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The Journey Within: Discovering the Sense of Becoming

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

THE JOURNEY WITHIN: DISCOVERING THE
SENSE OF BECOMING

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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Entitled: *The Journey Within: Discovering the Sense of Becoming*

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ABSTRACT

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To discover how the sense of becoming was experienced by advanced beginner Bachelor of Science in Nursing (BSN) graduates in the advanced beginner stage of Benner's (1984) Novice to Expert framework was the aim of this research. The purpose was to understand how new registered nurses (RN) survived and thrived in their first years of independent practice while balancing the need to provide high-quality, safe patient care. With extraordinary orientation costs and the current high turnover rate for new nurses, hospitals are concerned about hiring new nurses and their stability, preparation, and ability to provide safe care to patients in an acute care setting.

Fourteen new BSN graduate nurses participated in qualitative interviews and following grounded theory methodology of Strauss and Corbin (1990), the constant comparative method of analysis was used to discover the substantive theory of advancing in a new professional role. This theory emerged and claimed that as a new nurse transitioned during the orientation and post-orientation phases, he/she changed from a dependent to an independent practitioner through the processes of shaping, knowing, growing, and advancing. The consequences of these processes were connection to others, competence, self-confidence, and empowerment. These consequences led to independent practice, progressive connoisseurship, refining awareness, and reaching for a higher potential. Facilitators of these processes were positive relationship, trust, respect,

acceptance gaining experience, and support in the form of increasing responsibility, feedback, debriefing, and continued resources. Barriers to these processes were negative interaction and unprofessionalism.

Implications included nursing academia assuming greater responsibility to ensure professional role development, socialization, and professional role identity are introduced early to nursing students. Nursing practice needs to support preceptor development and selectively place new nurses with trained preceptors.

There is a need for innovative collaborative programs and partnerships that bridge education to practice. Creative programs such as coaching programs are needed to provide extended support for new nurses practicing independently in the first two to three years of practice. These research findings supported the nursing transition literature and deepened what is known about the advanced beginner stage of Benner's (1984) framework.

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION.....	1
Purpose of the Study	4
Problem Statement	5
Sense of Becoming	6
Research Questions.....	11
Theoretical Overview.....	11
Significance.....	14
Assumptions.....	15
Chapter Summary	16
CHAPTER II. LITERATURE REVIEW	17
Introduction: Understanding Becoming.....	17
Novice to Expert Theory.....	22
Formation.....	26
Human Ecological Theory	29
State of Healthcare Literature	31
Current State of the Nursing Profession	38
Transition Literature	43
Chapter Summary	51
CHAPTER III. METHODOLOGY	53
Introduction.....	53
Research Approach	53
Grounded Theory Methodology	57
Research Design.....	61
Participants.....	62
Data Collection	67
Trustworthiness.....	74
Chapter Summary	79
CHAPTER IV. RESULTS.....	81
Open Coding	84
Axial Coding.....	89

Selective Coding	139
Chapter Summary	146
CHAPTER V. CONCLUSIONS AND RECOMMENDATIONS	148
The Substantive Theory of Advancing in a New Professional Role	149
Returning to the Literature.....	156
Impact of This Research	164
Synthesis	166
Implications.....	173
Recommendations.....	185
Limitations	187
Conclusion	187
REFERENCES	190
APPENDIX A. INSTITUTIONAL REVIEW BOARD APPROVAL.....	205
APPENDIX B. CONSENT FOR HUMAN PARTICIPANTS IN RESEARCH	207
APPENDIX C. SEMI-STRUCTURED INTERVIEW GUIDE	210
APPENDIX D. CONDITIONAL RELATIONSHIP GUIDE	212
APPENDIX E. VISUAL MODEL	219

LIST OF TABLES

1.	Participant Demographics	69
2.	Research Questions and Interview Questions	74
3.	Example of Open-Coding Process	87
4.	Example of Variable Cluster and Property	88
5.	Context Table.....	91

LIST OF FIGURES

1.	Reflective coding matrix.....	82
2.	Advancing in a new professional role.....	150

CHAPTER I

INTRODUCTION

“The only journey is the one within.” Rainer Maria Rilke

As a newly graduated baccalaureate nurse, an extraordinary journey is just beginning for many young women and men. The journey will be a lifelong process filled with unforgettable and life forming experiences. Experiences encountered by an individual throughout life are believed to be interdependent and influenced through multiple interactions and environments according to human ecological theory (Bronfenbrenner, 1979). Therefore, a new nurse will impact his/her environment and his/her environments and elements within will impact him/her, thus forming his/her “sense of becoming.”

The journey of a nurse can parallel a well-known theory in nursing--Patricia Benner's (1984) Novice to Expert theory. The Novice to Expert model consists of five stages of proficiency, which emulates the journey a person experiences of professional nurse development: novice, advanced beginner, competent, proficient, and expert (Benner, 1984). In associating the nurse journey to the Benner model, some might ask, what is the destination? There is not a predetermined destination of the journey. As every nurse is unique and individual, so is his/her journey, sense of becoming, and professional nurse actualization. Although some nurses will advance through all of Benner's stages to the expert stage, not all nurses will want to become an expert nurse.

Some nurses might choose to practice at the competent and proficient stages for their practice. Some nurses will leave the profession and abandon their nursing career all together. Some people may think the destination is an event or accomplishment, e.g., college graduation, first job, career dream job, or even retirement. Truly the destination is in every step of life. Along with every step in life, there might be moments and times that are harmonious and balanced; they might generate feelings of success and accomplishment. We also know that within the journey there might be experiences that bring challenge and strife – times of vulnerability and fragility. These times can be sensitive and critical periods in the journey and be when the most learning and growth occur.

Benner's (1984) model classifies those in the novice stage as nursing students in a new clinical area or any nurse entering a clinical setting where they have no previous experience with that unit or the patient population. The advanced beginner is a nurse who can demonstrate a marginally acceptable performance based on having sufficient real situation readiness or prior experience in actual situations Benner (2001). This situational premise applies to new nurse graduates who had accepted an entry-level nurse position and have remained in that same position. The advanced beginner stage of Benner's model was the focus of this research. This period represents a critical period when the new nurse enters the workforce, transitions from graduate nurse to independent practitioner, and moves through the advanced beginner stage in his/her nursing practice. This stage in a nurse's life is one of the most vulnerable, challenging, and stressful times a nurse will encounter in their career (Bhanji, 2013; Duchscher, 2009; Greene, 2010;

Morrow, 2009; Phillips, Kenny, Esterman, & Smith, 2014; Suresh, Matthews, & Coyne, 2012; Thyrsoe, Hounsgaard, Dohn, & Wagner, 2011).

As the Benner (2001) model proposed advancement through the stages of novice to expert, the researcher viewed this process as a journey. More specifically, the movement through a stage was referred to as “transition” by the researcher. In the nursing literature, the term “transition” is commonly referenced as the first one to two years in practice for new nurse graduates; it was known as graduate nurse transition for this research (Bhanji, 2013; Duchscher, 2009; Hoffart, Waddell, & Young, 2011; Morrow, 2009; Phillips et al., 2013; Thyrsoe et al., 2011). In thinking about the critical period of transition, the evolution from novice through the advanced beginner stage for new graduate nurses is the time when the new nurse is contemplating and trying to figure out “who I am” personally and professionally.

This significant transition is not a linear experience or an easily defined, straightforward concept; it is a multidimensional experience. To research and capture the significance and magnitude of such a multidimensional experience of a person, following a framework that allows for multifaceted exploration is equally important. The human ecological theory by Urie Bronfenbrenner (1979) is a multidimensional theory that centers the developing person in his/her environment and considers the evolving interactions between the two. The theory postulates that human development is achieved through an interaction between the growing human and his/her environment. The theory considers the individual as center (microsystem) and then moves outward to consider the person’s immediate environment (mesosystem) that consists of family, work, peers, and school. Beyond the mesosystem is the exosystem—the person’s community in which

he/she lives, works, and attends school. Past the exosystem is the macrosystem, which consists of abstract environments of national and social customs, norms, and values. The chronosystem is the element of time and age and transcends the developing individual and all his/her environments (Bronfenbrenner, 1979).

This theory is the framework for examining the zone or transition between Benner's (2001) novice to advanced beginner stages as a means to bring dimension, depth, and time to the transition experience. How the entire process of the transition unfolds through the human ecology framework is the story of the nurse's sense of becoming—it is part of his/her journey.

Purpose of the Study

The purpose of this study was to contribute to the literature on discovering the “sense of becoming” among new baccalaureate graduate nurses immersed in the transition through the advanced beginner stage of Benner's (1984) model through the human ecological theory framework of Bronfenbrenner (1979). Through the eyes and voice of new nurses, the aim of the study was to reveal a different essence of the novice to advanced beginner transition experience in situ, the “sense of becoming,” as new nurses understand it. The rationale for the “sense of becoming” to be discovered is supported by the need for new, acute care, independent registered nurses (RN) to survive and thrive in their first years of independent practice through realistic expectations; high-quality, safe patient care; limited stress; and the development of a positive personal and professional identity, building of confidence, and socialization into the nursing profession. Better understanding of the “sense of becoming” during the critical transition period in new nurses' careers might reveal evidence that could impact the retention rate

of qualified nurses in the acute care setting, thus decreasing turnover costs for hospitals by contributing to safe, high-quality, patient care practice.

Problem Statement

Baccalaureate nursing education prepares students to be competent, safe, novice general nurse practitioners at the completion of a nursing program, culminating with graduation. Baccalaureate-prepared nurses “are prized for their skills in critical thinking, leadership, case management, health promotion, and for their ability to practice across a variety of inpatient and outpatient settings” (American Association of Colleges of Nursing [AACN], 2014, para. 1). Acute care hospital employers desire Bachelor of Science in Nursing (BSN) prepared nurses if they are from an American Nurses Credential Center (ANCC) Magnet Recognition Program institution or are anticipating applying for Magnet designation. As an acute care employer, they desire new graduate nurses whose performance demonstrates a high predictability of success; this includes passing the nursing board exam and being an asset to their organization. The employer will be investing a significant amount of human capital and financial resources into the new graduate’s orientation.

Even though employers have these desires and expectations, it is still reality when new nurse graduates do not meet these criteria; thus, programs have been designed and implemented to help decrease the gap. In an integrated review by Rush, Adamack, Gordon, Lilly, and Janke (2013), new nurses who participated in a coaching, mentoring, or preceptorship program, nurse residency, or intern programs had increased satisfaction, which resulted in good retention rates and improved competency. These types of programs are suggested to be available for six to nine months post-hire, should focus on

intervention and skill development, and include formal support and training for new nurses (Hoffart et al., 2011; Rush et al., 2013). Despite these efforts and their positive outcomes, many hospitals do not offer such programs as part of the new nurse contract. In a 2012 report from the Texas Center for Nursing, 60.9% of responding acute care hospitals offered a transition to practice program for new graduate nurses. The survey also revealed that such transition programs proved to be economically beneficial; the return on investment was up 884%, nurse satisfaction began to increase during the first year, and there was a reported improvement in quality of patient care. No further national statistics could be found relating to the percentage of transition to practice programs in the United States. Due to random fragmented programs, a gap remains between new nurse expectations and acute care employer expectations

Sense of Becoming

This study adds to the literature with the discovery of *how* the sense of becoming as a new nurse knows it is experienced and what factors influence it. The sense of becoming is a phenomenon. It is an abstract idea that is complex to define; yet, it is definite and individualized in the reality or mind of the person who has experienced it. First introduced by Aristotle, the term *becoming* has been used to describe the experience of interaction with the world and the result of change in one's life (Dillon, 2000). This term summarizes the momentous change a person undergoes as one prepares to become a professional registered nurse, which transcends through his/her nursing education and entry into the workforce as a nurse where he/she begins building a professional career. The transformation continues as long as the nurse continues to grow, learn, and develop to his/her fullest potential. There is no time limit, deadline, or ending to becoming if one

keeps the spirit of exploration free within their sole and mind; above all, it does not self-limit his/her possibilities.

What Becoming Is

Becoming arises from the root word *become*, which is a verb, an action word, meaning “to start to be something” (Agnes, 2002, p. 128). It can be represented in past, present, or future tense. It is used to illustrate an act of or state of being, e.g., “she is starting to become agitated.” The term *becoming* is defined as “the fact of coming into existence” and is expressed in noun form (Agnes, 2002, p. 128). It is implied as “coming into” and the term “becoming” is interpreted as a process in the noun sense as a series of occurrences. The interpretation of this instance is a process or transition that occurs over time and space. In transitive verb form, *become* (2012) means “to change and start to be something different, or to start to have a different quality.” In the author’s mind and in terminology used in this study, it is similarly thought of or equated to a journey. This *journey* (2014) in the noun sense is defined as “a long and often difficult process of personal change and development” as in “the journey to success,” or “her journey toward Roman Catholicism.”

In terms of the philosophy of Aristotle, *becoming* (2014) is stated as “any change from the lower level of potentiality to the higher level of actuality.” Great philosophers have long contemplated *being* and *becoming*. The meaning and understanding of being and becoming has been deliberated for much of time. This study did not answer the long standing questions put forth by historical philosophers but it did address and answer the questions posed by the researcher that specifically focused on the sense of becoming a nurse. Asking questions and eliciting stories brought about rich data with which to

analyze and measure the present in our 21st century world of nursing and health care in the United States of America.

What Becoming Is Not

The sense of becoming is not meant in the adjective sense of the word, i.e., a person is more attractive or appealing to the eye as in “that dress is very becoming on you” (Agnes, 2002, p. 128). This expression is used in the describing sense. It is also not a linking verb form that implies a state of being, e.g., “In 1603 James became King of England” or “he became a nurse in 1995.” This indicates a past action or event.

The sense of becoming is not to be confused with the closely spelled term or a term used in conjunction with “being.” “Being” is defined as the state of existence, living, or life; or it can mean the mental and physical qualities that comprise a person as in a human being. Philosophically, it is known as “essential completeness or fulfillment of possibilities” (Agnes, 2002, p. 132).

How It Is Known

The sense of becoming is not a popular or frequently used phrase. It is easily and most recognized in Rosemarie Rizzo Parse’s (1992) nursing theory--human becoming. The name of the theory reflects the construct of her original man-living-health theory to show unity of the three entities. The theory focuses on humans being active and participative as they experience the world. An interesting note to Parse’s theory is the qualitative research methodology in which a researcher does not have an interview with a participant but should experience a unique way of “becoming with” the participant (p. 42).

In fact, the term *becoming* is most commonly associated with the verb or action sense of the word such as “Jill is attending college and becoming a nurse” or “After becoming a nurse, my first job was working in a hospital.” The use of the term *becoming* implies boundaries with space and time as evidenced with beginning and ending points.

The question or mystery at hand is what does “becoming” or the “sense of becoming” look like during this transition? How is it experienced or known for entry-level nurses transitioning to independent practice? What does the sense of becoming mean to nurses or nursing during this critical period? So many questions for such an abstract notion--*becoming*. Conceptually, having an understanding in some measure of how nurses perceive their transition from novice to advanced beginner nurse has been studied in several contexts but the sense of *becoming* related to this critical time frame has not.

Several related concepts such as professional identity, professional socialization, and new graduate transition have been extensively studied; they somewhat directly and indirectly parallel the sense of becoming in the nursing literature. Other disciplines such as education and social work have sought to unveil the mystery of what the “sense of becoming” means for educators and parents, respectively.

The challenge of the limited research and information in the nursing literature relating to the “sense of becoming” presents an excellent opportunity to explore, define, and analyze the concept. This opportunity further spurs interest and promotes inquiry into a little known notion. To fully appreciate the sense of becoming, research must be conducted that allowed explication, organization, and presentation of the phenomenon. To best explore this, the researcher has selected the grounded theory method (GTM) to

explore how the sense of becoming is experienced by new nurses and what influences it. Grounded theory methodology best discovers the "how" and "why" of social processes when little is known about them (Creswell, 2007; Willig, 2013). To best elicit the meaning of the sense of becoming, the author captured stories through one-on-one interviews with nurses in their first year to two years of practice. Nurses willing to share their story on their personal experience were interviewed following a semi-structured interview process. The data collected underwent a constant comparative method of analysis that drove the identification of essential themes and exhausted the layers of meanings surrounding the sense of becoming during the critical period of a new graduate's transition to profession practice. This understanding was gained by reaching saturation, thus promoting the development of theory and discovery of empirical knowledge (Corbin & Strauss, 2008). The transition a person undergoes and experiences in becoming a nurse is an evolving, moving process; therefore the GTM approach, being specific and applicable to address processes that change over time, was a superior fit as a research methodology (Corbin & Strauss, 2008).

Conceptually, bringing a "look," "face," or a "voice" to the sense of becoming in relation to the first years of a new nurse graduates career enabled the discovery of a model or theory of the nurse journey for that critical period in a nurse's career. Pragmatically, the knowledge learned and gained from this study could be used two-fold. Stakeholders are academia--including nursing education programs, nursing faculty, and nursing practice—and include nursing administration and leadership in employing agencies. Empirical knowledge learned from the research might be used to support and enhance nursing program outcomes, e.g., student awareness, student development,

program outcomes, and pedagogy for which complex professional development concepts are delivered in nursing education. Nursing administration and leadership might recognize the value it could contribute to entry into the workforce, issues such as new nurse expectations, mentoring models, nurse residency or intern programs, nursing student extern programs, patient safety and quality of care issues, and nurse recruitment and retention efforts. Additionally, the information might prove valuable for pioneering collaborative initiatives between employing agencies and schools of nursing.

