people because you don’t know how much they know and you want to make sure that everything’s all right and that the patients are getting the best care that they can. I try not to make people feel like that but it is kind of like a necessity that you monitor what is going on. It is a totally different thing being a New Grad to not being a New Grad. [Sophie]*

In contrast to Phase Two, where the participants were concerned and focused on obtaining knowledge and skills, in Phase Three, the participants focused on a broader

spectrum, and demonstrated ICU team collaboration. For example, Adam was taking part in running in-services in the ward as well as in the hospital. He commented:

*Part of it [ being a senior nurse] entails doing in-service to both junior and people at my level and more senior nurses in terms of equipment.... also what is going on in the hospital we are doing in-services with that. [Adam]*

Education as a source of collaboration was identified in a study by Hawryluck, Espin, Garwood, Evans, and Lingard (2002), using ethnographic observation in a single ICU. They identified that instruction in education can foster a sense of shared goals and values between team members and trainees. In this study, the participants took an active role in education of other staff using their critical care nursing knowledge and technical skills.

In their cohort study of 229 registered nurses at two different time periods, Pellico, Djukic, Kovner, and Brewer (2010) discussed the experience of nurses within two and a half years of their initial registration. Verbal abuse experienced as new graduate nurses, unfortunately continued for the participants in that study. Interestingly in my study, although in Phase Two participants described challenges in interacting with the medical and nursing team, they claimed they received support whenever needed. It seemed the cultural pattern in this unit provided a supportive environment with a generally positive attitude to giving and receiving collegial support. Comparing the two time periods, a major change in interaction with others is noted: from being focused on day to day tasks relevant to their own patients and seeking support from others, to supporting others.

### **Trustworthiness**

Trust as a special form of reliance or confidence, and trustworthy as a person who can be relied on, are important terms for healthcare professionals, especially for nurses (Sellman, 2007).

*“A trustworthy person . . . is one who can be counted on, as a matter of the sort of person he or she is, to take care of those things that others entrust to one and . . . whose ways of caring are neither excessive nor deficient” (Hawley & Jensen, 2007, p. 7)*

The participants' perceptions of not being trusted by their patients when they were new graduates had faded. Now, they believed that the patients saw them as trustworthy and

confident. This is an important concept identified in a study by Deppoliti (2008) when the participants in the first three years after graduation developed a sense of a family, being happy and feeling professional. They described that gaining clinical experience, and relationships with their colleagues, medical team, patients, and families, resulted in a feeling that they were progressing in their nursing careers. They felt a sense of comfort and competence. In the current study, Sophie remarked:

*Your relationship with people is completely different, your relationships with the staff and the patients and everyone because they don't see you as someone who is just beginning.*

In a dynamic environment, such as the ICU, strengthening working relationships and awareness of each other's expertise may lead to building trust amongst clinicians and increase collaboration. The participants indicated that they felt trusted by their colleagues as they were no longer considered as beginners and they trusted their clinical judgement.

*My colleagues know my level of experience as an ICU nurse and trust my judgements.* [Linda]

This trustworthiness was also identified in an ethnographic study in three ICUs in England focusing on working relationships. Carmel (2006) found, that consultants in ICU trusted permanent ICU nurses because they considered them as highly skilled. In this current study, Sophie described how her colleagues placed trust in her clinical judgement:

*People trust you, which is the main thing. People can trust that you are going to make good judgments and if you don't, if you are not sure they know you well enough to know that you are going to ask... they have watched you grow so they know how much you ....how much more you know than when you first started and they trust you.* [Sophie]

McKenna and Newton (2008), in exploring new graduate development 18 months after graduation, found that the sense of belonging developed after one year. This was achieved in this current study when participants felt part of the ICU team. The ICU team is a self-organising, complex entity that expands and contracts depending on the needs of the moment. It involves ongoing exposure to the complexities of interprofessional team functioning (Hawryluck et al., 2002; Rose, 2011). The following statement depicts the feeling of being part of the team:

*You don't feel so much of an outsider and you feel supported in a different way... Now because I actually feel part of the team and people know me, and they trust me, I feel probably a little bit more emotionally supported. Because I have the connections with people, and I am able to help them and I have a rapport with them but as a New Grad, you haven't got a rapport with anyone really because you are just feeling your way [Sophie].*

After two to four years working as a nurse, they were able to deliver more than just look after their own patients. Now part of their interaction with their colleagues is assisting them with their workloads. Mary felt this created a positive feeling for her “*It is nice to be able to do your stuff and help others*”. A systematic review of papers for the period 1990-2003 by D'Amour et al. (2005) identified a common description for collaboration as ‘type of relations and interactions taking place between co-workers’ (p. 118). They also showed that collaboration is developed to meet patients’ and professional needs. Hence the two main components of collaboration are: (1) collective action aimed at meeting patients’ needs (2) a team of professionals with a mixture of perspectives at the same time experiencing mutual respect and trust.

Collaboration, as described above, was experienced by participants in the current study. Participants worked and interacted with their colleagues in a manner that allowed them to be available to share their knowledge, and skills. Hence, they could provide assistance to their colleagues to meet patients’ needs. Participants also showed interest in collaboration. Finally, the participants knew that their colleagues and patients trusted them.

#### **5.4.4 Theme cluster four: Expectations of performance**

The fourth theme cluster - Expectations of performance - was defined as the level of clinical performance considered reasonable for participants - as registered nurses with two to four years of experience in ICU.

The participants in Phase Two moved from novice to proficient nurse by Phase Three. Participants felt they had acquired knowledge and skills for professional development and were taking on new roles, making statements such as:

*Well I think I have developed quite a fair bit professionally since I first started.* [Mary]

Consistent with Benner's (1982) description of levels of proficiency, Sophie represented the nurse who, as a novice two years ago gained confidence in her acquired skills. She gradually became more aware of the need to pursue additional knowledge and opportunities to increase her level of professional knowledge and performance skills. She recalled:

*Because I knew that my basic nursing care was up to scratch, I had more time to concentrate on the advanced nursing.* [Sophie]

Benner (2001) also described a nurse as proficient when their practice is analytical and fluid and leaves the inflexibility of competent stage behind. In the current study, participants remained conscious of the need for routine and the relative inflexibility of the hospital policies, which demand compliance from the nurse. However, they had reached a level of comfort being able to be flexible in adapting the rigid routine of the unit to the needs of the patient. For example, Lucy related that:

*I know we have the day to day routine ....day one we do this day two we do this ....but I have learned to be probably a bit more flexible with that and realise that your patient is not going to crumble because you didn't change your fluids at 10am. But they may crumble if you don't...you know ... do your regular gases and get them out of bed ...you know...address their pain relief. I think I have become less task - oriented and more holistic in my approach.* [Lucy]

Critical thinking, as purposeful, informed, and outcome-focused thinking, was one of the abilities participants in Phase Three had developed. According to Alfaro- LeFevre (2013) critical thinking includes applying skilful reasoning and judgement. It is a quality that requires one to gain insight and focus in order to reach the desired result (Scheffer & Rubenfeld, 2000). Previously in Phase Two, participants had difficulty integrating pathophysiology, critical thinking, and nursing theory into the clinical setting. Over the time, they have gained the necessary knowledge to build critical thinking skills and at present, they can apply it in critical situations. For example, Mary recounted:

*I think you start to fit pieces of the puzzle together more [compared to new graduate nurse]... like you tend to think a lot more [compared to new graduate nurse] about what*

*you are doing and what it all means in the grand scheme of things. You are more confident and comfortable ... you can actually interpret your data that you are getting... like your obs [observation] and things like that and you can sort of think about other things as well. [Mary]*

*To care for your patient you must think of the whole picture, more holistic for the patient. [Linda]*

Clinical judgment is another essential and complex skill for nurses. It is described as an interpretation or conclusion about a patient's needs, concerns, and the decision to take action (Tanner, 2006). The nurses in Phase Three commented that after few years' experience they were able to recognise relevant aspects of an undefined clinical situation, interpret its meanings, and respond appropriately. As Lucy noted she had to make judgments about priorities among competing patient needs:

*I think I have the ability to look at the bigger picture. For example, if I do have two patients I look at the two patients and figure out which one of these two patients actually needs my attention first... I think I am becoming better at looking at it not just from a systems approach but looking at how those systems sort of integrate.*

Knowing specific information about patients enabled participants to anticipate likely outcomes, which, in turn, guided decision-making. Linda described how using specific and sometimes subtle cues regarding individual patients resulted in important decisions about next the steps to follow with patients who were clinically unstable. She explained:

*It is day one cardiac patient I need to take the drains out ... I know from history that this patient is extremely anxious and is not coping well with the whole thing... now he is desaturating.. So I decide to give him some morphine to settle his anxiety... and help the discomfort of removing the drains, hoping that would fix his saturation as well...*

This finding is supported by Ebright, Patterson, Chalko, and Render (2003) who identified and described the complexity of work for registered nurses in seven different units from two separate hospitals in Ohio. They found that nurses use individual patient information to guide care activities and decisions.



The participants identified self - reflection as a skill obtained over two to four years of clinical experience. Taylor (2006a) described human reflection as ‘throwing back of thoughts and memories in cognitive acts, such as thinking, in order to make sense of them and to make contextually appropriate changes if they are required’ (p. 8). Reflection as a useful tool for education is a process of learning from experience, a lifelong learning process that can lead to changes in behaviour (Boyd & Fales, 1983). Sumner (2010) argued that in nursing practice only nurses at the expert level are capable of critical self - reflection. It is only when mastery of practice has been achieved the nurse can be comfortable with reflection. These findings conflicted with the responses of participants in current study. They were not at expert level yet however; they were able to reflect on themselves and their role critically and effectively:

*I can look back and reflect on, “well maybe I should have done that differently or maybe the reason this happened is because I didn’t do this” or “I could have done this better”. So it is more of a reflective capacity. [Lucy]*

Self-reflection as described by participants developed as their confidence grew. Participants in Phase Two felt too vulnerable and uncertain of the totality of the role and responsibilities, hence they were not comfortable with critical self-reflection.

Deppoliti (2008) reported that a sense of responsibility was inherent, among her study’s participants, in the first three years post-graduation. Similarly, participants in this current study understood that the expected responsibilities were due to their clinical experience. In the past, as new graduate nurses, their role implied meeting the needs of their allocated patients. In the present, their role implies a broader spectrum; it includes quality improvement activities and review of policies. The importance of cooperation within the team and meeting the needs of the unit, rather than just their allocated patients, became internalised in their narratives. Adam said:

*Before when I was at new graduate level, I was more just concerned with the one patient or two patients that I was looking after but... for instance now... on a typical day I have also got all the newer staff. You have to sort of keep in mind making sure that they are up to date and have done all their required work if they need a hand with anything as well. So it is also keeping an eye on the patients which I am looking after as well as sort of helping out with the unit if there are any jobs that need to be done any upkeep... It is*

*more sort of looking at the running of the unit in general than the focus on one or two patients. There is an associate role, which we are involved in ...policies are involved with, that ...in the development ...with new ones [Adam].*

Consistent with the current study is a study by Fagerberg and Kihlgren (2000) who explored the meaning of identity for 20 Swedish registered nurses, 2 years after graduation. One of the perspectives presented in the narrative was being a team leader. In this current study, one of the participants who had finished his postgraduate certificate in critical care, started to have training to assume overall responsibility for the unit after hours. His work included being responsible for planning work in the unit when the shift started. It also included monitoring staff or correcting them and ensuring that the patients received the care they needed. He also had to complete administrative work. This participant did not voice whether the responsibility of being in charge of ICU caused him any anxiety.

Participants felt they could make a difference by sustaining the lives of patients who are at risk of perilous, critical, or life-threatening situations. Hawley and Jensen (2007) related that critical care nurses experienced ‘Making the Life Threatening Life Sustaining’ (p. 670). Participants in Phase Three were expected to attend the emergency calls in the hospital. This was considered as a new role that had come about because of their years of experience in ICU:

*It is just more of the senior aspects and also running the.....like team leader in the arrest as well as part of it and the senior role. [Adam]*

Likewise, Lucy who was qualified with advanced life support skills proudly said:

*Now that I am trained in advanced life support, I have been able to run for arrests.*

Participants who were still working in ICU had all attended ‘introduction to ICU’ course. Furthermore, they had completed or were in process of completing an ICU/ Critical Care post graduate degree.

## **5.5 Exhaustive description**

According to Colaizzi (1978), providing an exhaustive description of the investigated phenomenon is the fifth step of the seven-step phenomenological data analysis method (for detailed account of process see page 66, chapter 4). In the exhaustive description, the researcher integrates the findings of the study. In the present study, the findings were organised into four theme clusters (Figure 5.2). Therefore, the exhaustive description is composed of the findings of the phenomenon being studied - the change in experience occasioned by years of clinical practice. The exhaustive descriptions of the lived experience of registered nurses with two to four years working experience in ICU were guided by descriptions of concepts and identification of consistent themes through qualitative data analysis. The exhaustive descriptions represent the experience as perceived by the participants as follows:

Over the two to four years of clinical experience, there were no changes in the participants' perception of ICU as a work environment. ICU was still a desirable workplace. What made ICU a desirable workplace as a new graduate nurse, caused the registered nurses with two to four years' experience to remain. These include challenges, learning opportunities, and the life-saving environment. The ICU environment, with critically ill patients, unexpected events, and exposure to a variety of patients and specialities, provided knowledge and skills development opportunities.