Research Questions

The research was guided by two broad questions intended to address what the nature of the “sense of becoming” meant to nurses in their first year of practice:

- Q1 How do advanced beginner nurses experience the sense of becoming?
- Q2 What influences contribute to and how do they impact the sense of becoming for advanced beginner nurses?

Theoretical Overview

The theoretical framework for this research was principally based upon Patricia Benner’s (2001) Novice to Expert theory. The Novice to Expert framework was the main structure; it had an intricate focus on the novice to advanced beginner stages and a look at “reading between the lines” or examination of the gap or zone that lies between them.

Novice and advanced beginners take in little of the clinical situation because it is too new for them; they have to concentrate on remembering the rules they have been taught and are unable to process or practice perceptual awareness. If confronted with a clinical situation--in pediatrics where they are doing an assessment and another patient starts crying, they become torn between the two patients and the priority (complete the task they were doing or tend to the one crying). Novices have no prior experience upon

which to recall. The environment and situations are new to them. Advanced beginners have limited experience from which to recall and draw upon to associate as aspects of the situation. This would include setting priorities and determining order of importance. The theory states nursing students are beginners; they do not have prior experience, are new to clinical arenas, and perform in the novice stage. As student nurses gain experience through exposure and time in clinical situations, as well as experience interacting with various populations, conditions, and the opportunity to practice psychomotor skills, they progress to the advanced beginner stage (Benner, 2001).

The exact time when one reaches the advanced beginner stage is not defined. As stated by Benner (2001), nursing students enter new clinical areas as novices; the advanced beginner stage is characterized by those who demonstrate marginally acceptable performance and have coped with enough real situations to identify the “aspects of the situation” otherwise known as the reoccurring meaningful components of a situation (p. 22). The advanced beginner stage is commonly associated to the period of time after a nursing student has graduated in their program; they may also be referred to as a “new nurse” (Benner, 2001, p. 25). What is known about this stage is the advanced beginner has progressed to a marginally acceptable level of performance. The person is still learning but is able to recognize characteristics and aspects of unique patient situations. They also need support in the clinical setting: support with setting priorities and organization, confirming skill and performance, discerning differences in findings, and judging relevance and importance of presenting situations (Benner, 2001). The literature states nurses are expected to function independently at this level with mentoring by an experienced nurse (Valdez, 2008). From Benner’s theory and the literature,

graduate nurses or independent practicing nurses characterize the advanced beginner level.

There are three major characteristics within the theory: (a) safe practice/perceptual awareness, (b) discretionary judgment/relevance, and (c) knowledge/connoisseurship. As progress through the stages from novice to expert nurse is developed, changes in performance occur; thus, there is improvement in the nurse's ability to communicate, organize, and deal efficiently with interruptions, anticipate needs, and integrate varied roles in their work. They demonstrate growth from reliance on abstract principles to the use of concrete examples from the past. The nurse also moves from recognizing bits of a situation to viewing it as a whole. The theory also predicts the higher the competencies and experiences of the nurse, the more quickly they can identify problems based on subtle cues (Benner, 2001). As the nurse becomes more proficient in these areas, it is assumed he/she will progress through the model.

Structural clarity of the Novice to Expert model is clear for each defined stage but movement and progression through a stage is ambiguous. The process of advancement through the advanced beginner stage is not clear and thus the impetus for this research--to determine what the transition or sense of becoming means. It is the researcher's belief that this movement or transition through the advanced beginner stage is in essence the "sense of becoming." What is not known is *how* the sense of becoming is experienced by those nurses experiencing it in situ. The aim of this research was to discover how this phenomenon was experienced and what influences and impacts it had on new nurses.

To best bring context to this, the researcher believed the Bronfenbrenner (1979) human ecological theory might help differentiate the gap. The theory's premise of

mutual interaction and influence between a developing person and their environment and vice versa speaks clearly to the lens or stance from which to consider the emersion of meaning. Since there are multiple layers to human ecological theory, it is unclear just which environmental factors (internal and external) might influence new nurses during this transition and how (Bronfenbrenner, 1979).

Significance

There is a large body of literature related to the transition of the nursing student to professional nurse. This process has been researched and is abundantly represented in empirical nursing knowledge. In addition to Benner's (2001) Novice to Expert theory, there is the theory of transition by Duchscher (2008), which looks specifically at the new nursing graduate's professional role transition in the stages of doing, being, and knowing along a one-year time continuum. The theory is relative to the nurse's personal and professional transition to professional acute care practice, noting specific ordered processes referring to a process of becoming. The stages within Duchscher's model correspond to a timeline in relation to the number of months a nurse has been in practice (Duchscher, 2008). It is specifically noted that the process of becoming is the progression through the stages of the role transition.

There is scarce and fragmented evidence on the "sense of becoming" in relation to nursing students, newly graduated nurses, nurses in practice, or the processes surrounding nursing such as nursing education or professional development spanning the entire advanced beginner stage of Benner's model. To better understand this concept, research is needed to discover and reveal *how* the sense of becoming was experienced and what it looked like throughout the nurse's journey. This represented an opportunity to learn what

new baccalaureate nurses experienced during that sensitive or critical period and apply it to the transition by way of Benner's (1984) advanced beginner stage through the human ecology perspective. Thus, we can better understand how nurses come to know who they are, how they fit, and where they are in nursing during this time so the information may be used to help identify strengths and limitations in the nursing education to nursing practice transition. Information gained from this knowledge might help better construct nursing education clinical experiences, student nurse externships, new nurse orientations, nurse residency or internship program; ultimately impacting the U.S. national nurse retention rate, improving patient safety, and promoting quality of nursing care.

Assumptions

The following were the author's assumptions:

1. Each individual nurse has his/her own story that is based upon unique and individual life experiences within his/her journey. It is believed these experiences begin early in life and continue through the life span.
2. Nurse stories contain valuable information discoverable through personal one-on-one interviews.
3. All stages of the nurse experience or journey are valuable and represent themes that contribute to how the sense of becoming is experienced.
4. The "sense of becoming" can be constructed into a representative model that has its own identity/character/face/look.
5. Nurse participant's will honestly, openly, and accurately discuss their story.

Chapter Summary

There is a gap between new nurse expectations and acute care employer expectations of new nurses. It is the time a nurse is contemplating “who I am versus who do they want me to be.” This research centered on capturing new nurses’ sense of becoming as they transitioned from Benner’s (1984) novice to advanced beginner stages through the lens of the human ecological theory of Urie Bronfenbrenner (1979). How the new nurses’ stories translated to how the sense of becoming was discovered through qualitative inquiry using the grounded theory method and the constant comparative method of analysis. In examining the influences that contributed to the new nurse’s sense of becoming and how he/she was impacted by it, grounded theory methodology identified emergent, conceptual, and relevant categories from the participants’ stories. These categories evolved into a substantive-level theory that addressed how the sense of becoming was experienced and what influenced it (Polit & Beck, 2012). It was uncertain what would emerge from the research. The researcher hoped the research would inform what the gap was, how it was described, how it could be narrowed or closed, and what impeded closing the gap.

CHAPTER II

LITERATURE REVIEW

Witness the American ideal: the Self-Made Man. But there is no such person. If we can stand on our own two feet, it is because others have raised us up. If, as adults, we can lay claim to competence and compassion, it only means that other human beings have been willing and enabled to commit their competence and compassion to us--through infancy, childhood, and adolescence, right up to this very moment. (Bronfenbrenner, 1979)

Introduction: Understanding Becoming

The nurse journey begins when a person decides to become a nurse and initiates the transformation from layperson through nursing school and to the pinnacle of graduation. The journey continues as the graduate nurse successfully completes the National Council Licensure Examination for Registered Nurses (NCLEX-RN), earns the status of RN, and enters the workforce as an entry level or newly graduated professional registered nurse. As much of an accomplishment as it sounds, earning one's RN licensure is not the final destination; it is just the beginning of the journey to the nurse's state of becoming. At this point, the sense of becoming does not cease or slow--quite the contrary. When the nurse earns his/her RN licensure, his/her career is just accelerating and a whole nursing practice path lies ahead of the nurse from which to experience and become. It is at this time that the nurse has left the safety and comfort of academia where he/she has been nurtured by nursing faculty, peers, study groups, and nurse mentors for clinical assignments and practiced under the safety net of simulation laboratories, high

fidelity human patient simulators, role-playing, and clinical nurse faculty. Now he/she is abruptly sent out into the real world of nursing practice with only the skills, knowledge, and attributes he/she has developed, acquired, and learned in the past three years in a baccalaureate nursing program (Drury, Francis, & Chapman, 2008). This time marks the beginning of a critical period for the novice nurse and commonly known as “reality shock” (Kramer, 1974). Reality shock describes feelings of powerlessness and ineffectiveness in a new nursing role. Within the first four months of the “reality shock” is the “transition shock” period, which is defined by Duchscher (2009) as the immediate stage in the professional role adaptation process for new graduates. It is the most intense, dramatic, and acute stage in adaptation and transition for the new nurse. The transition shock phase is characterized by new nurse doubt, confusion, bewilderment, feeling inadequate, overwhelmed and unsupported, and perception of loss due to disillusionment of the nurse role and not being sufficiently prepared. Thus, the new nurse’s expectations of becoming a nurse do not match the experiences of being a nurse (Thrysoe et al., 2011; Valdez, 2008).

To add more complexity and stress to this transition into the real world of nursing practice, hospital nursing administrators (chief nursing offices [CNO], nurse managers, nurse educators, and clinical nurse leaders) are looking for nurse graduates who demonstrate the following five most desired qualities: (a) safe patient care practice, (b) confidence, (c) accountability, (d) motivation, and (e) a strong sense of teamwork (Buteyn, 2010). They must also be ready to practice at the advanced beginner level of Benner’s (1984) model. The reality of employment in nursing in the acute care environments is intense--patient acuity levels are higher, patient populations are

increasingly complex, and the workload for the nurse has increased (Duchscher, 2008; Valdez, 2008).

Another concern is whether a new graduate nurse possesses skills, attributes, and knowledge; he/she must appear to be meeting the employer criteria and expectations but are they fully prepared for “real life” practice? The literature reports a significant gap between theory and practice and that nurse managers may have unrealistic expectations of new graduate nurses (Greene, 2010; Whitehead & Holmes, 2011). This discrepancy between acute care employment expectations and new nurse ability has two-fold repercussions. The first is the difference in expectations between employer and nurse, a primary source of stress and role ambiguity for new nurses working in the acute care environment (Duchscher, 2009; Morrow, 2009). The nursing literature indicates common stressors for new nurses are lack of confidence, uncertainty, unrealistic expectations, self-doubt, conflicts with values and role, fear, and lack of support (Duchscher, 2008; Jewell, 2013; Kelly, 1996; Morrow, 2009). Secondary factors are heavy workloads, inferior working conditions, inadequate staffing and skill mix, and horizontal violence such as bullying and victimization (Phillips et al., 2013; Suresh et al., 2012). Not only does a gap in expectations create emotional turmoil and stress for the new nurse, it leads to the attrition of new nurses transferring to other positions within one to two years or leaving the profession at alarming rates within the first five years of practice. This impacts the national nursing shortage the United States and the world is experiencing and it is expected to worsen by the year 2020 (Bowles & Candela, 2005; Greene, 2010).

The second concern is equally important--new nurses' actual skill levels and response levels are at a novice stage compared to employers' expected level of advanced beginner. New graduates are expected to "hit the ground running" by employers. In reality, new nurses are lacking in clinical practice areas of assessment skills, psychomotor skills, communication skills, critical thinking, time management, and teamwork. In recent years, this expectation has widened the theory/practice divide that has existed in nursing, explored the transition shock experience of new graduates, and fostered fear of unsafe nursing practice and fear of making medical errors, resulting in the crippling of confidence and self-image. Trends of decreasing clinical placement sites, limited clinical practice, insufficient exposure to clinical situations, expansion of nursing program capacity, increased student enrollments, and limited nursing student clinical experiences have contributed to this widening gap as well as emphasized concerns for patient safety and quality of care (Bhanji, 2013; Harwood, 2011; Hoffart et al., 2011; Morrow, 2009; Valdez, 2008). Employers, assuming that a new nurse is at the advanced beginner level when in fact he/she may not be, put unwarranted risk on patients and allow potential exposure for accidental harm. The Joint Commission (TJC; 2014) commented that 55% of serious adverse events and errors in the clinical setting could be attributed to inadequate orientation and training of nurses. The transition period for a newly graduated nurse to the stage of competent nurse is a rite of passage; it is a time that can influence a nurse's entire career. It should be a time for gaining nurse experience and competence to becoming a safe, independent practitioner (Jewell, 2013; Wagensteen, Johansson, & Nordstrom, 2008).

The new nurse transition period is anywhere from one to two years in length post-graduation and includes being employed; it does not include any time spent looking for employment (Hoffart et al., 2011). Meanwhile, only several months to a year of the one to two year transition period are dedicated to new nurse orientation; this is dependent upon the structure of the new nurse's orientation model. According to recent literature, 35-60% of nurses in North America will change their place of employment within their first year of work (Jewell, 2013). This equates to a large amount of orientation time, human resource allocation, and financial resources spent on a new nurse with only a small, if any, return investment for the services. In the United States, \$10,000 to \$67,000 is spent per nurse in turnover costs such as new nurse's orientation time, preceptor's time, coverage and back fill time, and unit educator time (Greene, 2010).

The profession of nursing is experiencing an interesting shift within itself and within its place in society. Many professional issues impact the profession; yet, there are many more issues within the profession. At the forefront of professional issues in healthcare is patient safety including human medical errors, ensuring high quality nursing care, and the national nursing shortage. Within the nursing profession, there are issues that are more specific, yet overlap and contribute to the larger picture of the national healthcare issues previously mentioned. According to the American Nurses Association (2006), the specific nursing issues center on safe staffing with concern over nurse-to-patient ratios, patient acuity, decreasing patient complications and mortality, nurse workload, nurse fatigue and burnout, job satisfaction, and nurse retention. The issues of nurse role satisfaction and self-confidence are discussed in more detail following the

major healthcare concerns as they specifically relate to the nurse role and are significant in establishing a solid information background on the issues at hand.

Novice to Expert Theory

The Novice to Expert theory was the framework and foundation for this study. The theory was introduced and published in 1982 by Patricia Benner (1984). The theory was based on the Dreyfus and Dreyfus (1980) model of skill acquisition as applied to nursing. There are five stages of competency in clinical nursing practice: (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert. This model can assist in conceptualizing the progression of a nurse's career beginning with their nursing education. Benner's model is an upward advancement through all five stages for the advancement of clinical practice. Benner's work provided a framework that supported lifelong learning and progression of proficiency with skills and abilities. A key factor in the model is experience. It does not mean time or longevity but is the refinement of preconceived notions and theory through encounters with actual practical situations (Benner, 1984, 2001).

Benner's (1984) Novice to Expert theory is the recognition of past experiences and how they affect current practice in terms of (a) perceptual awareness, (b) discretionary judgment, and (c) connoisseurship--key terms within Benner's model and applicable to each stage. Perceptual awareness equals safe practice. This is interpreted to mean hunches or intuition, i.e., perceptions that lead to evidence. Discretionary judgment and relevance are resounding to clinical reasoning, critical thinking, or nursing judgments. Connoisseurship is also known as knowledge and is equal to competence (Benner, 2001).

Novice

The novice stage represents the beginner with no experience. This group is a direct representation of nursing students in their first year of clinical education. The term used for this group is “generalist”--they are taught general rules to help them perform tasks. They are free of context and application is universal. They follow rules that limit their behavior and they do not have flexibility with the rules--they need to be told what to do and will do it (Benner, 1984, 2001).

Persons in the novice stage lack confidence and require verbal and physical cueing to perceptual awareness and safe practice. They do not possess discretionary judgment or relevance at this level-- it is not yet established but will come at a later stage. Connoisseurship or knowledge is based on learning the rules, learning what is important and relevant, and what expectations apply to the rule (Benner, 1984, 2001).

This stage is not limited to nursing students; it may also represent any nurse entering a clinical setting where she or he has no experience with that patient population. It could exemplify a competent nurse who changes his/her clinical nursing position from one specific area to another or among populations. An example would be a nurse who has worked for several years on an adult general medical unit and transfers to an adult intensive care unit (ICU). It could also be a pediatric nurse with many years of specialty experience in a large teaching hospital who moves to a general emergency department (ED) in a critical access rural hospital or vice versa. It is basically any one without prior experience or knowledge for the new setting or location. Practice in a prolonged time period is necessary for this stage and advancement to the next for inexperienced nurses (Benner, 1984, 2001).

Advanced Beginner

The advanced beginner nurse demonstrates a marginally acceptable clinical performance. It is a level above the beginner stage after nurses have gained some prior experience (in nursing school from actual situations in clinical) and their knowledge is developing. They have coped with enough real situations to note or have pointed out them by a mentor the recurring meaningful situation. Nurses in this stage are able to recognize patterns and meaningful events. The term most identifiable to this group is “aspects”--overall characteristics are present and rely on prior experiences to recognize them. In this stage, nurses need help articulating knowledge and help setting priorities. Feedback is also important for them as they are accustomed to frequent feedback in school. They begin to formulate principles that guide their actions; these are based on their experiences. This stage does not have a prescribed time frame; it is dependent upon the nurse’s proficiency and skills within this stage (Benner, 1984, 2001).

In the advanced beginner stage, nurses are efficient and skillful with parts of practice; perceptual awareness and safe practice are gained through practice, repetition of skill, feedback, remediation, and cueing decreases. Discretionary judgments and relevance are beginning to take form but the nurse has difficulty identifying important aspects and treats all attributes as equally important. Connoisseurship is evident through development. Nurses are still being told about the rules and reading about them. Practicing prioritization with oversight is performed with associated feedback (Benner, 1984, 2001).

Competent

In the competent stage, a nurse has two to three years of experience on the job in the same unit or area. There is consistency in the routine, population, diagnosis, and care. This is the stage where nurses are more aware of long-term goals. They gain perspectives from conscious planning, analytical thinking, and abstract thinking. Here they can achieve greater efficient and organization in their practice (Benner, 1984, 2001).

In the competent stage, perceptual awareness is recognized as the nurse is beginning to see his/her own actions as long-term goals or part of the overall plan--it is conscious planning. He/she has a more direct, purposeful practice that still requires feedback and debriefing but on a lesser scale. There is a decrease in the cueing necessary and only first and second level cues are necessary. Discretionary judgment and relevance emerge as the nurse feels the ability to cope and manage unforeseen events. Connoisseurship is exemplified by a beginning ability to distinguish between relevant and non-relevant attributes. Analytical and abstract thinking are pronounced in this stage (Benner, 1984, 2001).

Proficient

The proficient stage is where nurses perceive and understand the whole parts of a situation. In their perceptual awareness, they can appreciate the whole picture rather than pieces to a puzzle. Relevance and discretionary judgment are noted to be when the nurse can recognize that the expected normal picture is absent or what is missing. There is a holistic appreciation and understanding that contributes to improved decision-making processes. They are able to take prior experiences and anticipate and apply certain behaviors or events to the current situation. They can also modify plans based on

previous experiences; this demonstrates a higher level of connoisseurship (Benner, 1984, 2001).

Expert Stage

For the expert stage, the nurse no longer relies on principles, rules, or guidelines. At this stage, the nurse has much more background experience plus has an intuitive grasp of clinical situations. The hallmark of the level of expertise at this stage is the ability to see the unexpected; background tacit awareness is now at the foreground of thought and action. He/she connects situations and actions through a performance that is fluid, highly proficient, and flexible. The expert has a difficult time explaining what he/she knows and how he/she knows it because it has become internalized to him/her. His/her perceptual awareness entails engaged practical reasoning. His/her knowing is intuitive and he/she is astutely attuned to the situation at hand. Discretionary judgment is exemplary through extraordinary management of clinical problems. Connoisseurship is noted when he/she is considered an expert by others (Benner, 1984, 2001).

It is important to note that time or longevity does not equal experience according to the model. The premise is that refinement of preconceived notions and encountering practical situations is what makes the difference in this theory. Reflexive thinking has been identified as the most important element of clinical nursing expertise (Benner, 1984, 2001; McHugh & Lake, 2010).

Formation

In the writing of Benner, Sutphen, Leonard, and Day (2010), the term *formation* is stated to best articulate the transition of a nurse. Formation is meant to be the way in which a person is prepared for a role or task; it is achieved through a formal curriculum.

In sum, formation is the end result of a student's experiences--what they have done, perceived, and interpreted (Benner et al., 2010).

The term formation is an emerging term used in the nursing literature and information through the work of Benner et al. (2010) and the Institute of Medicine (IOM). Benner et al. (2010) relates the term *formation* as the process of becoming a nurse; it is "being constituted by the meaning, content, intents, and practice of nursing" which is described as more than just being socialized or learning the nurse role (pp. 86-87). It is expressed as a shift from being a layperson to becoming a professional.

According to research by Benner and colleagues (2010), nursing students' sense of identity undergoes a profound change as they are transformed by their increasing self-knowledge, understanding, and reassurance of their decision to enter the nursing profession. Formation is a strength in nursing education in the United States and occurs in the realm of formal nursing education. It is the product of the nursing students' experiences during their time program; it consists of curricula, pedagogies, assessments, and all aspects of the program including clinical and non-clinical experiences, formal and informal teaching, gaps and discrepancies between theory and practice, communication and collaboration with other healthcare professionals, student reflection, and planned and hidden curriculum agendas (Benner et al., 2010).

The IOM (2010) used the term formation in a limited context. *Professional formation* was the term of choice used to refer to the educational process of training nurses and the need to expand competency development to include quality improvement, systems thinking, decision making, and team leadership (IOM, 2010).

Benner's (1984) Novice to Expert theory is an exceptional model relevant to clinical career ladders within nursing practice. Clinicians can use the theory as a guide for knowledge development in the clinical sector that relates to proficiency of skill and can be correlated to improvement of patient quality of care (Benner, 1984). Movement is not well defined within the model. The stages are clearly outlined and defined; however, transition or navigation between or among the stages is not entirely clear, thus the purpose of this study. This researcher felt the gap or space between the lines or the movement from one stage to another needed further investigation to determine meaning and how it was known. Learning what the meaning is, how it is understood by those immersed in the experience, and listening to how nurses are experiencing this journey bring light to the sense of becoming. This is more so for the critical time period of the new graduate nurse's first year of practice and the time in a nurse's career when he/she is most vulnerable and needs support--Benner's novice stage to the advanced beginner stage. It is the period that represents a gap between the new nurse's expectation for the nurse role and the expectations that acute care employers have for new nurses. This researcher believed this multidimensional experience of the developing nurse could be equated with Bronfenbrenner's (1979) human ecological theory. With the developing nurse interacting with his/her environment and the environment impacting him/her, multiple dimensions and influences can impact him/her during this sensitive time.

The transition process is just one aspect or segment of the nurse's journey; nonetheless, a greater understanding of this critical time might influence a nurse's decision to remain in nursing or change his/her career path. Understanding how this was

experienced and what influenced it will contribute to better appreciating Benner's (1984) framework and possibly support and extend her theory.

Human Ecological Theory

Human ecological theory (Bronfenbrenner, 1979) is based on the underpinnings that human development is progressive and active. It is also the changing of properties between the developing person and his/her immediate settings as well as extended settings in which he/she is embedded and interacts. For purposes of this research, the developing person reference was reserved for the new nurse.

There are five environmental components to the model: (a) microsystem, (b) mesosystem, (c) exosystem, (d) macrosystem, and (e) chronosystem. The developing individual is within the microsystem as well as his/her attitude and behaviors. The other systems are layered and feature external activity that interacts with a developing individual (Bronfenbrenner, 1979). Environmental components can be any supports, challenges, or neutral entities that have or are touching nurses in this period in their career.

Microsystem

A microsystem refers to the activities, relationships, and roles experienced by the individual person in a given setting. This *is* the new nurse; it is his/her personal and professional identity, nursing practice, health, emotions, values, beliefs, experiences, communication, nursing skills, clinical reasoning, flexibility, adaptation, commitment, stress, support, and meaning (sense of becoming; Bronfenbrenner, 1979, p. 22).

Mesosystem

A mesosystem is a new setting for the individual outside the traditional environment. It is the interrelationship among two or more settings in which the developing person actively participates. For a nurse, this would be his/her employer and unit where he/she works, involvement with coworkers, patients, significant other, family, friends, school, and social life (Bronfenbrenner, 1979, p. 25).

Exosystem

An exosystem is an outside setting in which the developing individual does not have to be involved, yet is an active participant. The person is affected by what happens in this setting, however. This would include the community where the nurse lives or practices, social media, and the local medical community (Bronfenbrenner, 1979, p. 25).

Macrosystem

The macrosystem refers to “consistencies in the form and content of lower-order systems (micro-, meso-, and exo-) that exist or could exist at the level of the subculture or the culture as a whole along with any belief systems or ideology underlying such consistencies” (Bronfenbrenner, 1979, p. 26). To the nurse, this would be professional nursing organizations, the NCLEX-RN examination, the U.S. economy, U.S. government, and cultural beliefs.

Chronosystem

The chronosystem is the passage of time. This alludes to age, developmental states, and historical time (Bronfenbrenner, 1989).

Ecological Transition

Ecological transitions are a consequence and an instigator of the human developmental processes. These transitions occur throughout the human life span and include every transition that involves biological changes and environmental circumstances, i.e., accommodation between the human and its surroundings (Bronfenbrenner, 1979).

Overall, the human ecological theory is a complementary framework for exploring the experiences of new nurse graduates. The theories are reciprocal tenants of the developing person being interactive with their environment. The environment impacting the person provides an appropriate medium for examining the new nurse transition in his/her environment and the environment upon the new nurse.

State of Healthcare Literature

In examining the one-year period of time from when a nurse graduates from a baccalaureate program through to the beginning of independent practice, it is a time period filled with many factors and variables. Primary concerns for the state of healthcare literature are patient safety, quality of care, and retention; sub-categories are competence, clinical reasoning, and nursing turnover. Professional identity, socialization, and nurse satisfaction are found in to the transitional literature. The only sub-category is stress. Each of these areas must be looked at in a more in-depth manner to appreciate the components that may influence the sense of becoming for a new nurse. The issues of safety, quality, and retention are considered external environmental factors; while identity, socialization, and satisfaction are internalized attributes.

Patient Safety

Patient safety has always been a present concept within health care training but it strongly emerged with the Institute of Medicine's (IOM; Kohn, Corrigan, Molla, & Donaldson, 1999) *To Err is Human: Building a Safer Health System* report that estimated 44,000 to 98,000 people die each year in U.S. hospitals as a result of patient safety issues that are preventable. Since patient safety culture was exposed, many forces have been mobilized to improve these statistics.

The Agency for Healthcare Research and Quality (AHRQ; 2004) noted patient safety is one of the U.S.'s healthcare challenges based on the 1999 report by the Institute of Medicine that estimated 44,000 to 98,000 people die each year in U.S. hospitals as a result of patient safety issues. Since then, the AHRQ has been a leader in the task force to put patient safety research to the forefront. It received \$50 million dollars to fund patient safety research and improvement activities--an area of intent focused on educating the public to become more involved in their care. They also have implemented education and training programs for healthcare providers. Additionally, the AHRQ maintains Comprehensive Unit-based Safety Programs (CUSP) to prevent healthcare-associated infections (HAI) that include catheter-associated urinary tract infections (CAUTI) and central line associated blood stream infections (CLABSI).

Patient safety practices are defined by the IOM as "those that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions" (Mitchell, 2008, pp. 1-2). Patient safety issue classifications include the type of error, communication, patient management, and clinical performance. Types of harm and errors are further broken down into domain classifications and are noted to be the

root causes of harm: latent failure (relating to organization policy, procedure, and resources--does not involve the practitioner), active failure (direct patient contact), organizational system failure (indirect failures relating to management, processes, organization culture, and external factors), and technical failure (external resources and indirect failure of healthcare facility). Despite the types and classifications of errors, nursing is known and noted to be a key component to improving healthcare quality through safe patient care. Quality of care dates back to Florence Nightingale's work in 1859 and the world's first performance measures of hospitals (Mitchell, 2008).

Patient safety, as identified by the World Health Organization (WHO, n.d.), means harm to a patient caused by healthcare errors and system failures that result in injury, increased length of stay in the hospital, or even death. Adverse events are not intentional but are results of the healthcare system being so complex. All healthcare providers are included: nurses, doctors, pharmacists, dietitians, social workers, and others (WHO, n.d.). The WHO (2014) recently published the *Leaders Guide on Patient Safety on Quality of Care in Service Delivery*. Patient safety is a serious issue related to global public health. The latest estimation is that

as many as one in 10 patients is harmed while receiving hospital care" in developed countries and this ranges from errors to adverse events. 1.4 million people worldwide suffer from healthcare acquired infections and it is leading to antimicrobial resistance. Economically it is estimated that hospitalization, HAI, litigation costs, lost income, disability, and medical expenses cost some countries 6 billion to 29 billion a year (US dollars). (WHO, 2014)

The Joint Commission (2014) has been a champion of patient safety for more than 60 years. They are designed to help healthcare organizations improve the safety and quality of care they provide. National safety goals for 2014 stem from nine key programs: ambulatory healthcare, behavior healthcare, critical access hospital, home care,

hospital, laboratory services, nursing care center, long-term care, and office-based surgery. In specifically looking at the hospital sector, the National Patient Safety Goals (NPSG) are correct identification of patients, improved staff communication, alarm safety, medication safety, infection prevention, prevent surgery mistakes, and identification of patient safety risks (www.jointcommission.org).

The IOM (2010) has called for an increase in the number of baccalaureate-prepared nurses from 50% to 80% by the year 2020. Rationale for this is call was in response to evidence that indicates a baccalaureate education makes a positive difference in patient outcomes including lower mortality rates and lower failure-to-rescue rates (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Baccalaureate prepared nurses have been determined to be more proficient in their abilities to make a nursing diagnosis, evaluate nursing interventions, and demonstrate professional integration (IOM, 2010).

As demonstrated, multiple large-scale and governmental agencies are champions for patient safety. Medical errors are not intentional but are preventable. Key factors that attribute to this awareness and make an impact ensure a high standard level of patient care across all sectors of healthcare include primary, acute, and long-term care. Every healthcare worker's moral duty is to ensure he/she is performing at a safe and competent level of practice.

Quality of Care

Quality care is defined by the IOM: "quality care is safe, effective, patient centered, timely, efficient, and equitable. Thus safety is the foundation upon which all other aspects of quality care are built" (Mitchell, 2008, p. 1). The IOM (2001) report *Crossing the Quality Chasm* drew attention to the inconsistencies of care provided to

Americans and brought awareness to the importance of outcomes. It outlined improvements for healthcare to be safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Providing high-quality, equitable care is the responsibility of all healthcare providers.

The AHRQ (2004) noted hospital nurse staffing has a direct effect on quality of care and patient safety. When quality of care is compromised, patient outcomes are negatively affected. This includes adverse outcomes such as patient length of stay, failure to rescue, 30-day mortality, pneumonia, shock, gastrointestinal bleeding, and urinary tract infections (UTI). Other conditions that can be attributed to low nurse staffing levels are patient falls, pressure ulcers, thrombosis, and pulmonary compromise. Furthermore, the AHRQ has researched stress, sleep deprivation, fatigue, staffing, shift work, and organizational culture in relation to patient outcomes (AHRQ, 2004).

The American Nurses Association (ANA; 2006) established the National Center for Nursing Quality (NCNQ) in 1998; the purpose of the NCNQ is known as an advocate for nursing quality care as it conducts quality research, measurement, and collaborative activity and learning. It is a driving force between nurse staffing and patient care outcomes (ANA, 2006). A nationally recognized initiative through the NCNQ is the National Database for Nursing Quality Indicators (NDNQI), which is a nursing quality measurement program that allows nurses to review and compare measures of their hospital against the norms of other regional, state, and national hospitals of comparable type, size, and unit level (ANA, 2014).

Within the realm of patient safety and quality of care are key points that specifically relate to nurses and are vitally important qualities for new nurses:

competence and clinical reasoning skills. New graduates should possess a strong foundation of these concepts, yet still be culminating and refining them toward proficiency, competence, and expertise related to practice.

Competence

The concept of competence gained significant attention from educators and healthcare employers in 2011 after the Institute of Medicine (IOM) called for educational strategies to include a focus on competence after identification of the gap between education and practice was brought to light. The IOM called for the development of “core competencies for health professionals to work in interdisciplinary teams, provide patient-centered care, employ evidence-based practice, use informatics, and apply quality improvement measures” (Tilley, 2008, p. 58). Essentially it was

acknowledged as an essential factor for ensuring qualified and cost-effective healthcare; an essential aspect of nursing practice that affects clients, families, and even other nurses; a basic element of ethical and responsible practice; and a realistic concern of public and professional nurses. (Tabari-Khomeiran, Kiger, Parsa-Yekta, & Ahmadi, 2007, p. 211)

It was summarized that prevailing perceptions of competence are defined as

a) composed of knowledge, skills, and a series of components related to personal abilities and attributes; b) allows the professional to select or combine components in order to maintain standards of performance; and c) constitutes a guarantee for the community of society that the processor will be able to perform to acceptable standards. (Fernandez et al., 2012, p. 361)

Competence as it relates to new nurses in entry-level nursing positions is prevalent in the literature; yet it indicates a gap in role-related skills, knowledge, and clinical judgment (Rush et al., 2013).

Clinical Reasoning

Tanner (2006) defined clinical reasoning “as the process by which nurses make clinical judgments by selecting from alternatives, weighing evidence, using intuition and by pattern recognition” (p. 204). The theoretical definition for clinical reasoning that best applies to the author’s research closely resembles Tanner’s (2006) definition with some slight variation: Clinical reasoning is a cognitive process in which the clinician (student nurse) works through to formulate a judgment or opinion. It is a cyclical process of gathering of clues and information, both objective and subjective data, that the clinician uses to understand what the problem is and then considers options and alternatives when planning care and implementing interventions so outcomes can be evaluated. This process can be done in practice, the real world setting, or hypothetically, e.g., a classroom working on a case study or practiced in a simulation lab. Clinical reasoning is not exclusively intuition or decision-making. It is the thought process that occurs prior to a clinician making an actual decision. Clinical reasoning must be learned over time; it is not inherently known or recognized.