Critical thinking as purposeful, informed, and outcome-focused thinking was one of the skills they developed. Previously they had difficulty integrating pathophysiology, critical thinking, and nursing theory into the clinical setting. Over time, they gained the necessary knowledge to build critical thinking skills and, at present, they could apply it in critical situations. After a few years' experience, they were able to recognise relevant aspects of an undefined clinical situation, interpret their meanings, and respond appropriately.

They were able to prioritise competing patient needs. By using specific and sometimes subtle cues, they were able to make important decisions regarding clinically unstable patients. In the six months of New Graduate/Transition to Practice Program, they felt their capabilities or skills were compatible with those required in ICU practice, as a result, they felt comfortable and at ease.

By learning from practice they developed competencies, thus they experienced feelings of confidence. Expanding their theoretical knowledge and insights, they experienced feeling

of proficiency. They demonstrated ICU team collaboration. They took on new roles and responsibilities. In the past they felt too vulnerable and uncertain of the totality of the role and responsibilities, hence they were not comfortable with critical self-reflection. As their confidence developed, they gained self- reflection skills.

Their role as new graduate nurses implied meeting the needs of their allocated patients. At present, their role implies a broader spectrum, which is due to their clinical experience. Cooperation within the team and meeting needs of the unit rather than just their allocated patients became significant to them.

As new graduate nurses, the participants were protective of themselves. They felt vulnerable and sometimes, in interaction with their colleagues, they experienced disruptive behaviours, which resulted in avoidance of the situations or the individuals. Comparing two time periods, a major change in interaction with others was seen: from being focused on day- to- day tasks relevant to their own patients and seeking support from others, to supporting others.

As they are no longer considered beginners, their colleagues trust their clinical judgement. They feel part of the ICU team. Part of their interaction with their colleagues was assisting them with their workload. They worked and interacted with their colleagues in a manner that allowed them to be available intellectually. The perception of not being trusted by patients had faded away. They feel that patients see them as trustworthy and confident.

As professionals they contribute to the development of newcomers, therefore, they experience feelings of satisfaction. They support their new colleagues, mainly by sharing knowledge and experience. They find themselves re-exposed to the concept of novice while preceptoring new graduate nurses; it is familiar to them as they had experienced it themselves a few years before. New graduate nurses were novices in ICU. New graduate nurses had no experience in ICU. They required rules to guide their performance and they were apprehensive learners. New graduate nurses were task-oriented and would usually miss even basic nursing care. This is almost the same view that they had of themselves when they were new graduate nurses. New graduate nurses did not consider the whole situation hence they were not able to think about relationships occurring in the environment. They help new graduate nurses and students to deal with the uncertainty of

the clinical setting and to gain clinical skills. These novices began to perform and to learn the required skills under their watchful eyes.

New graduate nurses, after two to four years experience, moved from the novice level to the proficient level. They gradually became more aware of the need to pursue additional education and opportunities to increase their level of professional knowledge and performance skills.

## **5.6 Fundamental structure**

Colaizzi's (1978) next step is to take the exhaustive description and write a clear statement of identification of the fundamental structure of the phenomenon (for detailed account of process see page 66, chapter 4). I developed the following statement of identification of changes in the experience of registered nurses after two to four years of practice in ICU. A diagram of the study's findings is provided in Figure 5.3, p. 122.

The Registered nurses in ICU articulated that a few years of experience had changed their typical day in ICU significantly. Currently as a proficient nurse, they have confidence in their task performance and manage the routine of the unit easily. They have developed sufficient competency and, therefore, confidence in that nursing practice. Their vulnerability and self-protective behaviour has turned to self-reflection. They are now capable of adjusting to the patient's needs rather than being task oriented. Their interaction with others is based on providing support rather than requiring them to manage their own duties. This growth and maturation result in satisfaction.

## **5.7 Summary**

In this chapter, the findings of data analysis of interviews with five registered nurses in ICU, who had already participated in Phase Two, were presented. Interviews focused on registered nurses' changes in perceptives after two to four years' practice in ICU. Colaizzi's (1978) method was utilised to conduct data analysis. Four major themes emerged from the data. Participants in this study, in the journey from novice to proficient nurse in ICU, experienced personal growth and professional development. In addition, they found ICU still a desirable workplace because of the challenges and variety. Experience of interaction with others including patients, doctors, and nursing staff was

described by participants. In chapter 6, conclusions, implications, and the limitation of study are discussed.

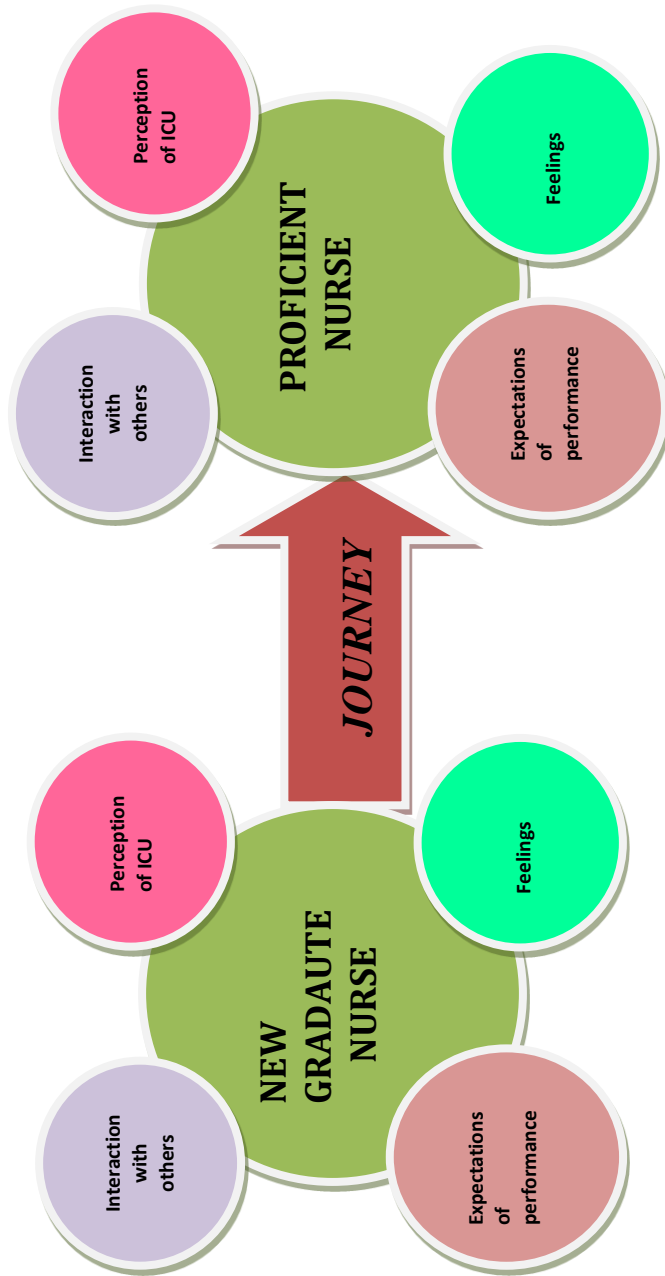


Figure 5.3 - New graduate nurses journey -

Illustrating the four identical theme clusters found in Phase Two and Phase Three. Each theme brought different meanings in journey of the same individuals.

## Chapter 6

### Conclusions, implications, and recommendations

*In this study, I have explored the phenomenon of being a new graduate nurse and their journey to becoming a proficient nurse in ICU. The findings are of importance to the nursing profession at the time when retaining nurses in the work force could be an answer to the nursing shortage (Australian Health Workforce Advisory Committee, 2002). I hope that knowing what new nurses experience will give a better understanding of how to prepare new graduate nurses at university before graduation, and, after graduation, in the orientation period. In addition, understanding how the experience of nurses evolves over two to four years of clinical experience could guide the development of retention strategies to effectively retain nurses in ICUs and assist them in their professional development. In this chapter, a summary of findings and the implications for further research and practice are discussed.*

#### 6.1 Summary of findings

The work situation of nursing in ICU can be considered unique. It is characterised by a highly technical environment, with extremely ill patients. Therefore, it presents specific demands and responsibilities to nurses, hence, greater numbers of highly educated, specialised nurses are required. In the past, only experienced nurses were employed to work in ICUs. Currently more and more facilities are employing new graduate nurses to work in these areas.

Australian research indicates that there is a significant interest among nursing students to engage in critical care (Halcomb et al., 2011). On other hand Australian Health Workforce Advisory Committee indicates an increased need for critical care services (Australian Health Workforce Advisory Committee, 2002). Hence, engaging new graduate nurses to work in the critical care setting seems to be an option to meet the demand. Health Workforce Australia (HWA) 2025 identified retention of nurses in the workforce as the most significant factor in reducing the gap between supply and demand for nurses. One of the HWA program's key activities, undertaken in 2012-13, includes identifying factors affecting nurse retention and training reforms in a review of the

literature (Health Workforce Australia, 2012c). The current study responds to this question.

The interviews conducted during Phase Two and Phase Three provide valuable qualitative data that are sufficient to create a detailed description of participants' experiences as new graduate nurses and their development professionally and personally, over two to four years of practice. The findings of this study demonstrate the ways in which registered nurses' feelings, interactions, and performances change from the first year of practice onward.

New graduate nurses as novices new to the ICU environment and the type of patients, had no previous experience as registered nurses in ICU. They lacked the knowledge required to respond to critical situations. The participants, as new graduates, were afraid that they would not be able to provide safe care for their patients. Once they found themselves in the ICU setting, some participants felt incompetent to practice. As novices, they performed tasks as they were taught and relied upon general rules which were applied universally. They gained knowledge and skills and over time, felt more accepted and trusted by the staff; they became more confident and progressed to next level. Repeatedly, participants shared the meaning of being a new graduate nurse as moving from the education environment by finishing their nursing degrees, to the practice environment where they had to learn to become a nurse. Some participants disclosed that with gaining knowledge over the time, they felt accepted and trusted among the team, and as a result, they felt satisfied and more comfortable. New graduate nurses changed within themselves as they acquired skills, knowledge, and the attitudes of an ICU nurse. They became accepted and legitimised in ICU nursing profession. Boshuizen et al. (2004) describes this concept as enculturation. In this current study, it included the process of developing from advanced beginner, to competent, and later on a proficient identity.

This research is informed by descriptive phenomenology. It describes the meaning of the lived experiences of ten individuals about being a new graduate nurse in ICU and the phenomenon of the journey to proficient nurse for five of them.

In the process of learning and constructing the meaning of the new graduate nurse journey, it was understood that multiple factors affected how they perceived the phenomenon of being a new graduate in ICU. These included perceptions of the ICU



environment, beliefs, interaction with others, feedback, being part of the team /enculturation, and unclear level of expectation. Participants perceived ICU as a unique environment. Initially they found ICU as a place full of challenges and learning opportunities. Placement in ICU, where patients and families were at the most vulnerable times of their lives, gave the new graduate nurses the opportunity of taking up the challenge of looking after acutely ill patients. They believed the intense nature of the nursing care given to patients, needs specialised and comprehensive nursing knowledge. The data revealed that they believe the nature of critical care nursing is lifesaving and highly technical. They perceive ICU as a desirable workplace due to social prestige, glamor and high technology, patients' severity of illness, patient to nurse ratio, nurse's autonomy, and a learning opportunity (Farnell & Dawson, 2006; Ganz & Kahana, 2006; McCann et al., 2010; Palese et al., 2007; Takase et al., 2006).

New graduate nurses believed that they had acquired the essential clinical skills at university to enable them to function as qualified nurses in general. However, they were aware that they did not possess the appropriate clinical knowledge and skills, especially critical thinking, to nurse critically ill patients or to be able to detect minor changes in a patient's condition. Hence, the challenges led to various feelings and emotions, which every participant dealt with differently. Negative feelings such as being overwhelmed, and anxious were associated with a lack of confidence and feelings of inadequacy to deal with very ill patients and unexpected events requiring fast action.

During their rotation in ICU, participants experienced some issues in interaction with others, including patients, doctors and nursing staff. They were not adequately prepared to communicate with ICU team, patients, and families (Casey et al., 2004; Dyess & Sherman, 2009; Kelly & Ahern, 2008; B. McKenna et al., 2003; Rosenstein & O'Daniel, 2008). There were numerous situations encountered in the ICU setting that required excellent communication skills. Some participants claimed that the personalities of nursing and medical staff affected how approachable they were. The participants' own lack of confidence was also a barrier. My study revealed that most participants felt that their interactions with doctors were 'a good experience'. They agreed that interprofessional relationships between nursing and medical staff in ICU are more equitable than in general ward. On occasions, participants believed that due to the temporary nature of their employment, the permanent staff did not consider them as

members of the team. They reported that the nursing staff were not aware of their level of knowledge and skills. Hence, sometimes they would explain the simplest nursing clinical tasks. In return, new graduate nurses felt that to be part of the team and accepted by their colleagues, they needed to prove themselves. The participants reported how positive feedback from their colleagues or patients boosted their confidence. Formal appraisal was important to participants. They believed this was as an opportunity to evaluate their progress and achievement during the New Graduate /Transition to Practice Program.

This study illustrated in Phase Two that new graduate nurses understand the importance of trust and they believe it can influence the care that patients received. Participants indicated that they endeavoured to gain trust by hiding their level of experience from patients and families. They believed patients felt less confident with them and felt unsafe under their care.

The participants sometimes felt undervalued. Conversely, sometimes they experienced high levels of expectation. This indicates that there is a lack of consensus about realistic expectations of new graduate nurses. Participants spoke of their commitment and determination to 'do their best' as new graduate nurse and their tendency for self-criticism caused stress. They felt vulnerable and uncertain about the totality of the role and responsibilities.

In this study, Benner's model of novice to expert was used as a philosophy to reveal how knowledge and skills acquisition for new graduate nurses occurred in ICU (Altmann, 2007). Benner's (2001) model states that the nursing students enter the clinical area as novices and new graduates enter the work force as advanced beginners with the expectation of support from a preceptor to teach competent care. In addition, Benner points out, that any nurse entering a clinical area with no prior experience, in the speciality is likely to be a novice. This study reveals that new graduates entering ICU are not at the proficiency level of advanced beginners. They are not able to demonstrate an acceptable level of independent performance; they definitely need rules to guide their practice. The new graduates in this study did not have the clinical knowledge and skills for ICU practice although they were well prepared at a novice level. However, in dealing with reality of the workplace, some did not seem well prepared. Negative feelings that emerged during New Graduate/Transition to Practice Program were due to not

understanding, or not accepting, the meaning of 'being a novice' and that level of expectations.

New graduate nurses in this study demonstrated to be learning professionals and this study illustrated their journey. This study found that new graduate nurses to be professionals who are continuously involved in professional learning as they pass through stages of proficiency. Simons and Ruitjers (2004) identified three activities that characterise a learning professional. In this study, new graduate nurses were involved in the three activities: they elaborated on their work-competencies, expanded their theoretical knowledge and insights, and externalised their practical and theoretical knowledge, which means contributing to development of the profession and/or to team and organisational learning (Simons & Ruitjers, 2004, p. 209). It seems that new graduate nurses after achieving the competent nurse level start to pass through different stages of professional learning and by the fourth year after graduation, they have achieved a proficient level. As Benner (1982) proposed, some never leave the competent level in their professional life. This was not the case in this study. I believe the culture of the unit and desire to grow among the participants made them different. Further postgraduate study was definitely a significant factor in assisting them to reach the proficient level. Registered nurses with two to four years clinical experience described the confidence they gain as an emotion bridging the stages of professional learning. They developed feelings of competence, and, as a result, feel satisfied. Simons and Ruitjers (2004) learning model is adapted to reflect the findings of this current study (Figure 6.1).

In a qualitative study Pellico and her colleagues (2010) compared the work experience of a group of registered nurses between 6 to 18 months after graduation and then one year later. They found that registered nurses were initially frustrated with their own lack of ability to perform necessary skills in a proficient and timely manner although a year later they were frustrated with the inefficiencies of colleagues. However, participants in my study, after two to four years in practice, felt more positive about their work than Pellico's study. The focus of participants in my study in Phase Three was not on frustration at work; they experienced this phase as a period of personal and professional growth and development.

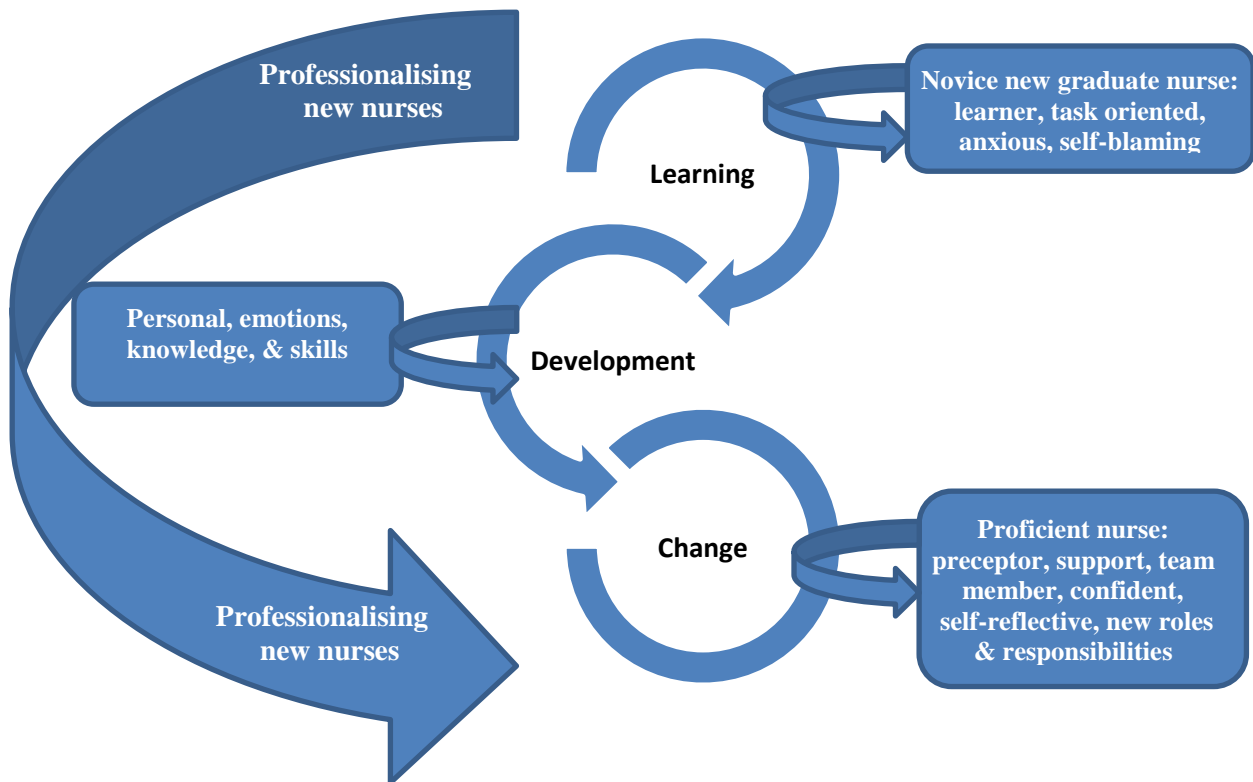


Figure 6.1- Diagram illustrating the professionalising of new graduate nurses in ICU- The learning process for novices takes them through personal and professional development, which leads to changes in knowledge, skills, emotions, and attitudes. As a result, proficient nurse takes new roles and responsibilities.

The nature of their interaction with the ICU team was not based on receiving support anymore but giving support. Participants indicated that the preceptoring experience was an important part of their interaction with others. Not only were they part of the team they were also actively participating in ICU team collaboration and ‘working together’ (see Chapter 5, page 111 for more details). Participants in Phase Three were available to their colleagues and allocated time to interact with new staff. They were interested in collaborating with patient care in general not just their allocated patients. They felt that their colleagues’ trust was based on their experience and knowledge. They were respected and recognised by other members of the team. As a result, they felt they were working together with the team in ICU, which led to a sense of satisfaction compared to when they were new graduate nurses.

In Phase Three the expectations of performance was quite different. They talked about responsibilities and achievements, the result of their experience, knowledge and skills gained over two to four years of working in ICU. Their role involved more than simply

meeting the needs of their allocated patients, it was now broader. The importance of cooperation within the ICU team and meeting the needs of the unit, rather than just their allocated patients, became internalised into their narratives. Research indicates that in nursing practice, until nurses reach the developmental level of expert, they are not capable of critical self-reflection (Sumner, 2010). It is only when confidence from mastery of practice is achieved that the nurse can be comfortable with reflection. The findings from Phase Three dispute these findings since nurses, although not at expert level, described their ability to reflect on themselves and their role, critically and effectively.

This study identified key professional and personal changes in new graduate nurses as they progressed through years of employment in ICU. They experienced different feelings as registered nurses with two to four years' experience compared to when they were new graduate nurses. Their feelings switched from the negative including anxiety, annoyance, distrusted, exhaustion, incompetence, intimidation, not being part of the team, picked on, overwhelmed, stress, and stupidity to trustworthiness, feeling proficient, feeling at ease, and being part of the team. This study found that new graduate nurses described a typical day in ICU differently as they became a senior registered nurse. Registered nurses' achievements during two to four years of practice, included new skills such as critical thinking which assisted them in their professional development. As a result, they took on new roles such as preceptorship, being part of medical emergency response team or participating in quality activities. Their tendency to self-blame had transformed to a reflective capacity which creates a dispute with Sumner's (2010) moral construct of caring in nursing where she argues until the nurse reaches Benner developmental level of expert they are not capable of being inwardly directed reflective on self.

Participants in Phase Three, when interacting with newcomers to the unit they found themselves re-exposed to the concept of novice. It was familiar to them as they had experienced it themselves a couple of years before. This sense of understanding facilitates the integration for newcomers. In the current study, there was consensus among participants that new graduate nurses were novices in ICU. Participants believed new graduate nurses have no experience, they require rules to guide their performance. The participants believe that new graduate nurses do not consider the whole situation, hence they are not able to practice holistically. The participants consider new graduate nurses in ICU as apprehensive learners. They believe new graduate nurses are task-oriented and

usually miss even basic nursing care. This was almost the same view that participants had of themselves when they were new graduate nurses.

Participants demonstrated support towards new colleagues, mainly by identifying their learning needs, sharing knowledge and experiences, and assisting them. For this purpose, participants took on the preceptor role; it comprises assisting the new employee and monitoring their performance. The participants indicated that they helped new graduate nurses to deal with the uncertainty of the clinical setting and gain clinical skills. The novices could then perform and learn further required skills under their watchful eyes. They acted as a learning resource for other staff member. This cultivated an environment of teamwork among the participants and newcomers.

Over the two to four years, there was no change in participants' perceptions of ICU. In Phase Three, participants still considered ICU a desirable workplace with a different environment compared to other clinical areas. After the completing their New Graduate /Transition to Practice Program, it seemed that the most important reason for staying in ICU was not social prestige or high technology.

For participants motivators to continue practising in ICU included challenges, learning opportunities and, life-saving environment, findings very similar to Phase Two. However, challenges, learning and development opportunities were still a strong driving force to remain in ICU. I argue that these challenges and the way they responded were different in Phase Two and Phase Three. After two to four years of experience, participants found challenges enjoyable. Moreover, they experienced positive feelings such as, being comfortable, feeling confident, and at ease. When participants after two to four years were re-interviewed, they believed they gained insight and focus to integrate pathophysiology, critical thinking, and nursing theory into the clinical setting. Over time, they gained the necessary knowledge to build critical thinking skills and they could apply appropriate clinical judgement in critical situations.

Concerning participants' work environment, perceived knowledge, and skills development opportunities appeared to be strongly related to their intention to remain in ICU. In this study, it was important to the participants that, in ICU, they had the opportunity to nurse variety of patients. Another reason for remaining in ICU was the perception of making a great difference in the care of patients.

Findings from this study provide valuable insight into how new graduates develop in clinical nursing practice (Figure 6.2).

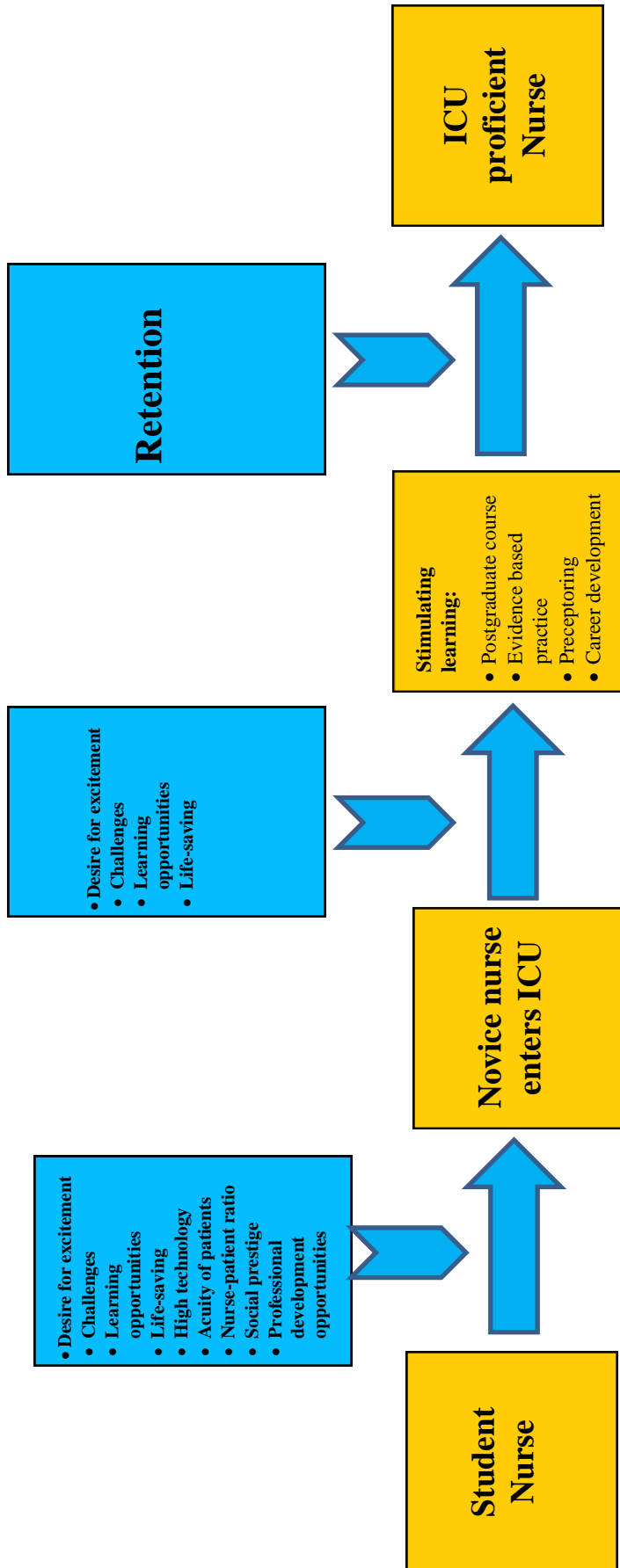


Figure 6.2 Journey of a new graduate nurse in ICU in view of career attractions-

Student nurse by completing their nursing degree finds ICU a desirable workplace to start their career as a novice. They find ICU a stimulating learning environment, as professional learner they develop to Proficient nurse level.