The concept of clinical reasoning has an established history with healthcare education and practice. It is an integral aspect of nursing student development and progression through his/her nursing education journey. Clinical reasoning is relevant to the nursing profession-- it begins in nursing school and is forever a part of a nurse’s career. How nurses employ their clinical reasoning skills correlates to their educational level, degree of nursing experience, and past clinical experiences. These elements are attributed to practicing and refining assessment skills, effective and therapeutic communication skills, recognition of errors, problem-solving abilities, planning ability,

and individualized care for each patient (Tanner, 2006). Clinical reasoning or nursing judgments are not felt to be a strong suit for new nurses. Clinical reasoning continues to develop over time and is evident and strengthened during the transition process (Rush et al., 2013).

Overall, in light of patient safety and quality nursing care, new nurses do not feel adequately prepared for their new role and responsibilities. That lack of experiential learning in the clinical setting is echoed among new nurses. New nurses do not know what they do not know or have not yet been taught or have experienced. Once aware of what they need to know, they will seek help and assistance from seasoned, experienced nurses. Awareness of one's limitations is powerful knowledge in understanding what one needs for development and support (Gerrish, 2000).

Current State of the Nursing Profession

Dr. Peter Buerhaus and colleagues announced that despite the current nursing shortage ease from the recession, the U.S. nursing shortage is still projected to grow to 260,000 RNs by the year 2025. This predication is supported with the most recent statistics found in the following. According to the U.S. Department of Labor, Bureau of Labor Statistics (2014), there are currently 2,633,980 licensed registered nurses employed in the United States of America. It is anticipated that the United States will need 3.45 million RNs in 2020, a 26% increase in growth over the next six years. The profession will have 1.2 million job openings for nurses by 2020 due to growth and replacements. In 2009, the National Council of State Boards of Nursing (NCSBN) reported the number of nurse graduates who passed the NCLEX-RN was 147,812. Not nearly enough new graduates are passing the NCLEX-RN to meet the demands. Incorporated into the

projections are the latest data from the National Sample Survey of Registered Nurses (NSSRN; NCSBN, 2009), indicating that almost 73,000 RNs leave the profession annually due to child rearing, returning to school, retirement, career change, other reasons, or death.

Recruitment

With new nurse graduates, recruitment is viewed in multiple ways. Depending on the nurse's geographical location, new nurse positions may be plentiful or scarce and competitive. A central concern to recruitment is the new nurse's transition to practice. This concern considers the increased patient acuity and complexity of care, technological advancements, the theory-practice gap phenomenon that exists for new graduate nurses, and new graduate reality shock (Rush et al., 2013).

There are many instances where new graduates or entry-level nurses need not apply. Hiring hospitals and units refuse to consider new talent and will leave a RN position vacant in hopes of finding a seasoned, experienced nurse. In many instances, full-time and part-time positions are not available and new graduates only have the option of being hired by an acute care hospital on an occasional, per diem, or temporary status, allowing agency and nursing units to "trial" the nurse to see if he/she is a good match for the institution. It also allows the institution to decide if it wants to extend the nurse's contract or separate the relationship if it is less than optimal or expected.

Retention

Nurse retention and nurse vacancy is a blurred issue when examining the statistics for U.S. nurses. The literature is well-documented with statistics regarding Canadian nurses. Publications relating to U.S. nurses leaving their position or the profession are

not recent and do not have substantial samples to validate their findings. In the latest reports regarding Canadian nurses in 1990, 20% of nursing graduate left the profession within five years (Spurgeon, 2000).

In examining practice patterns of U.S. nurses, Bowles and Candela (2005) indicated 30% of their sample of new nurses left their first job within the first year and 57% left by year two. Their results were higher than the national turnover average of 21.3% in 2000. It must also be noted that they had a low response rate of 12% for their sample and they could not determine if this was representative of the larger population. In 2010, almost one-third of surveyed U.S. employed RNs indicated they would be leaving their current nursing position within a year; furthermore, nearly 50% indicated they would be leaving their current position within one to three years (Advance Healthcare Network, 2010). Vacating their position was intent to leaving the nursing profession, reduce their direct patient care contact, or move to a less demanding nursing role.

Duchscher (2008, 2009) noted the professional practice of nursing in North America is facing challenging times for new nurses; less than 50% would recommend nursing as a profession to others and 25% would discourage others from the profession. Specific attention was paid to the 33-61% of qualified new nurses who left their place of employment or the nursing profession within the first year.

These studies and reports indicate that a large percentage of qualified, trained, and able nurses intend to leave the profession or have left the profession within a one to five-year time period; this applies to Canadian and U.S. nurses. Despite not having concrete numbers on the attrition rate for nursing in the United States, the generalizability for

these studies indicate and support speculation of a significant turnover rate of nurses in a profession that is already in a national shortage.

In a recent study on U.S. nurse retention, Dotson, Dave, Cazier, and Spaulding (2014) reported findings from an online study of more than 800 RN subjects conducted in the southeastern portion of the U.S. The results did not indicate any numbers or amount of the participants who anticipated or planned to leave their current position or the profession of nursing but did look at the factors that influenced their decision to remain in their position or nursing: reduction of stress, satisfaction with their job, and value congruence. The researchers noted that hiring the right person for the position decreased turnover rates and provided a valuable savings to the organization; this was described as value congruence. Value congruence between nurse and the healthcare organization was noted as an untapped potential factor relating to nurse retention and increased job satisfaction. Alignment of values between employee and employer should be considered in the hiring process (Dotson et al., 2014).

In 2005, a major national study was undertaken by the Robert Wood Foundation (Kovner & Brewer, 2009) to track career changes of new RNs--*The RN Work Project*. Originally it was a longitudinal study slated for five years; however, it was expanded to 10 years and will conclude in 2015. The study was designed to look at the first 18 months of a newly licensed nurse's work. What was known at the time the study started was 88% of new nurses will work in the acute care hospital setting and there appeared to be a high turnover rate among the newly licensed nurses within the first two years of their career. Study results indicated turnover rates were 15 to 78%, which was a significant problem. *The RN Work Project* results at different periodic intervals preliminarily

showed the turnover rate among new nurses was much lower than first thought. The latest statistics from the study showed 17% of new nurses left their first job in the first year, 31% left in the second year, 49% left by four and half years, and by six years, the post-graduation rate was 55%. The preliminary results also indicated that 92% of new nurses did not leave the profession but took other nursing positions with another organization. In addition, 55% of the reporting RNs indicated they had not received training in identifying good care that was evidence-based and less than one-third had been trained to participate in quality improvement activities. The majority of reporting RNs indicated they had not received any training to assess gaps in current practice. Forty-six percent indicated they had not participated in any team training to improve care (Fiester, 2013).

New nurse retention has been shown to be significantly impacted through nurse residency programs. A significant difference was demonstrated at the 12-month mark for new nurse retention but was not significant at the 18- or 24-month mark. Hoffart et al. (2011) called for further research regarding the pre-graduation component and exploration into collaboratives between nursing education and hospital. Both experience limited financial resources, outcomes research on residency, and transition programs (Hoffart et al., 2011).

Cost of Nursing Turnover

Nursing turnover affects nurse staffing and retention efforts. It is a global issue in nursing because it impacts many other issues in the profession such as patient outcomes, mortality rates, nurse satisfaction, nurse burnout, and nurse retention. Nursing turnover is a costly process to employing agencies (Hinson & Spatz, 2011).

The most recent cost of nurse turnover was reported to be \$22,000 to \$64,000 per turnover with an annual turnover rate of 8.4-13.9% (Robert Wood Foundation, 2009). This was lower than the findings of Salt, Cummings, and Profetto-McGrath (2008), which showed \$145,000 was the average cost per nurse turnover. Factors associated with nurse turnover in this study were difficulty in the role transition, job satisfaction, reality shock, compensation for the role, self-concept, horizontal violence, and negative organization culture. These costs and resources are of grave concern to nurse employers. Efforts to reduce voluntary turnover rates and improve retention are important to nursing administrators and hospitals (Hinson & Spatz, 2011).

Transition Literature

The transition literature encompasses issues that are personal to the new nurse. The first year after a new nurse's graduation is filled with immense professional and personal development (Newton & McKenna, 2007). The concepts of professional identity and professional socialization are two distinct concepts associated in many cases when establishing a sense of becoming. A nurse develops a professional identity through the professional socialization process (MacLellan, Lordly, & Gingras, 2011). Distinction is established between the two ideas of professional socialization and professional identity and how they are connected. The transition process for a new nurse is not a clearly outlined or defined event. Role satisfaction is a very ambiguous concept in the transition literature as the transition process is clearly a period of uncertainty, fear and stress. These terms do not signify satisfaction but more dissatisfaction.

Professional Socialization

Socialization is closely related with the sense of becoming. Professional socialization is a lifelong, complex, multifaceted process wherein people learn the norms, behaviors, roles, values, ethics, and status of a culture in which they join or become part of and eventually develop a relational self-concept from that process. Simply put, it is the realization and redefining of role expectations (Price, 2008). In nursing, professional socialization begins early in nursing education where lay perceptions of nursing are converted into a professional understanding of the role. That view keeps developing through a continuous, interactive process and transfers into entry to practice for the new graduate nurse. Socialization is a critical aspect of student to nurse development. Through the process of professional socialization, the outcomes are establishing professional identity and commitments. Understanding professional socialization within nursing enables students and nurses to cope with the demands of the professional nurse role and prepare for adaption to the real world of practice (Dinmohammadi, Peyrovi, & Mehrdad, 2013; Lai & Lim, 2012).

The concept of professional socialization is known as a process and an outcome. An early nursing student image of nursing is typically viewed as a service of helping sick people. This evolves over time in nursing school with a professional understanding that it is a combination of learning a new role, gaining new knowledge, skills, and developing characteristics of the professional group. As this transition occurs, the process is known as socialization. The process of socialization is the adoption of values and norms; whereas the outcome of socialization is the self-view of being a member of the nursing profession holding the requisite knowledge and responsibilities (Lai & Lim, 2012).

The many definitions of professional socialism generally agree that socialization is a process of a layperson being adopted into a profession. It is the explicit learning and adoption of the profession's attitude, norms, skills, behaviors, values, and role. Nursing students begin to internalize the attributes of values and norms of nursing and eventually into their self-concept (Lai & Lim, 2012).

Professional socialization is parallel to learning, i.e., it is a continuous, lifelong, and interactive process. The process professional socialization hopefully produces is the development of a professional identity. Thus, the nursing educational process creates educational experiences for the student that transitions from the role of the student to that of professional nurse (Lai & Lim, 2012; Price, 2008). Professional nursing socialization is greatly influenced by other nurses. This is important to note when considering mentor and supportive role model programs and recruitment and retention strategies for nurses (Price, 2008). Professional socialization is an essential aspect to a developing nurse's career. These behaviors, attitudes, and skills will impact a nurse's role.

Professional Identity

The National League for Nursing (NLN; 2013) contends professional identity begins with admission to a nursing program, is continuous, and evolves throughout the person's professional career in a dynamic process of interaction and collaboration between education and practice that leads to growth. Identity or professional identity is a career-long developmental process (Cook, Gilmer, & Bess, 2003; Serra, 2008). Identity simply put is the sameness or likeness of another; in human development terms, identity is the formation that occurs from processes people and their environments interact in and results in a change in the individual's characteristics (Bronfenbrenner, 1979).

Similarly, nursing professional identity is the development that occurs within nurses and is an internal representation of people-environment interactions (Öhlén & Segesten, 1998). In a landmark concept analysis by Öhlén & Segesten (1998), professional identity of the nurse was derived out of personal and interpersonal dimensions that held interaction, growth, and maturity as central foci in the description of the concept. Delineation was made between the feeling of being a nurse rather than working as a nurse (Öhlén & Segesten, 1998). In a concept analysis by Öhlén and Segesten on the professional identity of the nurse, it was conceptualized that there are two dimensions--personal and interpersonal. These theoretical perspectives focused on growth, maturity, and interaction. Interpersonal attributes included the continuing process of personal growth and professional maturity. Personal attributes were assertiveness, competence, confidence, compassion, commitment, conscience, courage, and an experience of being a nurse. Antecedents included the experience of professional socialization and having shared experiences with other nurses. The personal consequences of professional identity are genuineness, increased positive and professional self-image, and increased professional pride; whereas the ability to relate to other's self-insight and self-trust, independent thinking, and carry out of role responsibilities are the interpersonal equivalent. Related concepts of professional identity are occupational identity, self-image, role of the nurse, professionalism, and self-esteem (Öhlén & Segesten, 1998).

Development of professional identity was noted by Birks, Chapman and Francis (2010) to be planned and purposive in the process of becoming professional by nurses. Education is noted as the crucial element for this process as learning is the key to secure

individual enhancement and secure the profession as a whole. The synthesis of professional identity development is the combination of person, nurse, and professional fused to form the perspective of self. Just as Öhlén and Segesten (1998) found personal identity and professional identity could not be separated for the nurse, Birks et al. confirmed this stance.

Professional nursing identity is more than completing a nursing education program, graduating, passing the NCLEX-RN, and earning the title of registered nurse. Professional identity is a continuous process that begins in nursing education and maintains well into the nurse's role in the workplace and, in reality, their entire nursing career (MacIntosh, 2003). To further look at professional identity and the nursing profession, Ten Hoeve, Jansen, and Roodbol (2014) recently identified that nurse professional identity and self-concept are derived through the work environment and values, education, public image, and traditional social and cultural values. This was arrived at by examining 1,216 studies. It demonstrated the importance of nurses communicating their professionalism to the public to show what they really do. Social media, including the Internet and social websites, are mediums that reach out to the public and the current generation of nurses entering the workforce (Ten Hoeve et al., 2014).

Role Satisfaction

Role satisfaction or job satisfaction with new nurses is difficult to define but it is the overall satisfaction with one's job or role within their profession. It is a challenge to concretely define due to the generation of new graduates and lack of research. There is information on RN satisfaction on nurses in general but not so much on new graduates.

In a survey of new RNs, it was found that retention strategies are important and shape new nurses' perceptions about their jobs. What is known is that a new nurse's first professional nursing position plays an important role in that nurse's perceptions of his/her part in healthcare, patient outcomes, and satisfaction with career choice (Roberts, Jones & Lynn, 2004). Job satisfaction is synonymous with support systems and assignments that are fair and appropriate for the new nurse's level to promote high self-confirm, lower anxiety, and lessen role conflict and ambiguity. When this can be achieved, the result is higher job satisfaction and commitment (Boyle, Popkes-Vawter, & Tauton, 1996).

Pellico, Brewer, and Kovner's (2009) secondary analysis of responses relating to their work environment by 612 newly licensed RN's surveyed from across the United States was negative in nature; yet, the majority comprised the neutral or positive aspect. The 207-item survey assessed RN attitudes about work, intention for future work, job opportunities, and attributes of their current job. Many of the reporting subjects indicated they found fulfillment in their role at 18 months of independent practice. It was noted that between the one-year mark and the 18-month mark of practice, the nurses were developing competence, confidence, and comfort level with independent practice (Pellico et al, 2009). The development of confidence is a key ingredient to gain during the transition to an independent nurse. Higher self-confidence levels lead to feelings of preparedness and reduced stress (Newton & McKenna, 2007).

Stress. Job stress is characterized by challenges experienced in one's role. For new nurses, stress is stated to be a lack of confidence, feelings of not knowing, too high of expectations for self, too high of expectations from coworkers, conflict with role and values, mixed feelings of responsibility, lack of support, heavy assignments, feeling the

complexity of patient care is beyond skills and ability, actual job performance, family/work conflict, and tension within the social climate such as horizontal violence known as bullying (Gerrish, 2000; Morrow, 2009; Pellico et al., 2009; Zinsmeister & Schafer, 2009).

Support. Best practice initiatives are demonstrated to be innovative approaches to support new nurses. Types of supportive programs include orientation programs, coaching programs, mentorship, preceptorship, nurse residency programs, transitional programs, and leadership programs to name a few. Supportive strategies also include recruitment of new graduates prior to graduation from clinical placement sites. Hiring a new graduate who has some experience with a unit and has practiced nursing clinicals may help with preparedness of the graduate nurse. Manager support sets the tone for nursing staff and new nurse relationships. Activities include formal orientation, mentorship programs, and coordinated work schedules between new nurses and experienced nursing staff. Mentorship initiatives benefit new nurses through a variety of means; outcomes of mentorships are improvement in problem-solving skills, learning evidence-based practices, learning the culture of the unit and organization, and developing professional relationships (Morrow, 2009).

Nurse residency programs are specifically designed to promote and support the new graduate nurse's transition. Candidates in the program may be referred to as externs or interns. These programs allow hospitals to develop and guide new nurses in the culture of the organization. It is a time when not only are they adjusting to the new nurse role but they are becoming socialized into the mission, vision, values, and culture of the organization. It is an investment into the agency's future clinical staff. In a review of

literature by Anderson, Hair, and Toderro (2012), there was a wide variation in nurse residency programs relating to content and learning strategies. More research is recommended on the outcomes of nurse residency programs as well as the long-range impact on retention, satisfaction, and RN commitment.