The participants, as novices, initially learned to recognise situational facts and features relevant to particular skills required in ICU. Gradually, as they gained more experience, they were able to identify recurrent meaningful patterns. When participants were reinterviewed, they had between two to four years of experience, and were now proficient nurses. Along their journey they had gained knowledge and skills. Participants acknowledged that they had encountered significant learning challenges; these helped to consolidate their nursing knowledge and to gain proficiency in clinical skills and they were still learning. Participants started their journey at the lowest rank of the profession; while proving themselves, they became proficient nurses. They required support and guidance in this transition, and now they are guiding newcomers. Participants developed skills and understanding of patient care over time through a sound educational base as well as a multitude of experiences, the process of professional learning was self-evident.

Considering Benner's (2001) definition of an 'expert' nurse, during the progression of this study, this final stage had not yet been reached. An expert nurse has extensive experience; they use intuition, and no longer need to use rules. The expert is able to recognise patterns and quickly make decisions.

## **6.2 Implications and recommendations**

This study has introduced a concrete experiential description of new graduate nurses on their journey in ICU. The description elicited from participants in the study is far richer than just expressions of attitudes and opinions. It helps to understand the experiences, stories, and journeys of new graduate nurses. A clearer understanding of the new graduate nurse journey, from novice to proficient nurse, can assist in developing interventions for the education of nursing students, orientation of new graduate nurses, and a smooth transition. It identifies workplace practices that are positively related to nursing retention.

This study is relevant to what has been considered by government in the last few years, as a future challenge; providing a skilled health workforce. Due to the significance of this issue, a national health workforce agency (Health Workforce Australia - HWA) was established in 2008 to drive a strategic long-term program. One of the key activities to be undertaken by this agency in 2012-13 is to investigate factors impacting on nurse retention and training reform relevant to workplace employer, industrial and training practice (Health Workforce Australia, 2013). Health Workforce 2025 - Doctors, Nurses,



and Midwives (2012b) identified the retention of nurses in the workforce as the most significant factor in reducing workforce shortage. Hence retaining new graduate nurses in nursing is essential to help improve the shortage of registered nurses.

Improving retention of new graduate nurses can be particularly cost effective. At the organisational level, retention of registered nurses is important for maintaining adequate nurse staffing, critical for ensuring quality patient outcomes. In order to optimise retention of new graduate nurses, organisational leaders must be sensitive to the new graduate nurses' perceptions of their work environment and to their evolving needs as they continue their practice as a registered nurse over time. This study's findings indicate the factors that could be associated with retention.

This study makes a valuable contribution to our understanding that new graduate nurses, practising in ICU, need more than clinical nursing knowledge and skills. Sophisticated thinking abilities to guide their practice and inform their decision making are important. Training nursing students and challenging them with meaningful scenarios to promote critical thinking are essential. Critical thinking and clinical reasoning should become more overt in nursing curriculum and implemented into all clinical subjects. The level of complexity needs to be increased, as a student progresses through their degree. Education relating to communication strategies and techniques to employ, when dealing with difficult situations, is critically important, as is the need to improve communication processes in a complex healthcare environment such as ICU. In addition, time management is another concern. Although new graduate nurses overcome this problem as their level of proficiency increases, they would benefit from more education at university regarding effective time management in practice. There should be increased emphasis in nursing curricula to prepare new graduate nurses for foreseeable stressors, difficult and confronting communication situations in their clinical practice, so that they can become proactive, develop confidence, and be better prepared. An ICU clinical placement in the final year of university may assist nursing students to acquire knowledge and skills for practice at an advanced beginner level when they commence as new graduate nurses in ICU. This would accelerate their progress towards different levels of proficiency.

It is important for nurse educators and managers to develop knowledge that is culturally relevant and respectful of the social realities of those new graduate nurses practising for

the first time in ICU. Knowing that new graduate nurses do not have the knowledge required to cope with the level of patient dependency in ICU, initial rotation in general wards for six months before entering ICU would be beneficial. This could assist them in acquiring time management skills as well as basic nursing skills.

According to Benner's (1982) model and other research (Grochow, 2008), it takes minimum of two years experience to reach a competent stage. After two years nurses are expected to take further responsibilities such as, preceptoring new staff or, later on, being in-charge; ongoing education to prepare them for these responsibilities is suggested. This means that education for new graduate nurses should not finish as soon as the new graduate transition program is completed. Their professional life is just starting. Thus, a program for learning professional is suggested. This means an education plan that includes evidence based practice, preceptor and mentoring models, and contributing to development of the team/organisational learning.

### **6.3 Limitations of study**

Limitations of a qualitative study may be both conceptual and methodological which may reduce the trustworthiness of the research. In this thesis, the criteria of trustworthiness-credibility, dependability, transferability, and confirmability- are addressed in chapter 4.

The limitations of descriptive phenomenology as used in this study, are those inherent in the use of a descriptive approach. It is limited to the conditions under which the study was carried out. This study was limited to ten individuals' experiences on their own terms, so generalisability of the findings is limited.

In addition, the participants in this study are all employed by the same private hospital. Perceptions of new graduate nurses may vary in other hospitals, for example in the public sector, based on the individual nature of hospital environments, orientation programs, and hospital culture. New graduate nurses in hospitals of varying sizes, with varying populations, may also have different concerns to the nurses interviewed in this study. Purposive sampling method provided the study participants. This yielded nine female new graduate nurses and one male new graduate nurse. Limitations of this study include the use of a small sample and recruitment from only one private hospital in Sydney.

My bias may have been a limitation, as a nurse and as a researcher. Despite my endeavours not to allow my role as an ICU nurse to colour the descriptions, this tacit knowledge, and related assumptions may have constrained some interpretations.

While the research findings are not generalisable to other populations of new graduate nurses, I have provided rich, experientially intelligible insights about new graduate nurses in ICU to enable readers to make a determination regarding the transferability of data to other similar areas.

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## **APPENDICES**

**Appendix 1: Examples of equipment used in ICU:** Different equipment utilised in the ICU for management and treatment of patients. Every nurse in ICU should be able to work with the various types of equipment illustrated in the table below.

Equipment name	Image	Function
<b>Monitor</b>	 <p>(courtesy of <a href="http://www.medelco.com">www.medelco.com</a>)</p>	Physiological parameters that are routinely monitored in ICU include ECG, respiratory rate, oxygen saturations, central venous pressure and blood pressure (Intensive Care Coordination & Monitoring Unit, 2012a).
<b>Ventilator</b>	 <p>(courtesy of <a href="http://www.pulsebiomed.com.au">www.pulsebiomed.com.au</a>)</p>	Assists or replaces spontaneous breathing (Intensive Care Coordination & Monitoring Unit, 2012b).
<b>Continuous Cardiac Output Monitoring</b>	 <p>(courtesy of <a href="http://www.edwards.com">www.edwards.com</a>)</p>	Continuous CO, SvO <sub>2</sub> , EDV, SVR, and other measured and derived parameters are presented on customised displays selected by the clinician. It helps evaluate cardiac function (Kowalak, Welsh, & Mills, 2003)
<b>Intra Aortic Balloon Pump(IABP)</b>	 <p><a href="http://www.datascope.com">www.datascope.com</a></p>	Helps the heart recover by reducing the amount of work it has to do (Department of Biomedical Engineering, 2006)

Equipment name	Image	Function
<b>BIPAP(Bi-level Positive Airway Pressure)</b>	 <p>( courtesy of <a href="http://www.somatechnology.com">www.somatechnology.com</a>)</p>	<p>Delivers ventilatory support without the need for an invasive artificial airway. Such ventilation has a role in the management of acute or chronic respiratory failure in many patients (Sharma, 2006)</p>
<b>INOVENT</b>	 <p>(courtesy of <a href="http://www.gehealthcare.com">www.gehealthcare.com</a>)</p>	<p>Helps delivering nitric oxide therapy safely. Inhaled nitric oxide is indicated for the treatment of various lung disorders characterised by pulmonary hypertension and hypoxemia (Department of Respiratory Care Education, 2006).</p>
<b>Dialysis Machine</b>	 <p>( courtesy of <a href="http://www.193.15.174.143/.../Pictures/G">www.193.15.174.143/.../Pictures/G</a>)</p>	<p>Treats acute renal failure in the Intensive care setting (Mehta, 2006)</p>

## Appendix 2- Ethics approval from Human Research Ethics Committee

Australian Catholic University  
Brisbane Sydney Canberra Ballarat Melbourne



### Human Research Ethics Committee

#### Committee Approval Form

**Principal Investigator/Supervisor:** A/Prof Lyn Coulon Nth Sydney Campus

**Co-Investigators:** Ms Jennifer Hardy Nth Sydney Campus

**Student Researcher:** Ms Farida Saghafi Nth Sydney Campus

**Ethics approval has been granted for the following project:**

The lived experience of new graduate nurses in the Intensive Care Unit (ICU): A pilot study

**for the period:** April to December 2004

**Human Research Ethics Committee (HREC) Register Number:** N2003.04-28

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (1999)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimal risk. There will also be random audits of a sample of projects considered to be of minimal risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: .....  ..... Date: 6/4/2004  
(Research Services Officer, Strathfield Campus)



Human Research Ethics Committee

Committee Approval Form

**Principal Investigator/Supervisor:** Dr Jennifer Hardy Nth Sydney Campus

**Co-Investigators:** Dr Sharon Hillege Nth Sydney Campus

**Student Researcher:** Farida Saghafi Nth Sydney Campus

**Ethics approval has been granted for the following project:**

The lived experience of new graduate nurses in the Intensive Care Unit (ICU) - New Graduate Nurses in ICU

**for the period:** 21 January 2008 to 31 December 2008

**Human Research Ethics Committee (HREC) Register Number:** N200708 14

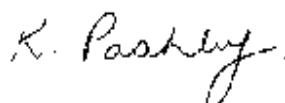
The following **standard** conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (2007)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.



Signed:

Date: 21 January 2008  
(Research Services Officer, McAuley Campus)

### Appendix 3- Developing interview questions for Phase Two

Quotes from the Survey (Phase One )	Some of the Interview Questions raised (Phase Two)
<p><i>The biggest learning curve in my life. One must adapt quickly.</i></p> <p><i>Physically, mentally and emotionally taxing, but richly rewarding also.</i></p> <p><i>As a new grad you have to be a sponge and soak all the information in.</i></p>	<p>What does it mean to be a new graduate nurse in ICU?</p>
<p><i>I have found 40% of staff approachable, 60% non approachable, I felt very isolated, but things are very slowly improving.</i></p> <p><i>Difficult doctors are frustrating.</i></p>	<p>As a New Grad, how did you find communicating with other members of the health care team? Any problems? Can you give me an example?</p>
<p><i>It has been a very stressful year. High expectations in certain areas, not confident with knowledge.</i></p> <p><i>I think too often more experienced staff nurses expect too much and feel you should know exactly what to do.</i></p>	<p>What were other staff's expectations of you in providing competent care to your patient? Did you ever feel overwhelmed by their expectations?</p>
<p><i>It was great though that this hospital had a CNE [Clinical Nurse Educator] who was great to the staff and who was with me the first time I did new things.</i></p> <p><i>It would be good if there was more support and educational days.</i></p>	<p>Can you describe for me the orientation process you experienced in the Intensive Care Unit?</p>
<p><i>Nearly a year along in my NG year and I still have the occasional day when I want to get out of nursing.</i></p> <p><i>I have definitely made the right choice in nursing.</i></p> <p><i>There was a great lack of support from senior staff in my first rotation. Throughout this time I felt very lost and alone I wished I never did nursing.</i></p>	<p>Have you ever considered leaving the Nursing profession?</p>

## Appendix 4-Flyer for Phase Two



### Nursing Research Project

#### **NEW GRADUATE NURSES IN ICU**

*Are you a New Graduate Nurse rotating in the Hospital New Graduate program?*

*Are you currently working in the Intensive Care Unit?*

*Are you interested in the research?*

**YES!!!**

**If so come along and participate in this interesting study... We will be delighted to listen to your story.**

For more information, please contact: Farida Saghafi, CNS, ICU.

We are looking forward to hear from you.

## **Appendix 5: Information sheet**

You are invited to participate in a Nursing Study to explore the experiences of new graduates employed in Intensive Care Unit (ICU). We hope to provide a clearer understanding of new graduate nurses' experience which may identify any challenges, dilemmas, or problems that are encountered. You were selected as a possible participant in this study because you are one of the new graduate nurses who have been involved in the new graduate program and who has chosen to be employed in the ICU of this hospital.

If you decide to participate, we (Dr Jennifer Hardy, Dr Sharon Hillege and Farida Saghafi) will invite you to complete a Demographic Questionnaire (data about your age, past work experience). Also semi-structured, one to one, audio taped interviews regarding your professional experience in ICU will be conducted. You will be invited to engage in providing feedback on the researcher's description of your experience which requires you read the findings regarding your experience in ICU as analysed by the researcher.

If you feel uncomfortable as you discuss your experience, the interview will be ceased, and you will not need to continue. And if you feel distressed or anxious and you are interested to seeing a counsellor, you will be referred to the ACU National, Mackillop Campus counsellor.

It is anticipated that this study will give the new graduate nurses an opportunity to express and explore their own consciousness, and dynamic learning needs for nursing care in ICU.

Your identity will not be disclosed to anyone other than student researcher ( Ms Farida Saghafi). Any information obtained in connection with this study which can identify you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing this document, we plan to publish the results of this study in publications. In any publication, every attempt will be made to maintain confidentiality and names will not be used.

This study has been approved by the Human Research Ethics Committee at ACU National., and hospital.

If you have any questions about this study, please contact the Student Researcher:

Student Researcher: Ms Farida Saghafi  
Intensive Care Unit, St. Vincent's Private Hospital  
406 Victoria St , Darlinghurst, NSW 2010  
Tel: 02 8382 9620

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator or Supervisor and Student Researcher has (have) not been able to satisfy, you may write to the Executive Officer to the University's Human Research Ethics Committee (Research Services, Australian Catholic University, Melbourne Campus, Fitzroy, VIC 3065, Tel: 03 9953 3838, Fax: 03 9953 3315).

Your decision whether or not to participate will not prejudice your future relations with ACU National and the hospital. If you decide to participated, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

You will be given a copy of this form to keep for your personal records.

Many thanks for your participation. It is highly valued.

## Appendix 6: Consent form

**TITLE OF PROJECT:** THE LIVED EXPERIENCE OF NEW GRADUATE NURSES IN THE INTENSIVE CARE UNIT

1. I,.....  
of.....  
agree to participate as a subject in the study involving 90 mins audio taped one to one interview described in the subject information statement attached to this form.
2. I acknowledge that I have read the subject information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.
3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.
4. I understand that I can withdraw from the study at any time without prejudice to my currently and future relationship to the **ACU National and this hospital.**
5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.
6. I understand that if I have any questions relating to my participation in this research, I may contact Farida Saghafi on telephone 02- 83829620 who will be happy to answer them.
7. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the, Executive Officer, St Vincent's Hospital Research Ethics Committee DARLINGHURST 2010 AUSTRALIA (phone 8382 2075, fax 8382 3667).

**Signature of Participant**

**Please PRINT name**

**Date**

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**Signature of investigator**

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## **Appendix 7: Demographic questionnaire**

**Project title:** ‘The lived experience of New Graduate Nurses in the ICU’

Dear Participant,

Please complete the following questionnaire. This will assist the researcher in her analysis of the study findings. Your time is valued and your participation is appreciated.

1. Age group :
  - i) 20-30
  - ii) 31-40
  - iii) 41-50
  
2. Gender:
  - a) Male
  - b) Female
  
3. How long have you been working in the ICU?
4. Do you have any past nursing experience as EN, AON...? If “yes” please explain where and for how long?
5. What is your highest qualification? Which university?
6. Do you have any other qualifications?
7. Do you speak any other languages?

## **Appendix 8: Interview questions (Phase Two)**

1. What does it mean to be a new graduate nurse in ICU?
2. What motivated you to choose working in the Intensive Care Unit?
3. As a New Grad, how did you find communicating with other members of the health care team? Any problems? Can you give me an example?
4. What were other staff's expectations of you in providing competent care to your patient? Did you ever feel overwhelmed by their expectations?
5. Can you describe for me the orientation process you experienced in the Intensive Care Unit?
6. Can you describe for me a typical shift you worked in the Intensive Care Unit?
7. Have you ever considered leaving the Nursing profession? If "Yes" can you explain why? If "No" why? Can you explain?

## Appendix 9: Examples of Colaizzi's steps-Phase Two

*Theme Cluster one: Perception of ICU: unique environment*

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>I think it is <b>the critical stages that the patients are in</b>. I don't know it sort of seems like Intensive Care to me is like the clinical sort.....<b>what a nurse can achieve in terms of how much responsibility you have. You have to be very knowledgeable as well. I think it is more the critical</b> ...how unstable the patients are that we do get is the major attraction.</p> <p><b>There are so many machines</b> you are not just looking after the patient there is everything else around you. <b>Gadgets and patients to look after.</b></p> <p>I like the challenges of ...<b>like the actual knowledge challenge the ability to have the amount of knowledge necessary to provide safe patient care because that is a real challenge</b> there is always something new. And also all <b>the technology</b> I like that because <b>that is always a challenge</b> because <b>there is always something new coming out or another piece of equipment that you don't understand or you have never used</b>. I like the challenge of understanding enough ...this is kind of what I turned up for but <b>seeing how all the systems work together</b> because on the ward we tend to treat systems separately but in ICU it is like you start to understand how all the systems of the body work together and how if one thing starts to go wrong it affects the other systems it is really interesting. At times I <b>like the challenge of dealing with the families</b>.</p>	<p>ICU environment attractions: critical patients, nurses' high responsibility, knowledge required</p> <p>ICU environment challenges include: high technology, acuity &amp; instability of patients.</p> <p>ICU environment challenges include: Amount of knowledge required for safe practice in ICU, continuous requirement for updating your knowledge, looking at all the organs and how they work together, &amp; dealing with families.</p>	<p>Challenges and opportunities make ICU an attractive place to work.</p> <p>ICU challenges include: vast knowledge and skills required to nurse critically ill patients, their families, and utilising various high technology equipment.</p>	<p>Attractions</p> <p>Challenges</p>



Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>there is so much out there in Intensive Care <b>you have to be keen</b> you can't be one of these people who wants to just sit back and watch you have to be keen you have to be jumping in and saying I want to know I want to learn <b>you have to be enthusiastic about learning</b>. I believe to keep up with the game <b>you have to keep educating yourself you have to keep on reading</b> especially in Intensive Care it is just great to sort of learn and just go over stuff and <b>just read books and journal articles and go to these different courses...</b> because the actual program in itself at the hospital I found wasn't sufficient.</p> <p><b>I really needed to have a good medical knowledge</b> because I look at the nurses here the high level nurses here they are the most unbelievable their anatomy and physiology even their chemistry their knowledge is just unbelievable I never even thought it would be as in-depth as what it is.</p> <p>I just think the most important thing about your shift is that <b>you have to be prepared for anything that goes wrong. You have to have good time management skills</b> and <b>I think you really have to be organised</b>. Like you have to have all of your drugs there you have to have ....you have just got to be really organised</p>	<p>The requirement for working in ICU: enthusiasm for learning.</p> <p>The requirements for working in ICU include: in-depth medical knowledge.</p> <p>The requirements for ICU: being prepared for unpredictable, organised, &amp; time management.</p>	<p>Working in ICU requires enthusiasm for learning, in depth knowledge, and time management skills.</p>	<p>Requirements</p>

Theme Cluster Two: Feelings

Raw Data/ Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>And just in the back of your mind thinking <b>what happens if I don't do something or I do something wrong.</b></p> <p><b>Still not having a permanent place in the team and not being accepted</b> all that sort of thing...</p> <p><b>Sometimes I get really frustrated by not being able to make a situation better for a patient who isn't going well ...what can I do I am not really helping at all.</b></p> <p>I think <b>that is one of the most rewarding things that the patient says</b> "I really appreciate what you have done for me today you know ....I don't know what I would have done without you". It is just really nice that is the most rewarding thing. The family will say thank you, thank you so much.</p>	<p>New graduate feels unsure, &amp; concerned about circumstances.</p> <p>NG feels they are not part of the team yet.</p> <p><i>NG feels frustrated not to be able to make a difference in patient's condition.</i></p> <p>Most rewarding</p>	<p>New graduate lack of required knowledge and skills for ICU bring feelings of: anxiety, annoy, distrusted, exhaustion, incompetent, intimidation, not being part of the team, picked on, overwhelmed, stress, stupidity, and scare.</p> <p>New graduate feels proud and satisfied by being part of a patient survival or recovery.</p>	<p>Negative feelings</p> <p>Satisfaction</p>

*Theme Cluster Three: Interaction with others*

Raw Data/Significant statements	Formulating Meanings	Theme clusters	Themes
<p>Because they would probably think: “Oh... my god! You’re not very experienced” or they might lose a bit of faith in you. And I probably would too if someone was looking after me and they said actually this is my first year out I would be like okay it would be like what are they doing now ...is this alright ...that’s fine. <b>No I don’t usually let on</b> and if some just say directly how long have you been nursing ....Oh well just avoid it. So no I don’t let them you know.</p> <p>I find that <b>most of them</b> (doctors) <b>are really supportive</b> and if I ask them why something is happening they will actually give you the time and go through it quickly and go well this is why this is actually happening and try and give me a background which I find really interesting a few of them have done that a few times to me explaining different stuff I found it really interesting why something has happened to a patient. Yes they give me more of the medical background it is really good to see and actually to put it all together.</p>	<p>New graduate nurse hides the fact of being a new graduate from patient.</p> <p>Being supported</p>	<p>New graduate hides being a new graduate from the patient.</p> <p>A new graduate finds good support in interaction with other member of ICU team.</p>	<p>Interaction with patients</p> <p>Interaction with other members of ICU team</p>

Raw Data/Significant statements	Formulating Meanings	Theme clusters	Themes
<p>It is good in a way because <b>it makes it quite clear as to who the best people are to ask for advice</b> ..... on different levels. For example if I needed advice on a technical nursing matter I would go to someone who was maybe a CNS or close to being a CNS. Whereas if I needed some more personal advice ...like I am finding this really hard and I didn't feel comfortable discussing that with someone that was sort of close to the top of that chain of hierarchy I might go to someone that was maybe a couple of years in.... that maybe hadn't done their Post Grad yet who maybe would be able to empathise more where I was coming from and be able to feel more comfortable communicating that information with them.</p> <p>I think they need to say yes you have had a bad day but <b>you did well</b> we will see you tomorrow <b>just a bit of positive feedback would do wonders...</b> Like I think I had a chat with one of the other New Grads and that was probably one of the most important things that we said we were never told that we were doing well. You can't judge how well you are doing unless you get feedback unless you are getting negative criticism all the time which you seem like you are when you are a New Grad there is no obvious sign that you are doing really bad.</p>	<p>Experience of communication with staff</p> <p>Feedback</p>	<p>In interaction with other staff new graduate identifies the approachable one.</p> <p>New graduate benefits from positive feedback.</p>	

*Theme Cluster Three: Interaction with others*

Raw Data/Significant statements	Formulating Meanings	Theme clusters	Themes
<p>Actually one of the New Grads also said sometimes it feels like other people take over <b>but other people have to take over otherwise if you don't know what to do who is going to do it.</b></p> <p>I think initially <b>when you start you accept that people are going to tell you things that you already do know and I don't get too fazed about</b> that but <b>some people find it frustrating.</b> If you can't see past that it would be frustrating. At the same time while you have expectations other people have expectations too. You have got to look at it from their perspective as well they are probably only saying it to help you and they are giving you advice.</p>	<p>Dealing with a certain experience</p> <p>New graduates find staff behaviour: some frustrating, some understandable.</p>	<p>NG perceives others' behaviours in various ways: understanding, accepting, doing the possible best, exaggerating negatively, or getting frustrated.</p>	<p>Interaction with others</p>



*Theme Cluster Five: Journey of novice nurse*

Raw Data/Significant statements	Formulating Meanings	Theme clusters	Themes
<p>I just got myself in a situation where the patient was really sick <b>and I hadn't been in that situation before and not knowing what the next step to do</b> and needing to do the step faster and then having to intervene... I would probably get there but it would take time</p> <p>I guess that me <b>being a New Grad is a transition period from when you finish your nursing degree to actually being ...it is a transition period I think to make sure the practicalities of being a nurse you are confident to do that.</b></p>	<p>Being a novice in ICU</p> <p>Transition from a novice to next level</p>	<p>New graduate nurse in ICU is a novice who lacks the knowledge required for the response to critical situations.</p> <p>A new graduate nurse in ICU is a novice who experiences challenges as they learn. It starts at a lowest rank of profession and while they prove themselves, they become confident.</p>	<p>Journey of a novice nurse</p> <p>Journey of a novice nurse</p>

## **Appendix 10: Interview questions (Phase Three)**

1. What kept you working in ICU?
2. Why did you leave ICU? (**For participants who left**)
3. What do you do as a nurse in ICU which you didn't do when you were a new graduate nurse?
4. Can you describe a typical day in ICU?
5. Have you ever been a preceptor for a new graduate since you finished your new graduate program? What attributes do you see in a new graduate nurse?
6. How do you understand your role in ICU as a nurse who has completed a new graduate program?