Transitional programs have recently emerged and are shown to demonstrate facilitation and support to the development and integration of new nurses. These programs range from one month to one year and have documented increased nurse satisfaction, increase in retention ration, and positive cost-benefit ratios (Rush et al., 2013). To challenge the discussion of transition programs, the debate continues for what the ideal transition program should be and the cost constraints for many units and hospitals. An alternative was the coaching program approach. This has been documented as an effective way for new nurses to transition to independent practitioners through a traditional orientation with additional support and guidance from expert nurse who serve in a coaching role and strategies for the new nurses (Jewell, 2013). This gives way to the critical aspect of the expert nurse role or the preceptor or mentor in a seasoned nurse-novice nurse relationship. It is noted in the literature how vital the experienced staff nurse is in the development of new graduates. Experienced nurses are resources who are valued for their competence, guidance, and as a resource (Ellerton & Gregor, 2003).

Another approach to new nurse support has been leadership programs. These programs are aimed at improving leadership in the clinical arena to improve patient care and service delivery. In a mixed methods study by Miskelly and Duncan (2014), the outcomes shed evidence on how nurses' self-confidence improved and led to "growing

up” or maturity professionally and psychologically through increased responsibility for clinical practice, engaging in quality and safety roles, and returning to graduate school.

Many variables and contributories have been identified as possible influences of the sense of becoming for new nurses. Many are very relational and intertwined. Inner environmental elements are professional socialization and professional and personal identities that are constructed within a new nursing student during this year of transition. External environmental factors must also be considered as outcomes or elements within the broader environmental layers such as patient safety, nursing quality, and includes values, competence, and nursing judgments. These are all relational in some way; only through face-to-face, one-on-one interviews can the sense of becoming be discovered through new nurses’ stories.

Chapter Summary

The literature review provided a detailed schema for Benner’s (1984) Novice to Expert framework, the current state of nursing practice, and the transition of the advanced beginner nurse into professional nursing practice. More precise was the experience of being a new nurse and the expectations of becoming a nurse, thus the phenomenon of the sense of becoming within the journey of nursing. This phenomenon was initially examined through the human ecological theory of Urie Bronfenbrenner (1979); however, it was realized the HET did not contribute any new knowledge or expand the substantive theory in any way. Application of the HET did not resonate with any meaningful connections and it was viewed as superficial upon analysis; therefore it was not exemplified or carried through the open coding phase of the constant comparative analysis.

Also included in this review were numerous factors that contributed to the phenomenon, both internally and externally. External factors related to the state of healthcare in the 21st century. Factors reviewed and applicable to the research were patient safety, nursing quality, competence and clinical reasoning, and nursing economics specifically looking at recruitment, retention, and the cost of turnover for nurses. Internal factors included professional socialization, professional identify, and nurse role satisfaction.

CHAPTER III

METHODOLOGY

“One today is worth two tomorrows; what I am to be,
I am now becoming.” Benjamin Franklin

Introduction

The purpose of this study was to discover how advanced beginner nurses experienced the sense of becoming and what influences impacted this process and how. Of particular interest was to explore how the process of transition, from a novice nurse or graduate nurse to the new independent, professional nurse role was encountered to generate knowledge to better understand the perspective of “who I am versus who they want me to be” during this critical transition period. Thus, nursing leaders in academia and acute care practice might learn how to better prepare and train nursing students and new graduate nurses for real life, independent nursing practice and how to successfully survive reality and transition shock.

Research Approach

There are many ways of looking at a problem or a question and trying to figure out the best way to approach a solution to the question. In research, there are various methods to approach a particular problem. The first step in research is trying to decide on the best approach (Creswell, 2007).

To start, researchers must ask themselves what method should be used. For this study, the method of interviewing was used (Crotty, 1998). The second question is the methodology that governs the researcher's choice and use of methods. The researcher selected the grounded theory methodology (GTM). The third question Crotty (1998) poses to researchers is the theoretical perspective behind the methodology. The theoretical perspective found in the literature was interpretivism, specifically symbolic interactionism. This stance originated early in the development of GTM through Strauss and Corbin's (1990) strong background with symbolic interactionism. Crotty's fourth question concerns the epistemology that informs the theoretical perspective; in the case of the GTM, Strauss and Corbin never directly addressed the underpinnings of the method (Crotty, 1998). However, it is suspected by critics that the epistemology for the Strauss and Corbin version was constructivism, a known constructivist epistemology (Mills, Bonner, & Francis, 2006).

The central issue for this study was to determine *how* nurses experienced the sense of becoming in their first years of practice. The researcher felt there was more to be discovered between Benner's (1984) Novice to Expert theory in relation to the movement and progress within the advanced beginner stage, especially from a human ecology perspective. The literature provided a limited account for transition when entering professional practice. Duchscher's (2008) theory of transition was the only attempt to explain the process based on Kramer's seminal work in 1974 that looked at the different phases through which new nurse graduates progress. Duchscher's work produced a theory based on 10 years of qualitative research through interpretive inquiry. The stages of transition theory proposed that the initial 12 months of nurses' professional

acute care practice were a process of becoming in a personal and professional respect. Nurses pass through ordered stages of doing (0-4 months), being (5-7 months), and knowing (7-12 months), specifically through an ordered process of “anticipating, learning, preforming, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring, and engaging” (Duchscher, 2008, p. 444). The theory did not claim to be prescribed or linear but transformative and evolutionary for nurses. However, the theory sought to make clear the relationship of its stages of growth and change (doing, being, knowing) to the passage of time. As new nurses advanced from stage to stage, their needs changed in the workforce. The theory suggested consistency, stability, predictability and familiarity in a new nurse’s regiment for at least the first four months of practice in acute care so they can adjust and develop their practice and thinking as they moved through the stages of role transition (Duchscher, 2008).

Jean Hershey’s 2007 doctoral dissertation was a qualitative, phenomenological study of the lived experience of becoming a professional nurse for associate degree nurses (ADN). Her work had the underpinnings of structural functionalism and reference group theory as she looked at the process of acquiring a professional identity for ADNs. The results of her phenomenological study showed professional identity occurred in four processes and was attributed to the creation of the professional nursing identity model for ADN students (Hershey, 2007).

Duchscher’s (2008) theory and Hershey’s (2007) work were the closest to incorporating the concepts of transition and becoming. However, they did not clarify the researcher’s questions about the nature of how the sense of becoming was experienced specifically for the advanced beginner stage in Benner’s (1984) framework with specific

attention paid to what influences contributed to the sense of becoming and how. The researcher believed that looking at this period or transition from a different perspective--one from an interactive position between developing person and their environment and the environment's interaction with the developing person--might shed more light on the issue and provide information from an introspective lens that considers environments at different levels, perspectives, experiences, and points in time. The human ecological theory was selected to provide this alternative view of looking at the advanced beginner stage for new nurses in their first two years of practice as a professional nurse.

Given the social context and the desire to discover how the phenomenon of becoming (as a process) was experienced, a qualitative research design was most appropriate to this study. The author considered qualitative surveys but did not feel rich enough data and information would have emerged from this method. Data obtained through qualitative approaches tend to be holistic and intense and would be more helpful in understanding the nurse's story. The researcher felt it was best to talk with participants to elicit their story--to give voice to their experiences and let them be heard.

Once the study was determined to be qualitative, the researcher had to further decide which method of qualitative research would best approach the research problem and questions. The author considered the many approaches to qualitative research. After much deliberation and consideration, it was narrowed to phenomenology and grounded theory through the use of one-on-one personal interviews. Since both of these methods shared similar features, the researcher determined that GTM would best fit the research study with its focus on social processes. Grounded theory methodology provides a broad theory or an explanation of a process; it is useful when current theories about a

phenomenon are nonexistent or inadequate. Grounded theory methodology is a contextualized and dynamic structured approach to answer the “how” and “why” in the study of some process (Creswell, 2007; Willig, 2013). In comparing GTM to phenomenology, the researcher was more interested in *how* the process of the sense of becoming was experienced. A phenomenological approach was not appropriate as it would be best used for asking “what” the meaning is of the sense of becoming. Phenomenology is useful when the concept is poorly conceptualized or defined. Although becoming was not prevalent in the literature, the process of transition is (Polit & Beck, 2012). Many studies examined the transition of new nurses relative to identity, socialization, safety, quality, and evaluation of different types of structured orientation programs. The researcher also wanted to know if there were influencing factors and if so, how they impacted the becoming process; the desire to explain the “how” was in alignment with GTM, whereas discovery of “what” was more applicable to a phenomenological approach.

Grounded theory methodology is concerned with the generation of hypotheses rather than the testing of them. Grounded theory methodology is an important approach for nursing as nursing is concerned with social interactions; therefore, this method was useful in the conceptualization of the “sense of becoming” (Nieswiadomy, 2012). Grounded theory methodology is noted to have realist ontology. Epistemology outlines objective truths, generates a testable and verifiable theory, and is generalizable; the researcher and participants join in the discovery of a theory (Denzin & Lincoln, 2005).

Grounded Theory Methodology

Grounded theory methodology (GTM) was first introduced in 1967 by sociologists Barney Glaser and Anselm Strauss. The basic and initial premise of grounded theory is “general methodology of analysis linked with data collection that uses systematically applied set of methods to generate an inductive theory about a substantive are” (Glaser, 1992, p. 16). It has since undergone modification; today, four main methodologies are recognized in academia: (a) the “classical” Glaserian version in 1978; (b) the systematic design or qualitative data analysis (QDA) approach developed by Strauss and Corbin in 1990, (c) a constructivist approach by Charmaz that emerged in 1995 and evolved through 2000 and 2006, and (d) a feminist approach by Wuest in 1995 (Creswell, 2007; Evans, 2013; Willig, 2013). Grounded theory methodology is one of the most popular and general research methods used to uncover basic social processes. It is meant to “generate or discover a theory” (Creswell, 2007, p. 63).

The author determined grounded theory was the best approach and design to research the problem of interest. Since the literature lacked definition of the sense of becoming in relation to the advanced beginner stage of the Benner (1984) Novice to Expert framework, the general premise of GTM allowed data collected from nurses in their first two years of professional practice to bring a voice to their story and how they experienced the sense of becoming for that time period through the human ecological theory lens. The researcher elected to follow the QDA approach by Strauss and Corbin (1990), also known as the systematic approach, for two reasons. The first was for its noted helpfulness to junior researchers who are learning about grounded theory methodology as it is considered the more structured approach, leading to a more rigid

coding structure (Evans, 2013). The researcher is an analytical and structured person; thus, following a prescribed and rigid methodology seemed like a logical match that would work well with the author's nature (Creswell, 2007). Later, it was learned that there was controversy as to which methodology was the most useful for junior researchers. Some scholars contend that classic Glaserian is the most straightforward methodology to use and many revert back to this methodology (Evans, 2013). Regardless of which methodology was used, it was imperative the researcher "stay true" to one methodology during the research process and avoid theory slurring or "skip and dip" activities (the switching between references or methodologies) as these can be common novice researcher mistakes (Evans, 2013).

Secondly, the Glaserian and Straussarian (1967) methodology uses a comparative method in the use of literature as data. However, the QDA approach (a three-step process) by Strauss and Corbin (1990) used the literature in the early stages to help with the development of theoretical sensitivity and hypothesis generation and Glaser (1992) used it later in the process (Evans, 2013). Glaser's method is a less rigorous process of constant comparison--using only a two-step process. Strauss and Corbin's coding process is noted to be more rigorous and defined through microanalysis consisting of word-by-word analysis. Glaser's method is a more neutral approach in order to not over-conceptualize the key points and compares incidents rather than using microanalysis. Also in Straussian methodology, the researcher is active, the theory is interrupted by an observer, and the credibility of the theory stems from the rigor of following the method versus the Glaserian methodology where the researcher is passive, the theory is grounded in data, and notes how credibility is derived (Jones & Alony, 2011).

The next step in the research process following Strauss and Corbin's (1990) method was theoretical sampling, which was interviewing participants chosen specifically to help best form the theory--a purpose sampling. After data were collected from an interview, the analysis began immediately (Creswell, 2007). The researcher was the primary and only instrument of data collection and analysis in the grounded theory method (Merriam, 2009).

Constant Comparative Method of Analysis

The specific rigor that made up the analysis portion of this theory was the constant comparative method of data analysis, a term coined by Glaser and Strauss in the original version of the methodology in 1967. This systematic strategy of the constant comparative method means simply to constantly compare (the data). This was a momentous process characterized by the researcher moving back and forth in a zigzag motion between and among the data, looking at the similarities and differences of the emerging categories (Creswell, 2007; Willig, 2013).

Coding

The coding process of the constant comparative method involved three stages: open, axial, and selective (Strauss & Corbin, 1990). The researcher coded the data in vivo, meaning used the participant's words and phrases, and identified concepts based upon the coded clusters; this was the open coding phase. The next analytic phase was the axial coding phase; this was an intense process that moved the data from the conceptual level to a categorical and beginning theoretical level. The selective coding phase was the intense examination of four prominent categories with the final selection of one core category or variable that was theoretically saturated, centrally relevant, and had "analytic

power” because it demonstrated the “ability to pull the other categories together and form an explanatory whole” (LaRossa, 2005, p. 851).

Memoing was the purposive task of the researcher taking notes, documenting ideas, and theorizing ideas that occurred during the entire coding process. These memos were valuable at the substantive-level as they contributed to the evolution of the theory (Creswell, 2007; Willig, 2013). Memoing was any style the author chose to use (Evans, 2013). There were no rules or direct guidelines on memoing; it was at the discretion of the researcher.

Substantive-Level Theory

The results from data collection, constant comparative analysis, and memoing allowed the emergence of the substantive-level theory. It was the final stage of the grounded theory method. Substantive-level theory was the integration and linkage of the categories and properties in all ways possible to capture the emerging theory (Creswell, 2007; Willig, 2013).

The transition a nurse underwent as he/she progressed through the advanced beginner stage was a change--a change to an independent practicing nurse. Grounded theory was a useful method for addressing how this change was experienced in the process; the changes that occurred over time justified this methodology as the best fit for examining how the “sense of becoming” was experienced by advanced beginner nurses.

Research Design

The research project used a grounded theory, qualitative approach to collect in-depth, open-ended question interviews with 14 participants. The systematic grounded theory design for the research accepted no preformed concepts of knowledge or reality;

knowledge was always emerging and transforming as it was interrupted. Grounded theory allowed true meaning and understanding to develop inductively from the data collected from one-on-one in-depth interviews with participants (Jones & Alony, 2011).

Semi-structured, individual interviews were conducted due to the constructivist approach that underpinned the data collection procedure (Merriam, 2009). Grounded theory methodology was used because there was limited research in the literature that addressed “becoming” or the “sense of becoming.” Additionally, there was an absence of literature or a gap that did not examine the sense of becoming researched through the human ecological perspective. Grounded theory method is the most commonly used approach for qualitative research from the social sciences and allows for the collective of descriptive experiences with the intent to generate a theory (Strauss & Corbin, 1990).

Participants

Participants for the current study were persons who graduated from undergraduate Bachelor of Science in Nursing (BSN) programs located in the United States. Participant inclusion criteria consisted of BSN-prepared nurse graduates who have graduated from an American Association of Colleges of Nursing (AACN) or National League of Nursing (NLN) accredited nursing program between December 2011 and December 2013 and began working as a RN in 2012 or 2013. Ten nurses graduated from a traditional undergraduate BSN program and four graduated from an accelerated BSN; as they graduated from second career BSN program, they held a previous bachelor’s degree in another discipline and earned a second bachelor’s degree. Nurses held active employment with an acute care hospital. This was their first professional entry-level graduate nurse or registered nurse position since graduation from their nursing program.

All participants spoke the English language, were willing to be audiotaped during the interview process, were willing to participate for a 40 to 60-minute interview, and signed an informed consent prior to the interview.

Exclusion criteria were an Associate Degree in Nursing (ADN) prepared nurses, diploma prepared nurses, RN to BSN prepared nurses, foreign educated nurses, RN to graduate student program nurses such as RN to Doctor of Nursing Practice (DNP) or RN to Doctor of philosophy (Ph.D.) program nurses, unemployed nurses or nurses seeking employment, nurses who have vacated a previous graduate nurse or registered nurse position, and nurses employed in primary care, clinics, medical offices, long-term acute care, long-term care, skilled nursing facility, nursing home, or in the rehabilitation setting.

The goal of using the grounded theory method was to reach theoretical saturation. This included continuous sampling and coding procedures until no new categories emerged or were identified (Glaser & Strauss, 1967). The researcher initially estimated that 20 to 24 in-depth interviews might have been necessary to reach theoretical saturation. This number fluctuated based on variation in the sampling and the insights gained into the phenomenon. The sample was adjusted as emerging concepts became known and informed the sampling process. Saturation was achieved with 14 interviews. The researcher verified that conceptual and theoretical saturation had occurred and was confirmed by testing, refining, and strengthening the theory as the constant comparative analysis process ensued. This included comparisons among gender, age ranges, units worked, BSN program type, and familiarization with unit pre-graduation.

Recruitment of Participants

The snowball or chain method was used to recruit participants for the study. The snowball method of sampling was a cost-efficient and practical method for finding participants with similar experiences, in this case, nurses within the first two years of practice. A weakness to this method of sampling was getting referrals from other sample members, which may be affected by lack of trust or cooperation with the researcher (Polit & Beck, 2012).

To address these issues, the researcher networked with other nurse educators in her region by sending an e-mail message to them as well as contacting them via telephone follow-up. The e-mail introduced the researcher as a doctoral student and briefly explained the study. The message also included participant inclusion and exclusion criteria. The researcher asked nursing educators and program chairs or coordinators to forward the e-mail to recent graduates. Another strategy included the researcher reaching out to nurse acquaintances, nurse managers, fellow classmates, program coordinators, clinical nurse specialists, and nursing educators in her work, school, and home locations. She also used social media as a recruitment method to elicit participants; however, this method was unsuccessful in producing any interested participants.