## Appendix 11: Examples of Colaizzi's steps- Phase Three

### *Theme Cluster one: Perception of ICU*

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>We are <b>always seeing something different</b>. I feel like I have got the ability to <b>learn something new</b>...like nearly <b>every shift I feel like I learn something new from different situations</b>.</p> <p>I think it is a real time issue that faces the nurses on the ward and I do think they tend to become more and more task oriented and less holistic because they don't have the time. And sometimes they don't have the knowledge either because they haven't undertaken post grad study or they have always worked in the same ward and hence they are focused on cardiac and not focused on respiratory or they become very focused on their area of expertise. Whereas I think, we do have the benefit of <b>being exposed to huge areas of different types of nursing and different types of medicine</b>.</p> <p>Because it [working in ICU] would continue to offer me <b>more challenges</b>.</p>	<p>ICU attraction: learning opportunities</p> <p>ICU attraction: being exposed to variety of cases</p> <p>ICU attraction: challenges</p>	<p>ICU challenges and learning opportunities remain the main attraction to continue working in ICU.</p>	<p>Perception of ICU</p>



*Theme Cluster Three: Interaction with others*

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>You need clear communication and again a lot of them [new graduate nurses] with the equipment and everything... with the patients... they are a little bit <b>scared</b>, so a lot of reassurance is part of it.</p> <p>they are still at <b>the learning level</b></p> <p>Okay it is day one cardiac patient I [new graduate] need to take the drains out... need to get my patient out of bed and I need to do this...this...and this... forgetting what it is... maybe your patient is extremely anxious and is not coping well with the whole thing. Or is in enormous amounts of pain... you need to pick up on the subtle sort of cues. Or you know the nutritional needs are not being met because of the enormous amounts of nausea [<b>New grad caught up in the immediate tasks and routines not able to pick up subtle cues</b>]</p> <p>I do see a lot of myself in them [new graduates nurses] I can see they are sometimes a little bit <b>overwhelmed</b> and they are probably <b>facing some of the challenges</b> that I faced in terms of <b>learning to prioritise and learning the routine.</b></p>	<p>New graduate nurse attribute: being apprehensive</p> <p>New graduate nurse attribute: at learning level</p> <p>New graduate nurse attribute: Lack of critical thinking</p> <p>New graduate nurse attribute: Overwhelmed with challenges of learning the routines and prioritising</p>	<p>RN after few years of practice in ICU sees new graduate as apprehensive learner who is task-oriented and misses basic nursing care.</p>	<p>New graduate nurse a novice</p>

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>That is what I think I did as a New Grad... I would be so <b>worried about what this machine is doing</b>, how it works and all that when I am <b>missing basic things</b> ... do you know what I mean?.... and I think New Grads.... I think... miss a lot on the wards and in ICU ...do you know what I mean? ... Just the really basics and sometimes I think New Grads feel that they should be getting all the really advanced things done and all their skills together but really what it should be it should be a time to get those basic nursing skills and I think that was something that I missed as a New Grad I didn't necessarily see it as that was what the plans were.</p> <p>There are times you know when you take over for example from a junior nurse and you can see <b>this hasn't been done that hasn't been done and this hasn't been done</b> and it is exasperating sometimes and you think this should really have been done not only because it is routine but for the safety of the patient.</p> <p>I can <b>use my experience and reflection as a tool for students and new nurses</b>. I explain to them it is important to find senior nurses you feel comfortable with and express your feelings. I always advise them it is important if you are unsure about a situation or you make a mistake speak up.</p>	<p>New graduate nurse attribute: too worried about equipment, misses basic nursing care</p> <p>New graduate nurse attribute: In handover, unattended duties are found.</p> <p>Role: Preceptor</p>	<p>Registered nurse after few years of practice in ICU takes an active role in education and supervision of other staff.</p>	<p>Preceptor</p>

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>junior staff come on and they ask you things and you can actually answer and explain and know what you are talking about [<b>Education of junior staff</b>]</p> <p>You have become more part of the team because you are not so insular in just trying to make sure your patients are safe. You know what is going on in the rest of the unit and things like that so <b>you become more part of the team</b> I think.</p> <p>I actually feel part of the team and people know me, and they trust me. I feel probably a little bit more emotionally supported because I have the connections with people and <b>I am able to help them</b> and I have a rapport with them</p> <p><b>people trust you</b> which is the main thing... people can trust that you are going to make good judgments and if you don't, if you are not sure they know you well enough to know that you are going to ask.</p>	<p>Role: Education of staff</p> <p>Feeling being part of the team</p> <p>help other staff</p> <p>Perceived being trustworthy</p>	<p>RN after few years of practice in ICU feels being trusted by their colleagues.</p>	<p>Trustworthiness</p>

*Theme Cluster Four: Expectations of performance*

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>On a typical day, <b>I have got all the newer staff</b>. You have to sort of keep in mind, making sure that they are up to date and have done all their required work. if they need a hand with anything as well.... it is also keeping an eye on the patients which I am looking after as well as sort of <b>helping out with the unit</b> if there are any jobs that need to be done any upkeep..... It is more sort of <b>looking at the running of the unit in general than the focus on one or two patients</b>.</p> <p>So I guess I have been given more responsibility.</p> <p>I think particularly once I finish the course [ post graduate course] ...I will be finished in about a month... there is going to be more and more of a push on me to go toward CNS [Clinical Nurse Specialist] status because we are quite short on CNSs at the moment and we have lost a few of our senior staff so I think there is going to be more of emphasis on me really stepping up and going towards that CNS role and acting more in a supervisory and educational capacity</p>	<p>Role: looking after everybody- staff and patients</p> <p>Expected to take higher responsibilities</p>	<p>Registered nurse after few years in practice in ICU feels more responsibilities toward the unit than just caring for their allocated patients.</p>	<p>Responsibilities</p>

Raw Data / Significant Statement	Formulated Meanings	Theme Cluster	Themes
<p>I think I have <b>the ability to look at the bigger picture</b>. For example if I do have two patients I sort of look at the two patients and figure out which one of these two patients actually needs my attention first and <b>what is going to be my immediate priority</b> for this shift</p> <p>I think I am becoming better at looking at it not just from a systems approach but <b>looking at how those systems sort of integrate</b>. Your patient's respiratory system is compromised because they are in enormous amounts of pain and they are not doing their physio and they are not doing this and they are not doing that. I just feel I am becoming a much better nurse in terms of being able to address more of the.....I am not saying they are not immediate needs but a more of a subtle kind of need rather than the immediate tasks that we tend to get caught up in as nurses.</p> <p>Now that I am trained in advanced life support I have been able to <b>run through arrests</b></p> <p>Because I knew that, my basic nursing care was up to scratch I had more time to <b>concentrate on the advanced nursing</b>.</p> <p>I am involved in the <b>development of policies</b>...with new ones... also there is an associate role which I am involved in.</p>	<p>Skill of prioritising</p> <p>Skill of critical thinking</p> <p>Role: being part of emergency response team</p> <p>Professional development</p> <p>Role: Quality improvement</p>	<p>Registered nurse believes few years of practice in ICU has given them skill of critical thinking.</p> <p>Registered nurse professional development after few years of practice in ICU brings them new roles.</p>	<p>Achievement</p>

## **Appendix 12: Publication**



## New graduate nurses' experiences of interactions in the critical care unit

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*This paper reports on one of the key findings from a recent descriptive phenomenological study on lived experience of 10 new graduate nurses (NGNs) in an intensive care unit (ICU) in a major acute care hospital. Interpersonal relationships experienced by NGNs in ICU give rise to diverse thoughts, perceptions and feelings that may have significant impact on their professional development, job satisfaction and retention. The researcher conducted in-depth, semi-structured audio-taped interviews to collect the data. Interaction with others as key theme and related subthemes: interaction with patients; interaction with other members of the ICU team; who is approachable; and feedback emerged. The NGNs' perception of their ability to interact with others, as part of their professional development, is influenced by both (i) how they see themselves and (ii) how they perceive that others see them.*

**KEYWORDS:** nursing; intensive care unit; graduate nurse; interaction; interprofessional relationship; transition program; confidence

As new graduate nurses (NGNs) enter the workplace, they are faced with many demands and challenges (Butler & Hardin-Pierce, 2005). Literature on the issue indicates that NGNs are expected to reach prescribed milestones within a very short timeframe. Other challenges which arise are: persistent criticism about being ill-prepared for the real world of clinical nursing practice; reality shock; and unsupportive work environments that do not foster trust (Halfer, 2007; Kramer, 1974; Parker, Plank, & Hegney, 2003). These factors impede nurses in accomplishing their work and increase pressure on retention (Laschinger, Finegan, Shamian, & Wilk, 2001). Some of the milestones that need to be achieved, especially in the first six months of the new graduate program are; establishing oneself as a healthcare team member; acclimatising to the new job and organization, developing confidence and competence in clinical skills, and making sense of the role as a nurse relative to other healthcare professionals (Duchscher, 2008; Halfer, 2007). Novice registered nurses in their transition to the professional role in intensive care unit (ICU) have a variety of experiences with patients, families, and health care professionals especially nurse co-workers and doctors. These experiences give rise to diverse thoughts, perceptions and feelings that may negatively impact on

NGN's professional development, job satisfaction, and retention.

Despite extensive research on the work experience of NGNs, few studies have addressed the perception of NGNs of interaction with other health professionals and patients in ICU.

In a larger study (PhD), the day-to-day experiences of NGNs in an ICU are explored. The researcher aims to discover what the experience is like for NGNs when they commence in the ICU as well as to explore the changes that occur in their attitudes and experience after 2–3 years of clinical practice in critical care setting. The focus for this paper is to highlight the importance of *interaction* in the intensive care setting from the NGNs' perspective. For the purpose of this study, interaction represents relationship between NGNs and senior nurses, doctors, patients and their families and the effect it has on the NGNs. The study uses descriptive qualitative methodology.

### BACKGROUND

Most NGNs in New South Wales (NSW), Australia, on completion of a Bachelor of Nursing degree, progress through a New Graduate Program in their first year of practice. They are able to choose different clinical specialities in the employing hospital. Some specialities include ICU, orthopaedics, plastic surgery, urology,

neurology, neurosurgery, gynaecology, and vascular surgery. An example of a program could be two rotations of three months each in a chosen speciality and or a six month rotation in ICU. In 2009, NGNs could enter ICU as their first clinical placement.

The delivery of care in ICU demands a team effort and without the support and collaboration of the full ICU team little can be achieved (Vincent, 2006). Casey, Fink, Krugman, and Propst (2004) identified that the NGN may feel unaccepted by their peers and experience difficulty communicating especially with doctors, as a new member of the team, in an acute care setting. McKenna and Newton (2007) conducted research which involved 21 NGNs from four hospitals in Victoria, Australia. In this study it was recognised that after completing the new graduate program, NGNs felt a sense of belonging to a particular clinical setting.

There is considerable discussion in the literature about the nurse–physician relationship, nurse–patient relationship, nurse–nurse relationship, and communication skills in ICU (Belcher & Jones, 2009; Dyess & Sherman, 2009; Kelly & Ahern, 2008; Manojlovich, 2009; Schmalenberg & Kramer, 2009; Ulrich et al., 2006). Conversely, there is little information available that provides insight into the NGNs' experience and perception relating to the interactions with other members of critical care team and critically ill patients and their families.

Effective communication is vital to successful care in ICU (Gauntlett & Laws, 2008). Skilled communication is one of the standards for establishing and sustaining healthy work environments. Nurses must be as proficient in communication skills as they are with clinical skills (The American Association of Critical-Care Nurses, 2005). As new members of the team in ICU, NGNs, need to develop into their professional role, have a variety of experiences of interaction with others. These experiences give rise to diverse thoughts and emotional responses that may have a significant impact on the nurses' own professional development and socialization into this role. Other concerns of introducing new graduates into high acuity areas include capacities

related to cognition, clinical judgement and decision making (Duchscher, 2008). However, the focus for this paper is on new graduates' experience of interacting with medical and nursing staff, patients and their families.

#### METHODOLOGY

A phenomenological approach has been adopted for this study as it aims to explore, analyse and describe particular phenomena. According to Husserl (1970), the experience perceived by human consciousness has value and should be an object of scientific study. Human beings generally go about the business of daily living without critical reflection on their experiences. However Husserl (1970) believed that a scientific approach was needed to bring out the essential components of the lived experiences specific to a group of people (Lopez & Willis, 2004). It is assumed that there are unique everyday experiences of the phenomenon of being a NGN in ICU, that can be abstracted from the data and that this structure is independent of context. In addition, as the researcher was a nurse, applying 'bracketing' ensured that the description of the participants' experience would be free of personal experiences and biases.

The interview questions were constructed to encourage in-depth reflection on the experiences of being a new graduate in ICU by participants. Bracketing prior knowledge helped to ensure purity of the analysis. The researcher also returned to each participant and asked if the exhaustive description was a true reflection of the participant's experiences. Requesting negative descriptions of the phenomenon under the investigation such as 'Can you describe a situation in which you would feel that you were underestimated by other staff?' was helpful in comparing and contrasting the data (Speziale & Carpenter, 2007).

#### Data collection

The research was conducted in an ICU in a major acute care hospital in Sydney, NSW, with NGNs undertaking their new graduate program. After Ethical approval was granted by hospital and university's Human Research Ethics Committee, an informal meeting with all NGNs in the hospital assisted the researcher



to develop questions for the interviews. In addition, this information session, oriented the new graduates to the research project. An advertisement flyer was displayed in the unit inviting potential participants. The researcher approached the NGNs who contacted her regarding the flyer. After informing the participants about the study verbally, via the information sheet and in person, consent was obtained prior to the interview. A clear explanation was given to participants indicating that they had the right to withdraw from the study, and that participation was voluntary. Confidentiality and anonymity of the data were assured. All transcript data were de-identified and the names of participants were kept separately to the interview transcripts and tapes. Whilst the researcher was familiar to the study population, the participants were not in a dependant or unequal relationship with researcher as the interviews were only conducted when the NGN no longer worked in the ICU.

Ten NGNs participated in the study. The participants were registered nurses who had graduated in the past 12 months. The participants were invited to provide demographic data, including: age, gender, past experience, and qualifications. Individual in-depth, semi-structured audio-taped interviews were conducted away from the immediate workplace and in privacy. The interviews began with the researcher asking participants what it meant to them to be a NGN. Thereafter, a flexible interview guide was followed which included exploration of the NGNs' perceptions of communication with other health professions, other nurses, patients and their families. Each interview lasted from 1.5–2 hours (Minichiello, Aroni, Timewell, & Alexander, 2008).

**Data analysis**

The audio-taped interviews were transcribed into a Microsoft word program. Each transcript was read and reread until themes were uncovered. This was done in order to understand the meanings of the experience of being a new graduate. Computer Assisted Qualitative Data Analysis System (CAQDAS) was used to: (i) automate and accelerate the coding process;

(ii) provide a more complex way of looking at the relationships in the data; and (iii) provide a formal structure to develop the analysis (Hahn, 2008). The researcher used Colaizzi's (1978) seven-step procedure – a methodology which 'involves analysing and observing behaviour within its own environment to examine experiences' (Burns & Grove, 2009, p. 530). Significant statements relevant to the experiences of NGNs were extracted. These significant statements then were developed to formulate meanings. Themes were organised into clusters and were then integrated into an exhaustive description. The essential structure of the phenomenon was formulated. Finally, for further validation of the data, the participants were asked to evaluate the findings and to indicate if they truly represented their experience.

**Findings**

The participants (Table 1) represented mostly a similar range of ages and had similar length of experience in ICU. NGNs in this research revealed that they held different views about interactions with other members of the ICU team some found these interactions to be challenging whilst others found them to be supportive. One key theme that emerged from the data was *interaction* with others. Related subthemes were: *interaction with patients; interaction with other members of the ICU team; who is approachable; and feedback.*

**TABLE 1: CHARACTERISTICS OF NEW GRADUATE NURSES IN THE STUDY**

Participants (Pseudonym)	Age (yrs)	Experience in ICU	Past work history
Adam	20–30	5 months	Nil
Caroline	41–50	6 months	Nil
Kate	20–30	3 months	Nil
Kylie	20–30	6 months	AIN
Lily	20–30	6 months	EN
Linda	20–30	6 months	AIN
Lucy	20–30	3.5 months	AIN
Mary	20–30	4 months	Nil
Rose	20–30	6 months	Nil
Sophie	30–40	6 months	Nil

### Interaction with patients

Interaction with patients refers to the communication between the NGN and patients in ICU. This level of communication had varying influences on the NGN. Some of NGNs expressed how they tried to hide their level of inexperience in ICU from their patients and their families. They felt this lack of experience would influence the level of trust the patient might have in their ability to carry out their care. Two examples are as follows:

... They would probably think 'Oh ... my god! You're not very experienced' or they might lose a bit of faith in you. And I probably would too if someone was looking after me and they said actually this is my first year out I would be like okay ... it would be like what are they doing now ... No, I don't usually let on and if some just say directly how long have you been nursing ... Oh well I just avoid it. So no, I don't let them know. (Caroline)

... I was looking after a patient who had had major heart surgery and here I am looking after this person and the family says 'have you been working here for long?' ... how do I get around saying oh yes I have only worked here for a month? ... I just get around it and say I have been working here for a while instead of saying I am just learning everything and just get around it in a way to change the conversation and stuff. Because you don't want the family to think you have only had a month worth of experience, I change it by saying everyone here is very experienced and everyone has done other qualifications after their nursing degree. (Linda)

Some NGNs in this study used different ways to hide the fact they had limited experience in ICU. They avoided answering the question related to experience and even tried to camouflage their appearance, which labelled them as junior staff. Sophie expressed:

I would never ever wear the light colored shirt because if I wore the light colored shirt they would always ask me how long I had been out of uni ... But if I wore the dark colour, they would always think that I had been out for a certain amount of time. For some reason they had in their head the dark uniform means that you are more senior and patients would trust things that you say and families would trust things that you said ... it would just make things easier. It's really bad ... it's pitiful.

### Interaction with other members of ICU team

Interactions with other members of ICU team, within the context of this paper refers to NGNs' communication with doctors and nursing staff in ICU and its effect on NGNs. Participants in this study agreed that interprofessional relationships among nursing and medical staff in ICU are more equitable than they had experienced on a general ward. For instance, Kylie noted:

At first coming from the ward, it is really different ... the doctor situation ... it is a lot easier to talk to the doctors in Intensive Care, because you work in a tight [relationship] ... you have to be communicating well with the doctors in Intensive Care whereas on the wards it wasn't really like that ... nobody spoke to the doctors.

Most of participants revealed that in interacting with doctors they found support and identified it as a good experience, '*I think their (doctors') communication with us is quite good*'. Lily claimed. Participants identified that as soon as the doctors knew they were NGNs they would patiently explain different clinical matters to them. The following quotations illustrate the NGNs' experience of communication with doctors as being supportive and understanding:

... Doctors were actually quite good I thought. Generally, I think most of them, if they knew you were new and ... you were introduced as soon as you came onto the unit as being a New Grad and someone new ... so I found that that was quite good because they knew that you were new ... they had no issue with explaining things. (Sophie)

... Most of them (doctors) if they know you are a New Grad; they tend to explain things a bit more. (Mary)

However, three participants claimed different personalities among doctors would affect how approachable they were, especially at the beginning of their rotation. At times NGNs found interaction with doctors challenging and intimidating. For instance, Linda claimed:

I think first out ... yes I was very intimidated by the doctors, I didn't know how to approach them and sort of things like that, whereas if you are a more senior level you know how to communicate to the doctors and you can get things done a lot faster.



One of the factors that NGNs believed affected their relationship with the nursing staff and acceptance as a member of the team was their transiency in the unit. New graduate registered nurse transition program in NSW (Australia) is a 12 month contract. On occasions the new graduates believed that because of the temporary nature of this employment, permanent staff did not consider them as a member of team. The participants identified having other new graduates as their peers, available to talk to and to share clinical experiences was a relief. Mary comments on lack of acceptance:

I think sometimes when you are a New Grad, not specifically in ICU but other places as well, they don't expect you to be there that long and sometimes they don't get to know you and things like that.

New graduate nurses in the study reported that the nursing staff were not aware of their level of knowledge and skills hence, on occasions they would explain fundamental clinical nursing skills. Therefore, graduates stated they felt the need to continuously prove themselves as competent nurses to be part of the team and be accepted by their colleagues, as Sophie and Lucy explain:

... it can be difficult sometimes interacting with staff because they don't really know you and they don't know how much you know. (Sophie)

I think it is only to prove myself and I think there will be a time when I will have proved myself, not to be the perfect nurse but to be a competent nurse ... not that I am incompetent but I am not quite at that stage yet. (Lucy)

In addition, one of the NGNs expressed how she found that some senior nurses' interactions with NGNs were different compared to other staff:

... one of them, a CNS when I see how he interacts with other nurses that are above me I think there is hope for me, he is just testing me and making me do stuff and maybe in six months, nine months everything will be fine. (Lucy)

#### Who is approachable?

The NGNs quickly identified the most approachable staff members for support and guidance. In the majority of cases, this person proved to be the

closest to them in the nursing hierarchy. Lucy and Linda commented:

It is good in a way because it makes it quite clear, as whom the best people are to ask for advice ... on different levels. For example if I needed advice on a technical nursing matter, I would go to someone who was maybe a CNS or close to being a CNS. Whereas if I needed some more personal advice like: I am finding this really hard, and I didn't feel comfortable; discussing that with someone that was sort of close to the top of that chain of hierarchy. I might go to someone that was maybe a couple of years in ... that maybe hadn't done their Post Grad yet, who maybe would be able to empathise more where I was coming from, and be able to feel more comfortable communicating that information with them.

You sort of find out who you can ask and who you can't, and those more willing to help you and you keep going back to those people and asking.

#### Feedback

When asked to share their experience of communication as NGNs in ICU, the participants reported how the positive feedback from their colleagues or patients boosted their confidence. Caroline described her experience as: 'It just took the pressure off and I thought well maybe I am not that useless'. Another participant shared feeling of satisfaction achieved by the positive feedback that confirmed her role in patient's recovery:

I have had a couple of patients that have said: ... 'you are a really good nurse keep going this way, don't change, make sure you stay in nursing so that other people have the same experience that I have'; and you come out and you feel really good; and you think like wow ... I really made a difference to someone, and maybe I did make the right decision by being a nurse. (Rose)

Formal appraisal was important to NGNs whilst they were going through their placement in ICU. The participants believed feedback from the nursing manager was as an opportunity to evaluate their progress and achievement during the new graduate program:

I think, they [senior nurses] need to say 'yes you have had a bad day but you did well we will see you tomorrow' just a bit of positive feedback would do wonders ... Like I think, I had a chat with one of the other New Grads and that was probably one of the most

important things that we said we were never told that we were doing well. You can't judge how well you are doing unless you get feedback; unless you are getting negative criticism all the time, which you seem like you are when you are a New Grad, there is no obvious sign that you are doing really bad. (Rose)

Feedback was also seen as playing a role in NGNs' reflection on their performance and development during their time in ICU. One NGN expressed:

I do strive on feedback, I find that really important just so I can take it on and improve my skills. Sometimes I will ask people and go 'am I doing the right thing' and different stuff, because I like to get feedback off people about doing stuff. (Linda)

## DISCUSSION

In this paper the experiences of a number of NGNs' interaction with other health care professionals in a critical care setting (ICU) has been described. Effective communication is integral to the success of any work environment; it is vitally important that NGNs have positive and effective communication experiences, and recognition of their expectations.

Perhaps of a great significance is the new graduates' interaction with patients and their need to 'hide level of expertise' to prevent loss of the patient's trust. There is sufficient support in the literature to identify that trust is a crucial element in establishing an effective nurse-patient interaction (College of Nurses of Ontario, 2009; Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009; Lotzkar & Bottorff, 2001; Mok & Chiu, 2004; Sellman, 2007). The importance of trust and feeling safe in nurse-patient interactions was highlighted, as NGNs in this study tried to gain the trust by hiding their perceived lack of expertise so that the patient felt safe under their care. Endeavour to disguise feeling of inadequacy as a normal behaviour by new graduates has been reported by Duchscher (2008). The importance of previous nursing experience in developing trust between the NGN and patient has been described by Belcher and Jones' (2009) study in a qualitative research study involving NGNs in a Melbourne Metropolitan hospital, in Australia. They explored the NGNs' experience of developing trust in the

nurse-patient relationships and found that developing rapport was the first step to building a trusting relationship with the patient. In order to develop rapport, new graduates identified the previous nursing experience as a major theme. There is a paucity of research regarding NGNs' perceptions about developing a trusting nurse-patient relationship. However this study illustrated that these NGNs understood the importance of trust and they believed it could influence patient's acceptance of care (Belcher & Jones, 2009).

During the interviews over half the participants frequently used the term 'supportive' to describe the nursing and medical staff in ICU. The term 'support to them' was described as; support in their clinical practice as well as guidance in patient management. Conversely, NGNs reported experiences of poor communication with some doctors and nurses in ICU. Kelly and Ahern (2008) in a phenomenological study in Australia noted the different personalities and attitudes among doctors and senior nurses overwhelmed NGNs, and in general, they found communication with doctors relatively uncomfortable. The lack of respect from the experienced nurses toward NGNs; has often been cited in the literature as a major challenge (Casey et al., 2004; Dyess & Sherman, 2009; Kelly & Ahern, 2008; McKenna, Smith, Poole, & Coverdale, 2003). Rosenstein and O'Daniel (2008) concur with these findings and revealed that if the participants experienced difficulties or challenges in communication with a member of the ICU team they elected to avoid approaching that person voluntarily in the future.

The new graduate, can be described as a novice, and therefore, needs guidance in applying knowledge to clinical experiences (Benner, 1984). Senior nurses could reinforce this guidance by providing feedback to NGNs. The findings of this study indicate that the NGNs prefer to receive frequent and regular feedback and formal appraisal from senior nursing staff. This resonates with Duchscher (2009) NGNs' transition conceptual framework. In sociocultural and developmental aspect of transition shock experiences, Duchscher identified the need for affirming and critical feedback from senior colleagues and also absence of

formal feedback for novice practitioners. Casey et al. (2004) also found there was a relatively high level of satisfaction with positive feedback from managers and co-workers among NGNs.

The NGNs in this study reported a lack of regular feedback, especially formal feedback, from their senior colleagues and managers. The participants emphasised that they valued constructive feedback. They perceived feedback as an indicator to measure their clinical practice progression.