The email asked nurses to contact the researcher directly by e-mail or telephone if interested in participating in the research. Once a potential participant has contacted the researcher, she contacted the potential participant via e-mail or telephone and provided an overview of the study and screened the nurse based on inclusion and exclusion criteria. Potential participants who met all criteria and were willing to participate were scheduled

for an interview at a neutral, quiet location or via telephone. At the conclusion of telephone contact with a participant, the researcher e-mailed the participant a copy of the interview questions and the informed consent form in order for the participant to begin thinking about the questions to be asked during the interview. The time given prior to the interview was used as a time of reflection for the participant and was intended to produce more rich and pure responses rather than possible superficial responses due to feeling rushed for an impromptu response. Some participants did prepare in advance and reflect upon the questions, while several other participants admitted they did not.

The researcher also asked each of the nurse participants if he/she knew of any other qualified potential participants who might be interested in participating in the study. At that moment, most did not but did agree to pass along the research name and contact information if anyone came to mind. Several nurses did know of other nurses who fit the participant criteria and did forward the researcher's e-mail invitation to participate in research onto several other nurses they knew. This proved to be a successful method in the recruitment of participants.

Protection of Human Participants

Due to the nature of the study, which involved work and interaction with human subjects, protection of their rights and confidentiality was of utmost importance and concern. Thus, the study was submitted to the University of Northern Colorado's (UNC) Institutional Review Board (IRB) for exempt review on May 29, 2014 prior to any contact, recruitment, interviewing, or collection of any data. The study received approval for exempt status on June 17, 2014 (see Appendix A). Training and certification with the

Collaborative Institutional Training Initiative (CITI) was completed by the researcher prior to the research study submission to the IRB.

Following IRB approval, participant recruitment ensued by reaching out to nurse colleagues, educators, classmates, nurse friends and family, nurse acquaintances, and undergraduate nursing program administrators via e-mail, in person, and via telephone. The networking process consisted of informing the contact about the research background, purpose, design, and methodology, and then asking them to share an invitation to participate in the research with qualified individuals. Several classmates, colleagues, and nursing program administration were instrumental in passing along the invitation that initiated the snowball method of participant recruitment. The researcher sent out 32 invitations to participate in research to personal contacts and nurses. It is estimated that from that chain reaction, at least 100 to 150 nurses were contacted via e-mail with an invitation to participate in research.

Once an interested participant voluntarily responded to the invitation, either directly to the researcher or to their primary contact and then directed to the researcher, contact was first made between the researcher and the participant. All participants were adequately briefed on the research, were capable of comprehending the information, and were free to make their own decision to become a participant or decline the opportunity. Participation to consent in the study was an entirely volunteer process on the part of the participants. The informed consent (see Appendix B) and the interview guide (see Appendix C) were reviewed in detail with each candidate prior to the participant agreeing to participate. The researcher explained the purpose of the study; the research method; potential risks, which were minimal; their rights as a research participant; protection of

their privacy, anonymity, and confidentiality; their right to withdraw from the research at any time; and that they would not receive any compensation for their time and participation. All nurses agreeing to participate signed the consent form (see Appendix B) prior to their interview.

Participant confidentiality was maintained; only the researcher knew the identity of participants. Confidentiality was further secured with the researcher assigning an arbitrary pseudonym to each participant. Hard copies of data and the voice recordings were stored in a locked file cabinet in the researcher's office to which only the researcher had access. Excerpts from transcripts were used in the final report of this study using participants' pseudonyms. This was specified in the consent form (see Appendix B). At the conclusion of the study, all data results were downloaded from the researcher's computer to a jump drive and data on the computer's hard drive were deleted. The jump drive was also kept in the locked file cabinet in the researcher's office. The voice recordings will be kept for no more than three years post study and then destroyed. Data and consent forms will be retained and stored appropriately for a minimum of three years in Dr. Faye Hummel's office and then destroyed.

Data Collection

Meet the Participants

The participants of the study were baccalaureate-prepared registered nurses who were initially hired by an acute care hospital and continued to work for the same agency. Participants were from various states throughout the United States. The participant's pseudonym, age at the time of interview, and their unit specialty were noted. The 14 participants were happy to share their stories of how they experienced the sense of

becoming as they progressed from graduate student nurse, or novice nurse level, through the advanced beginner level as an independent practicing RN (see Table 1).

The participants ranged in age from 22-58 years old with a mean age of 30.57 years, a median age of 25 years, and a mode of 23 and 25 years. Twelve females and two males comprised the study sample. Thirteen of the nurse participants worked full-time and one was employed part-time. Geographically, participants were from four different states and represented seven different acute care hospitals. Unit representation covered critical care, intermediate step-down units, general medical-surgical units, and emergency services. Patient populations included adult and pediatric services.

Table 1

Participant Demographics

Pseudo Name	Age	Unit	Familiarity with Unit	BSN Degree Type	Grad. Year
Patricia	22	Intermediate cardiology	None	Traditional	2012
Lisa	48	General medical-surgical	Nurse technician	Traditional	2012
Jennifer	23	Critical care unit (CCU)	Nurse technician	Traditional	2012
Amy	23	General medical-surgical	Nurse technician and summer externship	Traditional	2012
Becky	23	Pediatric intermediate cardiology/General cardiac	None, but familiar with similar unit for clinicals	Traditional	2012
Heather	28	General medical-surgical	None	Accelerated second career	Dec. 2011
Caroline	58	General medical-surgical	None	Accelerated second career	Dec. 2011
Gail	25	Pediatric Intensive care unit (PICU)	Nursing student senior immersion (288 hours)	Traditional	2012
Julie	25	General medical-surgical	Summer externship	Traditional	2012
Jessica	27	General medical-surgical	None	Accelerated second career	2013
Tamara	25	Emergency services	None	Traditional	2012
Melissa	33	Emergency services	Nurse technician	Traditional	2012
Ryan	24	General cardiac	Nursing student clinical, senior practicum, and summer externship	Traditional	2011
Thomas	44	Intermediate neuro-medical	None	Accelerated second career	2013
Natalie-Key Informant	24	General medical-surgical	None	Traditional	2012

During the interviews, participants revealed any familiarity with their employing unit. Four nurses were previously nurse technicians on the same unit with one of them also holding a summer externship position. Two of the participants held summer externships on the unit where they now worked. Two participants disclosed they completed their senior immersion or leadership practicum on the unit where they are now employed. One participant noted she completed her senior immersion on a similar unit in the same agency but not the unit where she now works. Five participants did not have any prior familiarity with the unit through nurse technician positions, externships, or completion of practicum or immersion experiences on the unit where they are employed. One participant (Tamara) stated she was hired into and completed a formal six-month residency orientation program for her specialty emergency care unit. The remaining 13 participants stated their new nurse orientations were traditional hospital orientations followed by a unit-specific orientation. These traditional orientations were eight weeks to three months long with the majority being three months in duration. Two participants (Patricia and Melissa) indicated their orientations ended early by approximately one to two weeks due to the agencies' need for staffing appropriations; they were mandated to abruptly end orientation and accept their first independent nursing assignment. Given the demographics for the group of participants, it was considered a homogenous group in the context they were all BSN graduates with one to two years of nursing experience and they were all employed in an acute care hospital.

Interview Procedures

Seven of the interviews were conducted in-person. These interviews were held in a variety of locations such as a coffee shop with a quiet corner booth (two interviews), a

vacant workroom at a public library (two interviews), a restaurant with a secluded conference area, an empty classroom on a university campus, and an outdoor venue such as park at a picnic table away from the public. None of these interviews were held during a busy time of the day; this was purposely arranged to avoid crowds or the public to ensure the participant felt comfortable talking. Six interviews were via the telephone and one was via Face Time (an audio-visual telephone application). All of the electronic/telephonic interviews took place while the researcher was in her home office, which was distraction-free, provided for privacy and confidentiality, and allowed the participant to speak openly and share information.

Interviews ranged in length from 37-75 minutes. All interviews were audiotape recorded and transcribed verbatim following the interview within several hours or up to five days post interview. Data collection occurred through semi-structured interviews conducted over a six-week period from July through August 2014. All of the participants met the inclusion criteria for the study. Each participant received a copy of the interview guide (see Appendix C) at least two days to one week prior to the interview and each participant signed a copy of the informed consent form (see Appendix B) prior to the interview. For interviews via telephone and Face Time, the participant faxed or e-mailed the signed informed consent to the research prior to the start of the interview. The interviews were audiotaped from the start of the interview questions through a mutual closing of the interview questions.

At the end of each interview, the author journaled her gut reaction, thoughts, and perception of the interview in a dedicated notebook. She wrote her thoughts in random order as they came to her. This strategy was not intended to be theoretical memoing but a

personal account of the author's raw thoughts at that particular time and place in the research process.

Interview Questions

As the researcher sought to discover how the sense of becoming was experienced, four initial questions were piloted with three registered staff nurses in the advanced beginner stage of practice. The responses and comments were not used or considered in the data collection process.

Based upon their responses and input, the initial four central questions evolved into the following five semi-structured interview questions:

1. In the process of becoming who you are today:
 - What did you need?
 - What did you want?
 - What did you get?
2. Describe for me what ways you have evolved during your transition to practice. Probes/examples: communication, critical thinking/clinical reasoning, advocacy, prioritization, etc.
3. You have encountered many experiences during your transition to practice. Tell me what stands out to you and why. Probes:
 - a. Orientation
 - b. Positive aspects
 - c. Negative aspects
 - d. Supports
 - e. Challenges

4. If not mentioned, what is your age? What patient population do you work with?
5. Is there anything we haven't discussed today that you would like to mention?

The first question was a general guiding question in three parts designed to be reflective and information-eliciting. The second question was reflective, open-ended, and designed to allow the nurse to tell his/her story with several probes if required. The third question was aimed at eliciting more precise, specific events and details that encompassed how they experienced becoming. The fourth question was directed at collecting demographic information of the age and population for which they cared. The fifth question was an open-ended opportunity to state any other information not previously covered. Upon completion of the interviews, the researcher completed verbatim transcriptions of the recorded interviews. Transcriptions of the interviews were completed within seven days of the interview and coding of the interviews was done line-by-line and word-by-word.

In a side-by-side table, the research questions and the interview questions were aligned to demonstrate the applicability of the interview questions with the research questions (see Table 2). Interview questions were not limited to the specific list due to the nature of the grounded theory method and constant comparative analysis process.

Table 2

Research Questions and Interview Questions

Research Questions	Interview Questions
How do advanced beginner nurses experience the sense of becoming?	Describe what ways you have evolved during your transition to practice. Probes/examples: communication, critical thinking/clinical reasoning, advocacy, prioritization, etc.
What influences contribute to, and how do they impact the sense of becoming for advanced beginner nurses?	In the process of becoming who you are today: <ul style="list-style-type: none"> • What did you need? • What did you want? • What did you get? You have encountered many experiences during your transition to practice. What stands out to you and why. Probes: orientation, positive aspects, negative aspects, supports, challenges

Trustworthiness

With any research, reliability, validity, and ethics are the major concerns.

Trustworthiness of qualitative research is expressed in the quality of the research and the credibility of the researcher. The following standards were used to judge and indicate the quality of qualitative research and establish trustworthiness (Lincoln & Guba, 1985): credibility, dependability, confirmability, transferability, and authenticity. The research was carried out in a rigorous and ethical manner (Creswell, 2007; Merriam, 2009; Polit & Beck, 2012). This process began with the researcher's dissertation committee review and critique and resulted in clarification and modifications to the study. The proposal was then submitted for review to UNC's Institutional Review Board. Approval was obtained

as written for exempt approval. After notification of IRB approval, the researcher began data collection and constant comparative analysis concurrently.

Credibility

Credibility, also known as internal validity, deals with truth or reality. It is how reality is known and measured. This relates to the meaning of reality. Qualitative research is assumed to note reality as ever changing, multidimensional, and holistic. Reality can never be captured because of these attributes. Reality is, therefore, interpreted through observations and interview. Data collected brought the researcher close to the reality. Internal validity or credibility is also relative; it is a goal to strive for, not an end product (Merriam, 2009; Polit & Beck, 2012).

Just as there are multiple versions of eyewitness accounts to a crime, there were multiple versions of accounts to a nurse's sense of becoming. This research interpreted the reality of how participants experienced the phenomenon of the sense of becoming and moved the researcher closer to understanding the reality of the collected data. It was a way of determining if the researcher's interpretation of the data "rang true" with the participants (Merriam, 2009, p. 217).

To ensure internal validity, the researcher used the process of member checks to verify the emerging findings from the participants (Polit & Beck, 2012). The terms "validity" and "reliability" were not comfortable terms for Corbin, co-author of the Corbin and Strauss (2008) version of GTM, when discussing quality as it applied to qualitative research. Instead she proposed use of the term "credibility" (Corbin & Strauss, 2008). To accomplish this, the researcher met with several of the participants (Becky, Heather, and Gail) individually a second time and reviewed codes, concepts, and

categories derived from the constant comparative analysis after their interview. Discussion with the participants yielded validation through confirmation of truth and reality based upon their feedback. The researcher also used a key informant. The purpose of the key informant was to have a person who had insight to the participant population; so the key informant fit the participant criteria but was not interviewed. The key informant was Natalie; she was an advanced beginner nurse in her first two years of practice in an acute care hospital. Natalie initially contributed to the construction and organization of the interview questions asked during the participant interviews. After the interviews and analysis were complete, she was consulted to verify codes, concepts, and categories in addition to the member checks.

Reflexivity was a control measure this researcher used to guard against her own personal bias and supported the credibility of the research. It was the process of self-reflection on personal values, known by Lincoln and Guba (1985) as “human as instrument” (p. 183), and clarified the researcher’s position. It was the explanation of the researcher’s assumptions, disposition, biases, experiences, theoretical orientations, and worldview on the phenomenon or topic. The purpose of reflexivity was to understand how the researcher interpreted the data or arrived at a particular understanding of the data (Merriam, 2009; Polit & Beck, 2012). The researcher bracketed or set aside any biases or assumptions about the phenomenon by maintaining a reflective journal.

Dependability

Dependability refers to reliability or consistency and means the extent for which the findings of a study can be repeated or replicated and find the same results. This is a challenging aspect of qualitative research because it deals with human behavior, which is

not considered a static entity. For qualitative research, the goal is to seek, describe, and explain an experience. There is no benchmark for repeated measure or established reliability. What is important for qualitative research and reliability is if the results are consistent and dependable. Credibility cannot be established without dependability (Merriam, 2009; Polit & Beck, 2012).

An audit trail was used to ensure reliability for research. The researcher kept a detailed account, or diary, of how the data were collected. This strategy is also called memo writing. Use of an audit trail chronicled how the researcher conducted the research and got to the final results. The diary detailed how the data were collected, how the categories were derived, and how decisions were made throughout the entire research process. After each interview and each session of constant comparative analysis, the researcher wrote memos in the notebook that included definitions of categories, label justification, labeling of emergent relationships, and notations of any changes of direction or reflections on the research questions.

Confirmability

Confirmability ensures the data's meaning is congruent between two or more participants providing the data. It is imperative that the interpretations of the data resound through the participants' voice and not that of the researcher or the researcher's perspectives (Polit & Beck, 2012). As mentioned above with credibility, the researcher performed the practice of reflexivity for this research. This was also confirmed through member checks with three participants at different points during the analysis.

Transferability

Transferability, also known as external validity, means the potential for the findings to be applied or transferred or applicable to other situations, groups, or settings. Before the study can be generalizable, it must first be internally valid and then transferability may be established. If the research is not internally valid, then it is not necessary to confirm transferability. In the case of qualitative research, the use of small purposeful sample sizes cannot constitute generalization as it is unknown where transferability may be sought; this is arguably a limitation of qualitative research. It may best be related to the researcher approaching this concept in terms of a new angle, which would be that of a reader of the findings and try to determine if they apply to the situations of others. To accomplish this, the researcher must be vigilant in reporting rich, thick, sufficient, descriptive information to make the evidence clear to make transferability possible to others (Merriam, 2009; Polit & Beck, 2012).

Maximum variation is another strategy researchers can attempt to enhance transferability. This particular research included selecting a variety of participants with a variation in age, gender, geographical location of nursing education program, and a variety of acute care hospitals. To assist with this, networking and reaching out to a broad number of nursing educators at various BSN schools of nursing, as well as a variety of nurse managers at multiple acute care hospital sites, was essential and indeed enhanced the snowball sampling method (Merriam, 2009; Polit & Beck, 2012).

Authenticity

This quality criterion was the fairness and faithfulness of the researcher to show a wide range of realities. Authenticity reports the feeling and tone of an experience as told

by the participants. Interviewing participants from several states across the United States and several acute care hospitals helped achieve authenticity with a wide range of geographic location and distance between the participants. It created heightened sensitivity for the reader through a better understanding of the feeling, mood, context, and experience of the participants (Polit & Beck, 2012).

Chapter Summary

The Strauss and Corbin (1990) methodology of grounded theory was used to guide the interview process in capturing the stories of 14 nurses. The interviews were collected through one-on-one audiotaped interviews over a two-month period of time. Constant comparative analysis of the interviews began immediately after the first interview and this process ensued with each interview and analysis of the raw data. Theoretical saturation was achieved and become known through the constant comparative analysis process. The researcher was vigilant to ensure the Strauss and Corbin methodology was followed and that slurring or blurring of other approaches did not cross into analysis.