#### CONCLUSION AND RECOMMENDATIONS

The NGNs who participated in this study provided valuable descriptions of both their positive and negative experiences with nursing and medical colleagues, as well as patients during their transition to practice phase. The results of this study provide considerable insight into NGN's perceptions of interactions with patients and other health professionals in ICU. Many reported that they attempted to hide their inexperience from the patients and the fact that they have been out of university for less than a year and had only a few months of experience in ICU. The participants were able to describe their experiences in this new role in terms that reflected interaction with other members of ICU team that was both supportive as well as challenging. They described characteristics such as 'not approachable' among some senior colleagues. They reported that they expected to receive regular feedback while acquiring the knowledge and skills necessary to be trustworthy and accepted by other members of ICU team.

There were some variations in the responses from these NGNs that could be linked to individual personalities. The more outspoken the participant was, the more positive their experience. These experiences so richly described by the NGNs in this study indicate that while giving positive feedback rarely occurred, this feedback could have provided support and guidance; including the confidence necessary to practice nursing successfully and perhaps may have impacted on the retention of NGNs in ICU.

Further studies in cross clinical settings would be helpful to determine the prevalence of these experiences for NGNs in other areas of clinical practice.

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## **Appendix 13: Conference presentations**

- **Paper (speaker) titled: “new graduate nurses growing into proficient nurses as leaders in critical care setting, an Australian perspective” the 6<sup>th</sup> International Nursing Management Conference, Oct 2014, Bodrum, Turkey.**
- **Paper (Speaker) titled: “New graduate nurses in critical care setting: novices in Intensive Care Unit” the 3rd EfCCNa Congress & 27th Aniasi Congress, Oct 2008, Florence, Italy.**
- **Poster titled “The role of new graduate nurses in critical care: Implications for interprofessional practice” , Australian and New Zealand Annual Scientific Meeting on Intensive Care, 12-15th October 2006, Hobart.**
- **Paper (speaker), Nursing Research Symposium, Nov 2005, Sydney**
- **Paper (Speaker), RCNA’s Annual conference: Leadership, Image & Culture, July 2005, Adelaide**
- **Poster titled “The lived experience of new graduate nurses in the Intensive Care Unit”, 6<sup>th</sup> Intensive Care Education (ICE) meeting, April 2005, Perth.**

# The Role of New Graduate Nurses in Critical Care: Implications for Interprofessional Practice

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## Abstract

Providing new graduate nurses with opportunities to share their experiences in a critical care environment formed the basis for this research. A phenomenological approach involving new graduate nurses was deemed the most appropriate method to ascertain their lived experience. Data was collected using in-depth, semi structured audio-taped interviews which were transcribed, coded and analysed using Max Van Manen methodological interpretation until themes emerged. One of the major themes that emerged was Interprofessional Relationships in Critical Care Practice. The findings highlighted new graduate nurses' challenges and dilemmas in critical care. Such findings have indicated the need for continuing educational support for new graduate nurses working in ICU. It is proposed, a Professional Practice Support Program (PPSP) be implemented and include: web-based materials; clinical skills competency portfolios; on-line orientation manuals, and critical thinking challenges based upon patient scenarios utilising evidence based practice (EBP).

## Background

Most new graduate nurses in NSW after completing a Bachelor of Nursing degree progress through a New Graduate Program (NGP) in their first year of practice. This program has been designed to smooth role transition from student to an employee registered nurse (RN). New Graduate (NG) nurses experience reality shock and stress as they enter the workforce and the professional world of a healthcare provider. Many nurses choose specific areas where they intend to practice based on their experiences as undergraduate nursing students. Research studies have verified that working in health care settings with high levels of technology such as critical/intensive care (ICU) are significantly more desirable to nursing students than other areas of clinical practice (Happell, 1999, Steven & Dulhunty, 1992). It therefore becomes important to explore their experiences in such a 'desirable' area, and ask the question: Do NG nurses have the same experience as that of undergraduate students, or does undertaking the new role as an RN result in more challenging and less desirable experiences?

A feature of working in an ICU is interprofessional practice. Different professions coordinate their services to meet the needs of the patients in the most effective time, place, and manner (The Interprofessional Commission of Ohio, 1999). Because care is delivered by a group of professionals, team work is built on interdependent practice (Coombs & Ersser, 2004).

Two issues or concepts are highlighted in professional nursing: interprofessional practice and interprofessional relationships. Interprofessional practice as a broad or general term is based on a multidisciplinary or across disciplines framework where the delivery of patient care is achieved through team work and collaboration. Whereas professional relationships refer to status, perceptions, and power between and among different health care professions. The characteristics of professional relationships are based on an obligation to solve a problem which is aimed at improving patient's health which is: planned and purposeful, time limited, patient centered and includes non-judgemental acceptance of each professions perspective. The elements in these relationships include: self-awareness, trust, respect, acceptance, sharing or transferring information, mutual understanding, collaboration, and power of control (Chitty, 1997; Duld, Giffin, & Patton, 1984).

Peret in 1993 using qualitative research explored the meaning of the interprofessional relationship from the perspective of practicing nurses in an ICU. Nurses in this study believed physicians showed respect for their knowledge and they were involved in clinical decision making for patients. Although is not clear if there was any correlation between this perception and the experience (being a senior nurse) of the nurse. The question therefore needs to be asked: Would the NG nurse see her/himself as a member of team in a sharing and contributory relationship. In an ethnographic study by Coombs and Ersser's (2000) the nursing role in clinical decision making in three ICUs in the south of England were examined. This research revealed the conflict existing between physicians and nurses based on medical hegemony (dominance of one group over other groups), and devaluation of the nursing role in clinical decision making. Such activities, in fact form the bases for interprofessional practice in ICU.

The studies highlighted illustrate a high interest in practicing as a RN in a high technology environment from nursing students and significance of interprofessional practice in ICU. However there has been little research to discover NG nurses' experience in their new role in collaboration with different professions in ICU. Thus, research to explore the lived experience of NG nurses in interprofessional practice in ICU was indicated.

## Aim

To discover the lived experience of NG nurses in their new role as a NG including interprofessional relationships in an ICU and scope the methodology for an extended study.

## Study design, Method

A phenomenological approach involving graduate nurses was deemed the most appropriate method to discover their lived experience.

## Participants

Registers nurses who graduated in last 12 months, are employed in a NSW private hospital's Intensive Care Unit, and are on a rotation through a new graduate program. Data was collected using in-depth, semi structured audio-taped interviews which were transcribed, coded and analysed using Max Van Manen methodological interpretation until themes emerged.

## Result

One of the major themes that emerged was inter-professional relationships in critical care practice. Two sub themes titled "stereotype of NG nurse" and "tensions in professional relationships" were derived from this major theme.



interprofessional relationships in critical care practice

stereotype of NG nurse

tensions in professional relationships

Stereotype of NG nurse: "...these are only New Grads they are not fully capable like you.... as Senior Staff..." *New graduate Linda*

Tensions in professional relationships "...As a New Grad in particular they (doctors) just think you are this clueless student who doesn't know what they are doing which maybe the case but they should show some form of respect..." *New graduate Kate*

## Discussion

The study findings show that NGs understand the importance of effective communication and team work in the ICU environment. They try to establish proper interprofessional relationships with their colleagues (other nurses and physicians). The attitudes displayed by nursing and medical staff make it difficult for NGs to establish trusting relationships within the team. In this study the findings related to communication issues and the stereotyping of NGs are consistent with the nursing literature (Benner, 1984; Farrell Daingerfield, 1993; McKenna, Smith, Poole, & Coverdale, 2003; The University of Newcastle, 1997). The emphasis in the literature is on power and control as imposed by senior nurses or physicians toward the NGs. Therefore, the discussion that follows highlights the essence of team work (being a member of the team) and stereotyping (beliefs about NGs).

## Conclusion

The findings highlighted new graduate nurses' challenges and dilemmas in critical care. Such findings have highlighted the need for continuing educational support for new graduate nurses working in ICU. It is proposed, a professional practice support program (PPSP) be implemented and include: web-based materials; clinical skills competency portfolios; on-line orientation manuals, and critical thinking challenges based on patient scenarios utilising evidence based practice (EBP).



# New Graduate Nurses Lived Experience in an Intensive Care Unit: A Pilot study

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## Abstract

Providing new graduate nurses with opportunities to share their experience in an Intensive Care Unit (ICU) formed the basis for the current research. A phenomenological approach involving graduate nurses was deemed the most appropriate method to discover their day to day experience. Data was collected using in-depth, semi structured audio-taped interviews which were transcribed, coded and analysed using a constant comparative approach until themes emerged. The three dominant themes were named as: *Being a Novice in ICU*, *Being in the World of ICU*, and *Interprofessional Relationships in the World of ICU*. The findings from the pilot study highlighted the challenges, dilemmas, and educational needs of new graduates undertaking a rotation in ICU. The development of a Professional Practice Support Program (PPSP) is one of the recommendations arising from the research.

## Background

Most new graduate nurses in NSW after completing a Bachelor of Nursing degree progress through a New Graduate Program in their first year of practice. This program has been designed to smooth the transition of role from student to employee registered nurse. Still many new graduate nurses experience reality shock and stress as they enter the professional world. Many nurses choose specific areas where they intend to practice based on their experiences as undergraduate student nurses. The results of a few research studies have demonstrated that working in health care settings with high levels of technology such as critical/intensive care are significantly more desirable to student nurses than other areas of nursing practice (Happell, 1999, p.499).

The impetus for this study arose from reflections of my own experiences and observations of newly qualified nurses. Working for 10 years as a Registered Nurse in Intensive Care has given me enough experience to feel confident in delivering care to critical patients. Encountering many challenges and dilemmas in this unique environment (Intensive Care Unit) gives one ability and capacity to handle huge fluctuations in the patients' physical condition. Such experiences are very special and include: feeling satisfied at the end of a shift to be part of a rescue in a CPR team, or weaning a patient off the ventilator after couple of days. But what about the nurse who has just graduated a few months ago? A number of questions come immediately to mind:

- Will s/he have the same feelings?
- What are her/his expectations?
- What are her/his needs? Are they met?
- Why does s/he desire to work in an Intensive Care Unit?
- Does this experience influence her/his future career?
- Does it encourage her/his to see her as a skilful and expert nurse in the next ten years or s/he wants to leave nursing profession for good?

The question therefore has to be asked, what is the significance of researching issues surrounding the experiences of new graduates in an intensive care environment? To answer this question a pilot study was undertaken.

## Objectives

To:

- Discover the lived experience of new graduate nurses in the Intensive Care Unit in New South Wales (NSW).
- Determine the appropriateness of the methodology in Pilot Study in preparation for the main study.

## Benefits of the study

It is anticipated that this study will provide a clearer understanding of new graduate nurse's experiences; their problems, motivations, and challenges. In addition it will give them an opportunity to express and explore their own consciousness, and dynamic learning needs for providing nursing care in ICU. Examining the experience of new graduate nurses in ICU in light of phenomenological findings may raise awareness for the need to change. This has implications for new graduates, senior nurses, nurse educators, nursing administrators, and other educational institutions engaged in the preparation of undergraduate nurses.

## Research question

What is the lived experience of new graduate nurses in an intensive care unit in a private hospital in NSW?

## Study design, Method

A phenomenological approach involving graduate nurses was deemed the most appropriate method to discover their lived experience.

**Participants:** Registered nurses who graduated in last 12 months, are employed in a NSW private hospital's Intensive Care Unit, and are on a rotation through a new graduate program. Data was collected using in-depth, semi structured audio-taped interviews which were transcribed, coded and analysed using a constant comparative approach until dominant themes emerged.

## Results

Three dominant themes emerged: *Being a Novice in ICU*, *Being in the World of ICU*, and *Interprofessional Relationships in the World of ICU*. The findings highlighted the new graduate nurses' challenges; including the pace of work in ICU, dilemmas; such as making decision in some areas of patient care, and educational needs; for example knowledge and skills require for providing care to the variety of patients who are critically ill. Further research will be undertaken and it is proposed by the researcher that there is a need to develop a Professional Practice Support Program (PPSP) for new graduates rotating through ICU.

## Themes evolved from this study

### Being a novice in ICU

#### Subthemes:

- Self- Understanding
- "Knowing that" versus "Knowing how"
- Feelings Negating Learning

*When you learn about ECG and different stuff [in the university], of course you came out knowing the P and S wave and what was sinus and Tachy and Brady and sinus rhythm and stuff like that... like your basics. You could tell... like from an ECG... all that. But then to come down to Intensive Care or a Cardiac ward you have to do more education. You can't just get out of your degree and say okay I will just go and do this area. Because what you learn in your degree is sort of like the basics. That is what I see it. As the three years only covers the basics, it sets you up for learning more through other courses that you apply for yourself, through the other organisations.*

[New graduate Linda]

### Being in the world of ICU

#### Subtheme:

- ICU a Complex Environment

*Just the variety of the patients we are getting, the pace that is in ICU. Just the whole atmosphere in ICU that is completely different to ward nursing... you can sort of see all your clinical skills in Intensive Care it is just there... It is just thinking about everything... just dealing with an environment that is so different... that I haven't been in before and everything was new. ...Just learning everything... it seemed every day that you went in there that it wasn't just one thing it was a hundred things that were... and I was trying to remember that hundred things each day.*

[New Graduate Kylie]

### Interprofessional relationships in the world of ICU

#### Subtheme:

- Tension in Professional Relationships
- Stereotypes of New Graduate Nurses

*As a New Grad in particular they (doctors) just think you are this clueless student who doesn't know what they are doing which maybe the case but they should show some form of respect.*

[New Graduate Kate]