Trustworthiness, credibility (internal validity and reflexivity), dependability, confirmability, transferability, and authenticity were assured through a rigorous research process involving 14 nurses from four different states in the United States, and spanned seven different hospitals. There was a mix of gender, age range, BSN program type, unit type, and familiarity with the employing hospital pre-graduation. Approval from the UNC IRB was obtained prior to conducting research. After the research was underway, there was a concurrent process of interviewing and constant comparative analysis. In addition to these processes, the researcher kept a journal and made notations with each

interview. She also kept a journal of general memos about the research process and analysis process. Three member checks were made during the analysis along with verification from one key informant at the end of the data collection and analysis process.

CHAPTER IV

RESULTS

I am not what happened to me, I am what I
chose to become. Carl Gustav Jung

The purpose of presenting the findings in this chapter is to allow the reader to share the participants' experiences in which the grounded theory of advancing in a new professional role was founded. Utilizing Strauss and Corbin's (1998) unique three-step coding method from the first step of coding--open coding, all data were filtered and fractured through the researcher and placed into categories. In the second step--axial coding, the categorized data were put back together in new ways following a systematic organization using tools suggested by Scott and Howell (2008)--the conditional relationship guide (see Appendix D) and the reflective coding matrix (see Figure 1). In the final coding phase of selective coding-- the core category, advancing in a new professional role remained central in focus and other sub-categories were integrated back, resulting in the story line to support the core category (Strauss & Corbin, 1990). The processes of shaping, knowing, growing, and advancing that comprised the core category were supported with the data from the participant interviews. The conditions, consequences, patterns of interaction, and the causes were also supported directly from the data.

Reflective Coding Matrix					
Core category	Advancing in a new professional role				
Context	Advanced beginner stage (following Benner's novice to expert framework)				
Causal Conditions	New RN beginning work in an acute care hospital and going through phases (pre-orientation, orientation, post-orientation [immediate zone and comfort zone])				
Processes (sequences of action/interaction)	Shaping	Knowing	Growing	Advancing	
Modes for understanding the consequences (processes outcomes)	Independent practice	Progressive development of connoisseurship	Refining awareness	Reach for a higher potential	
Properties [consequences] (characteristics of category-defines and gives meaning)	Connection to others	Competence	Self-confidence	Empowerment	
Dimensions (properties of a category location on continuum=range) Ex: intensity, frequency, duration, etc.	<u>Facilitators</u> Relationships Support <ul style="list-style-type: none"> • Responsibility • Feedback • Debriefing • Resources Trust Respect Acceptance Gaining experience	<u>Barriers</u> Negative interaction Unprofessional behaviors	Knowledge base Application of theory to practice Continued development	Ability to perform role Reinforcement	Engagement Action/Reaction Improvement
Contextual Condition(s)	Working together	Conscious effort and concentration	Balancing skills and ability with experience	Professional development	

Matrix adopted from Scott & Howell (2008)

Figure 1. Reflective coding matrix.

Data analysis began with the collection of the first interview in keeping with grounded theory methodology. Straussian methodology of coding uses three stages of coding: (a) open coding, (b) axial coding, and (c) selective coding. Coding, in essence, is the process by which extracting concepts from raw data is done. It is also the development of properties and dimensions for the concept (Corbin & Strauss, 2008). This coding structure is specific to Strauss and Corbin (1990) and must be followed to “stay true” to this methodology (Evans, 2013).

After the first interview was completed, the author transcribed it verbatim. After transcribing, it was read and reread with the identification of codes extracted in a line-by-line analysis. During this process of open coding, statements and phrases were coded and initially clustered with both low- and high-level concepts as they were initially identified. The author transcribed the first five interviews herself immediately after completing the interview. At one point, the interviews were scheduled closer together for participant convenience so the transcription was delayed. The author hired a transcriptionist to assist with the interview transcription and to keep the data analysis process moving forward. The turnaround time for the transcriptionist to complete the transcription was on average five to six days. To properly code the transcribed interviews, the author listened to the audio recording and read along concurrently. This process was rigor enhancing. The author preferred this method as she could focus on what she was hearing and reading without being distracted with critiquing her own typing and proofreading. The author also felt she had a heightened attention span as she did not want to miss any points or valuable information.

A limitation to this aspect of data analysis included listening to the researcher's own voice on the tape; she learned that she needed to allow the participant to speak and finish his/her thoughts and not ask them a clarifying or secondary question that came to her mind. In subsequent interviews, she started keeping a question list for each interview; then at an opportune time such as a long pause or hesitation by the participant, or in between questions, or at the end of the participant's comments, she would look to her list and begin structuring questions with a reflection back to a previous discussion. The researcher found this strategy was effective, it did not distract the participants and their current train of thought in their response, and it helped them reflect back to a previously discussed issue and expound upon it. The researcher did have to be careful in taking notes during a face-to-face interview so it did not appear that she was preoccupied or not paying attention to the participant's story as she was writing down further question(s).

Open Coding

Open coding involved opening up the data to all potentials and possibilities within it. From this brainstorming process, all possible codes were recorded and all possible meanings were explored. Labeling of the codes was *in vivo*, i.e., words and phrases used by the participants only. Language was not placed upon or outside of the participant's language. Concept emergence from the raw data came through an analytic focus but allowed the data and interpretation to guide the analysis. This required the researcher to remain open to abstract thinking while analyzing the data. The procedure as set forth by Strauss and Corbin (1990) was to break down or fracture the data into discrete parts, closely examine them, compare them for similarities and differences, and then ask

questions about the phenomenon reflected in the data (Corbin & Strauss, 2008; LaRossa, 2005; Willig, 2013).

Schreiber (2001) suggested the novice grounded theorist should begin with a line-by-line analysis for either classic Glaserian or QDA. The first level of coding is the *in situ* or *in vivo* open coding process, i.e., the participants' own words. This was the style the author used; this process quickly led to many codes as well as it allowed her to "compare incident to incident and identify similarities and difference" (Schreiber, 2001, p. 70). An example of open coding is presented in Table 3.

With the first step of open coding completed and over 200 words or phrases identified as "codes," the next step was to conceptualize and categorize the data. Strauss and Corbin (1990) indicated this might be predetermined by the data itself (emic) but also came from the researcher (etic). Seasoned researchers in GTM are sometimes able to open code at the basic line-by-line level and identify conceptual categories at the same time (Schreiber, 2001). This was not the case for this researcher. This part of the analysis was time intensive and had to be done in an orderly succession for it to be clearly understood. One of the greatest challenges was ensuring that theory slurring was not occurring and that only the Strauss and Corbin methodology for QDA was utilized. To ensure purity of QDA, the researcher coded line-by-line on hard copies of the interview, noting the open codes in the margins. Then in a second read of the interview, concepts were identified and written in different color ink or highlighted to draw attention to higher-level concepts.

To become further immersed in the data, the researcher had to organize it into a workable and visual tool. The author created a Microsoft Excel spreadsheet to help

organize the data. As it turned out, the raw open codes or in vivo codes were condensed to 135 codes. At that point in the analysis, it was apparent to the researcher that the codes belonged to higher-level and lower-level groups called concepts. After refinement and organization of the spreadsheet, 25 concepts emerged.

Categories were defined as higher-level concepts that shared properties and represent relevant phenomena. They were also referred to as themes. Categories had properties and were dimensionalized. Properties were referred to as the characteristics that defined and described the concepts; it was the most concrete feature of an idea, thing, person, event, or activity. Dimensions were meant as variations within properties and they gave range and specificity to the concepts (Corbin & Strauss, 2008).

The concept-indicator model was a basic start at systematically analyzing the most frequently stated concepts abstracted from the data. The most frequently noted categories were relationships, self-confidence, competence, and empowerment. These four themes were prominently consistent throughout all the interviews, which correlated with the number of open codes initially generated for these concepts. The next step the researcher took to analyze these four categories was through a variable cluster and property table. For each of the four main concepts, a table was made and the differentiating “types” and “properties” were noted (see Table 4).

Table 3

Example of Open-Coding Process

Participant	Interview Data	Open Codes
Tamara	My <u>preceptor</u> was my greatest cheerleader, <u>She's made me the nurse I am today</u> , in which I am very <u>grateful</u> .	Preceptor Cheerleader She's made me the nurse I am today Grateful
Julie	You hear <u>stories</u> of how nurses " <u>eat their young</u> ." Some of the <u>older nurses are just miserable</u> and <u>mean to the new nurses</u> . New nurses feel they have to <u>prove themselves</u> to the older nurses to get them to like them or something. I have a lot of <u>friends who have struggled with this</u> . I have had such a <u>good experience with my coworkers and my unit</u> , I feel I am <u>lucky</u> .	Stories "Eat their young" Older nurses are miserable and mean Prove themselves Friends who have struggled with this Good experience with my coworkers and my unit Lucky
Becky	Overall, it's crazy to think about <u>how I felt when I first started to how I feel now</u> . I also <u>can acknowledge that I don't know everything</u> , and while I am a lot <u>more confident</u> with what I do now, I <u>have been in a code before and it was my patient that coded while I was holding him</u> . <u>You think you know what you are doing and you get in your groove</u> and then you have a <u>curveball</u> that is thrown at you that makes you <u>take a couple steps back</u> and <u>acknowledge that I'm still learning and growing as a nurse</u> . You are <u>never going to know everything</u> . You <u>never know what your patients are going to do</u> . So while you do have an <u>increased confidence</u> , you do <u>feel more comfortable</u> , I think it is important to <u>remember that you should never feel too comfortable</u> . While the code was a really stressful shift and stressful couple of hours, <u>looking back on it, I am really glad that it happened</u> . And then <u>if it happens again, you can try to remember that and know more what to do</u> .	How I felt when I first started to how I feel now Acknowledge what I don't know More confident Been in a code before while I was holding him You think you know what you are doing Get in your groove Curveball Take a couple steps back Acknowledge that I'm still learning and growing as a nurse Never going to know everything Never know what your patients are going to do Increased confidence, feel more comfortable, remember that you should never feel too comfortable Looking back on it, I am really glad that it happened If it happens again, you can try to remember that and know more what to do

analysis of the HET and the categories, the HET components were simply supplementary and did not expand or dimensionalize the categories.

Axial Coding

This coding method was unique to the Strauss and Corbin (1990) methodology and was a key differentiation to the Glaserian methodology use of theoretical coding (Evans, 2013). Axial coding was meant to ultimately and intently focus on a single category (variable), which was noted as a core phenomenon (category or variable), and looked back at the data to find sub-categories or properties that surrounded this core phenomenon; it is also known as the stage to relate and integrate as the fractured data from open coding are combined in new ways (Walker & Myrick, 2006). Sub-categories are categories that answer the questions of “when, where, why, who, how and with what consequences” around a focal category (Strauss & Corbin, 1990, p. 125). A distinct feature of axial coding is the development of the “six C’s.” This specific procedure looked for (a) causes, (b) contexts, (c) contingencies, (d) consequences, (e) covariances, and (f) conditions around the central or focal category (Glaser, 1992; Konecki, 1997; LaRossa, 2005; Strauss & Corbin, 1990). The researcher connected the conceptual categories by tracing the relationships between and among the central phenomenon and identifying causal conditions: (a) what caused the condition, (b) strategies--response to the condition, (c) intervening conditions--factors that influenced the condition, and (d) consequences--outcomes from the strategies used. These four elements formed the axial coding paradigm or a logic paradigm (Creswell, 2007; Strauss & Corbin, 1990; Willig, 2013).

The axial coding commenced with examination of the four themes around the three different axes, which were the phases and respective zones. It was in this analytic process the researcher assembled the fractured concepts, took them apart, put them back together in new ways, and looked for connections (Strauss & Corbin, 1990).

During axial coding, connections between the four emergent categories—relationships, self-confidence, competence, and empowerment--were discovered using the six “C” framework prescribed by Strauss and Corbin (1990) through the conditional relationship guide (see Appendix D). This was a grid consisting of 25 categories and relational questions asked and answered about each category; this included what, when, where, why, how, and with what consequences? Once the conditional relationship guide was populated, the information was transferred into a Reflective Coding Matrix (see Figure 1). The consequence categories were quantified from the conditional relationship guide and the prominent consequences were moved forward for the next step in the analysis. The consequences that moved forward became the properties in matrix. As the reconstruction worked out, three of the primary consequences from the key categories were also properties or characteristics of a category. The properties of interest were (a) connection to others, (b) competence, (c) self-confidence, and (d) empowerment. These key properties were essential in understanding the consequences of achieving theoretical saturation. Their emergence over and over was confirmation that saturation was achieved and no new information come forward. After the properties were identified, the rest of the matrix was populated from the data, researcher memos and diagrams, all in association with language relative to Benner’s advanced beginner stage.

Context

The context under which the research was centered was embedded in the advanced beginner stage in Benner's (1984) novice to expert framework. The experience of the sense of becoming occurred over time for advanced beginner nurses through two stages--the orientation and post-orientation stages, which included the immediate zone and comfort zone (see Table 5). The stages were in sequence and followed a traditional time continuum. The element of time and the sequencing of the stages emitted a natural progression or advancement as well.

Table 5

Context Table

	Pre-orientation phase	Orientation phase	Post-orientation phase--Immediate zone	Post-orientation phase--Comfort zone
Characteristics	Any event prior to the first day in a new professional role, includes nursing school	Hospital orientation Unit specific orientation Dependent, supervised practice	Independent, unsupervised practice	Independent, unsupervised practice
Beginning	May begin with nursing school	Day 1 of new job in hospital	First day off orientation	When the nurse is comfortable in nurse role
Ending	Day 1 of new job in hospital	Approximately 3-6 months after start date	When the nurse has reached comfort zone Approximately 12-18 months after start date	When the nurse transitions to Benner's stage of Competent Approximately 2-3 years after start date
Benner's framework stage	Novice	Advanced beginner	Advanced beginner	Advanced beginner
Human ecological model	Exosystem	Mesosystem	Microsystem	Microsystem

Pre-orientation phase. The pre-orientation phase included accounts from nursing school, taking the NCLEX-RN, being offered their current position for employment, or any event prior to the start of the first day of the present position. The pre-orientation phase was characterized as the entry into practice. It was an unsolicited part of the interview in which participants offered to sequence their story and frame their responses to the interview questions in order for them to flow as a logical array of events. Six of the 14 participants were very excited and amazed at how quickly they were hired to their first nursing position. Only one participant commented on the challenge to securing a nursing position; however she acknowledged she was only seeking an intensive care unit (ICU) position. The other participants did not volunteer information about their hiring experience. Thomas opened his interview with the following:

I was basically hired by the unit right after graduating, like almost a week after I graduated but I hadn't taken my NCLEX yet. So there was a big opening in graduating and the job starting, but I had to get the NCLEX finished in that time period so in those two months I spent studying for the NCLEX.

Amy responded similarly by prefacing her response in chronologic order:

I graduated in May 2012. I took my boards at the end of June 2012. I was actually hired in before I even graduated! When I interviewed with my manager, I had already had some experience in the [Agency]. I worked as a tech and had done a nurse externship.

Patricia also had a positive hiring experience and stated, "The hospital that I interviewed at, the interview went really well. They hired me right there on the spot! I took the job and I got the job exactly that I wanted, which is surprising for a new graduate." Gail, Becky, and Julie also commented about their positive hiring experiences, which were similar to those exemplified.

Jennifer had a different experience with the hiring process in a climate where nursing jobs were not plentiful:

After nursing school it was actually really hard to get a job; [State] is really saturated with nursing schools. I knew it would be really competitive, I knew I did not want to just settle on something. Eventually I was offered a position in the ICU at [Agency] in [State] and relocated.

Eleven of the 14 participants referenced their undergraduate nursing education in some way. Two participants voiced comments of dissatisfaction with their program's organization. Three participants commented they felt well prepared for practice. Patricia stated, "I felt like nursing school prepared me as well, when I was becoming a nurse."

Two participants held the opinion they were not well prepared for "real-life" practice. Tamara specifically said this related to learning about interventions: "I feel that nursing school did not prepare me enough for the 'skill' part." Julie shared this in relation to her practice organization:

I think nursing school really did not prepare me for 'real nursing' at all and I think that that's something that I totally learned during my externship and on the job. I learned that a lot in nursing school and so I think that I was pretty prepared for that. You know what's more important, what needs to be done first. I felt prepared in that sense. But the organizing your day and actually doing your full assignment I definitely learned on the job.

Four participants acknowledged that nursing school could not prepare them for all they would see in practice but felt they were given the appropriate foundation and resources to transfer into practice. Amy commented, "In nursing school, they give you the theory and stuff but you don't really have it engrained in you until you see it like over and over and you're working with this population." This brought out the idea of repetition and practice. Thomas had a realistic perspective: "You can't prepare

everybody for every kind of clinical situation because it's all so different." Becky concurred:

You can't experience everything in nursing school or every type of patient, so there are a lot of things that you learn about in the classroom, and you see some of the things in clinical, but not all things. For example a code or something, then you wonder "how would I be prepared for this when I'm on the unit by myself."

This further built on the idea of transferring theory into practice for critical, but rare occurrences. Jessica's understanding of a theoretical foundation and transfer to practice was eloquently stated:

Everybody told me that you learn the most nursing when you're in your first job on orientation. You learn more in those short few weeks than you would in your entire nursing program and that was true. I did learn more practical stuff, but I feel like the base of knowledge that I was provided during nursing school definitely aided in understanding those concepts that were applied in practice and understanding the different conditions that I found on the unit.

In one account, Amy reflected and spoke about what shaping in the pre-orientation phase was like for her:

That is something that I really thought about during nursing school and was engrained in us to try to figure out what type of nurse that we wanted to be. Pick examples from our clinical instructors, our preceptors during clinicals, what did you like that they did and what didn't you like that they did. So I kind of had a picture of the type of nurse that I wanted to be.

The findings from analysis of the context (background and situation) revealed there were phases and stages in the process of progressing through Benner's (1984) advanced beginner stage. The participants' statements revealed accounts of important events to them such as graduation, taking the NCLEX-RN, and securing their first nursing position. Emotions of excitement were noted as a result of being offered a nursing position in an acute care hospital. One participant who wanted to work in a particular area found she had to wait and relocate to find her position of choice.

Participants discussed their level of preparedness for their first RN position. It was found there were mixed opinions on nursing school preparation for their RN role. Several nurses felt well prepared, several did not, and a small majority felt they were as prepared as possible and possessed the necessary skills for a strong foundation in preparation for their new role.

Orientation phase. The second timeframe was orientation and it consisted of two parts--hospital orientation and unit specific orientation. In all 14 interviews, hospital orientation always preceded unit orientation. There were noted variations in the length of time and content of the hospital orientation from those participants who spoke directly of their experience of hospital orientation. Basically, it is an introduction to the healthcare facility, the mission, vision, and values, organizational structure, as well as policy and procedures that blanket the entire organization for safety, quality, and culture. Some participants noted it was somewhat like an extension of nursing school with basic reviews of body systems and physical assessments.

Unit specific orientation is when the nurses are being introduced and familiarized to their specific work environment and patient population. This orientation period is always structured with the new nurse being paired with a seasoned or experienced nurse on the unit. This creates a dependent-independent dichotomy in the preceptor-preceptee relationship--the main stronghold of working together. The term preceptee (2014) is defined as a fully qualified practitioner entering practice for the first time. Because they are inexperienced, they are adopted by a preceptor who is an experienced nurse. Dependent practice is specific to the orientation phase and being paired with another independent nurse and being supervised. Dependent practice contrasts to independent

practice, which is characterized as being out on their own, not being paired with another nurse, but being counted as a staff member and not having direct supervision or a safety net. The majority of the participants stated they had a couple main preceptors for this orientation. One participant indicated she had one primary preceptor as she participated in a nurse residency program. Participants indicated they were oriented to different shifts to better understand the entire spectrum of care in a 24-hour period on the unit. They also indicated this process of orientation was a prescribed time; they had checklists that indicated the most common disease processes encountered on the unit as well as all common and rare skills and interventions they might be expected to perform. Participants indicated their preceptors and charge nurses attempted to expose them to as many different cases, situations, and instances as possible within their orientation time in order to adequately prepare them for when they would experience independent practice.

Nine participants indicated having prior experience or familiarization with the hospital and/or unit. This was through working as a nurse technician, having clinical experiences on the unit as a nursing student, or holding a nursing externship over summer months in their BSN program. This was termed as pre-graduation experience in the literature.

The length of time the unit orientation lasted varied among the participants; it ranged from three to six months with the average being three months. Tamara was an exception as she had a six-month orientation as part of a nurse residency for her specialized pediatric emergency services orientation. Patricia and Melissa were scheduled to have three month orientations; however their orientations abruptly ended early due to the hospitals needing to have them counted as active staff members to meet

nurse-patient staffing ratio needs due to a high patient census. The hospitals justified their early entry into practice based on the nursing administration's evaluation of the participant's readiness for an independent assignment of patient care. The participants viewed the orientation process as a means to "learn how to do my job," stated Caroline. Melissa recognized that "right out of school, I knew I needed to be experienced. Experience couldn't be taught; I just had to get it."

Facilitators. In response to the interview questions noting positive and supportive aspects of unit orientation, many codes emerged. The most relevant and frequent facilitators were relationships, support, trust, respect, acceptance, and gaining experience.

Relationships. Preceptor-preceptee relationships were the most frequently talked about influence when the participants were talking about their transition experience. Lisa stated it was "supportive nursing staff, nurses that support each other and management that is supportive of nursing" who were influential factors in her experience. She further elaborated, "Relationship building with the other nurses, somehow engaging with them was a sharing of knowledge and a resource." Becky commented that the best aspect of her orientation were her preceptors. She said they were "fabulous and very helpful, very non-judgmental. It was a very open environment; I knew I could ask about anything." Ryan stated he had a "very good relationship" with his two main preceptors: "They were helpful, experienced, and they knew me."

Support. Support was noted to have several principle elements. The participants outlined responsibility, feedback, the process of debriefing, and resources as the specific intervening conditions for this category.

In elaborating on what support meant, Heather commented on working with a preceptor while she was trying to establish independence: “The whole process is gaining more responsibility.” Thomas added he had to learn who had what “responsibility” on his unit so he could work on his delegation skills. Gail knew support as “I’ve got your back,” which was a philosophy shared between her and her peers who were also new nurses. It was a motto they lived by so no one felt embarrassed to ask “stupid questions.”

Heather incorporated the dependent factor in her view of orientation. Her perspective was that

when you’re on orientation waiting to take over the assignment, you still have your preceptor that’s there. You’re their responsibility. So in case they’re needed, they’re kind of just hovering –and in case they need to jump in they will. That was nice having, knowing that you had that safety net. The whole [orientation] process is gaining more responsibility.

Thomas concurred with Heather’s view and stated that being on orientation was a time of “supervision” and he felt as if he had “a safety net.”

Eight of the participants discussed feedback. They indicated it was something they wanted but only several received regular feedback and it was from their preceptor only. No one indicated they received feedback from management or nursing administration, yet three specifically stated they wanted to hear from that level but did not. Feedback from preceptors was “getting the feedback and having that debrief your day or a complex patient or a critical situation.” Gail said,

[Preceptor comments] Things like that that you really need to hear because you can be so unsure of everything and kind of questioning yourself. So it was nice having that kind of feedback. Always, at the end of every shift, we would sit down and reflect on the day and figure out what went well, what didn’t go well, and the plan for moving forward. That was really helpful for me.

Debriefing was a strategy four participants had experienced during their orientation. Amy and Gail regularly debriefed with their primary preceptors to discuss their day, a particular patient, or an incident. Patricia and Tamara commented on debriefing only critical incidents such as code blue events with their preceptors. The practice of debriefing was claimed to be “awesome follow through and just having someone to bounce ideas off of was so helpful in that first year” by Amy.

Resources were known to the participants as “go-to people” who were experienced nurses willing to answer their questions after orientation ended. Becky stated that she “always had go-to people who were above me and check in [with me]. Now I do that [check in] now for other nurses.” Thomas also stated that he had “go-to people” on his unit who were designated to answer his questions after he was off orientation.

Trust. Amy added she experienced “trust and continuity” with her “couple of” preceptors “so they knew what I [she] learned and what still needed to go over.” She indicated she “really liked somebody to explain to me why we were doing this and being a little bit more hands-on with me.” Jennifer discussed trust in the intensive care setting among other nurses and physicians as “they had put trust in me...but trusting yourself as a nurse is a lot different.” Jessica talked about learning to trust herself: “I should trust my intuition” in reference to patient care and status. Gail recognized she was trusted when senior nurses encouraged her to “take more difficult assignments” or trusted her to watch their patients when they went to the bathroom or took a break.

Respect. Lisa commented a lot on the influence of respect, especially “respect for one another.” Respect was specifically referenced with regard to between shifts, with

physicians, and between nurses working together. Becky sensed a new respect from other nurses when she became a “super-user” for her hospital’s new electronic charting system. On the topic of respect, Gail stated that on her unit “I feel like the majority of the older nurses, they will respect you but they won’t have respect and confidence in you until they see what you can do,” which also led into other concepts such as to having to prove one’s self as a nurse. Once a new nurse has proved him/herself [in patient care], she indicated that was when the “senior nurses began to respect the young nurse.” She also stated her intensive care unit had the culture of longevity on the unit, which inherently equaled more respect from physicians, residents, management, and nurses.

Acceptance. Tamara commented that in her experience her unit “created a family and help each other out to make sure one person isn’t ‘sinking’ or struggling. We communicate well with each other and support each other’s care.” Amy and Jessica also commented on how they felt there was a “family” feel to their unit, which indicated feeling welcomed and accepted among the nursing staff.

Gaining experience. Tamara described her nursing residency orientation in a pediatric emergency room as a “layering,” which referred to the assumption of responsibility and “building up to being on my own.” All participants indicated that in time they were able to accumulate more experience. This hands-on practice occurred during the orientation phase.

Barriers. Unsupportive or challenging aspects to orientation were noted as a “hands-off” preceptor style, which was attributed to negative interaction. Julie, Jessica, and Amy stated they encountered a preceptor with that style and each labeled it as “hands-off.” Each of them told how they were unable to work with a preceptor who

practiced that teaching approach and requested not to be paired with that particular preceptor for the duration of their shift and orientation. The characteristics of the “hands-off” preceptor were that they were unsupportive because they were not available to answer questions, “sat down a lot,” were “not very active,” and only “checked in” and said “how’s it going?” Julie stated she “didn’t know where her preceptor was” during her shift. Jessica also noted a “stand-offish attitude” with this type of preceptor, which was meant as unengaged, distant, and uninterested in orienting new nurses.

Becky appreciated the varied work styles of different preceptors to see how experienced nurses worked. She did not view varying styles as a challenge but commented they were “a benefit” to her learning and experience. It was further noted that she discussed this in general and did not describe any specific teaching or preceptor styles in her interview.

The orientation experiences the majority of the participants spoke of were in a positive light and provided many positive influential factors. However, in many of the interviews, the participants alluded to “friends” or “other nurses” they knew of who did not have “good” orientation experiences. They commented on how they felt “lucky” and “thankful” for their positive experience and glad they did not have any “bad” accounts to share. The researcher sought to find participants who experienced a “bad” or negative orientation. Comments that had filtered through that were remotely negative were accounts of the “hands-off” preceptor style. As the interview process ensued, the researcher interviewed Melissa who claimed she had a less than impressive orientation.

Melissa candidly shared her orientation experience to the emergency department and labeled it “not impressed.” She verbalized that she felt there were too many

computer modules to complete and “about 90%” of her unit orientation was spent on a shift different from what she would be working on. In her orientation experience, she did not have a dedicated preceptor. She had prior work experience in the department as a nurse technician and stated she was proficient in that role for several years. She indicated she was able to do a lot of “nursing tasks” as a result of that role, e.g., “drawing labs, starting IVs, doing EKGs.” She commented that in relation to unfamiliar situations and things she did not know, “it was whoever you could find to answer questions or help you with something.” When asked about her critical thinking, organization, and prioritization skill development, she felt at a loss because she did not have direction in those areas from an experienced person: it was “what I can pick up from watching other people.” She also said that sometimes when it was “crazy busy,” it was like “the wild, wild west,” and it was “challenging to find nurses to answer urgent questions or to help with something.” She shared the following excerpt from a night when she was on orientation to set the tone for how “busy” her unit environment was:

One of my worst nights was I had a patient in a hallway; she was possible OD [overdose]. We intubated her in the hallway, moved her into her room. This woman is on a Versed drip. I'd never had a patient on a versed drip before. I asked the doctor, I said, “What do I start it at?” He said, “I don't know, just start it.” I had no clue what to start a Versed drip at. So this woman is intubated, is actively trying to pull out her tube. I also have another patient across the hall who needs to be started on a Cardizem drip. And I am not real familiar with these drips. I don't do them enough every single day to do them. I also had to put a foley in this woman who was intubated. The day shift had left me the drip to start on her. This was the day I got in trouble because I asked for help too much. I finally, I ended up calling an ICU nurse and asked what to start the Versed drip at. And she told me, which was helpful. But stuff like that was not uncommon. Doing codes in the hallway was not uncommon.

Melissa was one of the two nurses who were affected by the hospital's decision to end her orientation early due to the hospital's need for staff to meet nurse-patient ratios. She indicated her orientation was cut short about two weeks.

Emotions. During the orientation phase, several accounts of personal feelings were shared during the interviews. Several participants described their feelings of being scared, nervous, and uncomfortable. Heather stated, "It's scary in the beginning and I think that it's good when you're scared and you're a little anxious. It means that it's important to you and it should be important to you. What we're doing, it's an important thing."

Even though orientation was a time that stirred many emotions, they took comfort in knowing they were not alone in their practice and had a preceptor--someone who was directly supervising them and was there to guide and coach them as needed. They also noted characteristics of self-doubt and requiring validation from preceptors and unit leadership. Caroline commented, "I was very nervous and scared and of course you want to do everything right. But I felt like the support was there and you could ask questions." Gail's recount of that time was vibrantly told:

I was actually hired into the unit that I did my last clinical rotations on for nursing school. So my transition was anything in the fact that I had finally gotten ridden of some of the butterflies that come with being on the new floor but at the same time, I feel I struggled, well not really struggled, had a hard time wrapping my head around, "Ok. I'm no longer the student. I'm now the one running the show, kind of thing." I remember some of my first days on the unit I was shocked by the fact that there is no double check. I am the one who is in charge. I remember just being like, "Wait. What? Am I ready for this?" And I remember, in particular one of my first days on orientation with one of our more senior nurses, who was one of my preceptors throughout orientation and feeling lost and like, "She hates me. She thinks I have no idea what is going on." And over a few weeks, being in orientation with her, she actually turned out to be one of my best and favorite mentors. And it was just kind of getting past that initial shock of, "I am the one running the show."

Gail expressed a flurry of emotions directed at her as well as extending out to her preceptor. These emotions corresponded to the reality shock described by Kramer (1974) and transition shock Duchscher (2009) in the nursing literature. These periods of shock referred to the professional role adaptation process for new nursing graduates. The feelings described by the participants mirrored those described in the literature such as doubt, bewilderment, lack of support, disillusionment, and not feeling sufficiently prepared. The concept of reality shock served as an antecedent in the substantive theory as this might be a precursor to the processes.

In summation, the orientation phase was identified as a time of dependent practice for new nurses “learning the ropes” from experienced nurses through the preceptor-preceptee relationship. With the average time of orientation for new nurses, the preceptor-preceptee relationship was crucial as this was the new nurse’s connection or bridge to learning the nursing role and start building experience. The influential factors to a satisfying orientation are trust, continuity, acceptance, openness, not being judged, hands-on, engaging, progressive, and transfer of responsibility. The new nurses experienced comfort and reassurance through the sense of a safety net as a result of direct supervision. In comparative cases, when a preceptor was not engaged and was known as having a “hands-off” style to teaching, the influential factors known to promote positive connections were not experienced. Consequences of the “hands-off” style were disassociation between the preceptor and the new nurse, an unsupportive environment, and an unapproachable preceptor. In each case, the new nurse elected to voluntarily end the connection and requested to no longer engage in any experiences with that preceptor.

This is a direct opposite of the condition of working together and is known as a contingency or unexpected event.

Post-orientation phase. The post-orientation phase is noted to have two sub-phases or zones--the immediate post-orientation zone and the comfort zone. The immediate post-orientation phase starts the first day the new nurses are off orientation. It is the first day they are counted and recognized as licensed staff. It is the day they no longer have direct supervision, they are on their own with a patient assignment, and they are labeled as independent but have identified “go-to” people or a “resource person” they could utilize if they had questions or needed help. The new nurse working independently and unsupervised to provide care to his/her patient assignment are the principle characteristics of the post-orientation phase; there is no direct supervision from a RN preceptor or mentor. Independence is the key dynamic in this zone. This is when the new nurse is “off orientation” and is expected to function independently within his/her scope of practice for his/her patient care assignment. As recalled by the participants, this day was recognized as a rite of passage for some as it was a significant event in their practice and a day they would never forget. Other terms in the literature associated with this milestone in the nursing literature were analogies to young birds and referring to novice nurses “leaving the nest, joining the flight,” or supporting the new nurses to “fly on their own” (Jewell, 2013; Morrow, 2009).

Immediate zone. The immediate zone is a very powerful and influential time for new nurses. This zone stirred many emotions for the participants with respect to time and the nurse role. In reference to this first day of independent practice, Lisa said, “Honestly, the main thing that I still needed when I graduated from college with my BSN was my

own confidence in my own ability. I was terrified when I first went up [to the unit], particularly the first day I was off orientation. I had to stand alone, I was very nervous.”

Julie’s statement echoed similar sentiments of anxiety remembering her first day as staff: “I remember my first shift because I was so scared. I was like, I totally must’ve forgot everything I’ve learned, because I was like ‘oh my gosh, what do I do?’”

In the immediate post-orientation phase, nurses commented on their experience in this newly independent, uncomfortable zone as being a time of significant growth. Lisa stated,

I do feel that as I gained confidence, especially once I was off orientation and practicing independently, I did start to get confidence, my own judgment did allow me to be a better communicator with physicians and staff. I did find that I had some knowledge I could put to use. I was more confident in sharing that.

Becky concurred and commented:

I was intimidated; I would get nervous before I’d go to work everyday, just because I didn’t know what I was going to have to do that day and it could be something I had never done before. Just an uncomfortable feeling because everything seemed so new. Even if we had done it in clinical, it had been a very long time, at least since my pediatric clinical. So I just knew that I needed to continue to go to work and get that experience, so that I could become more comfortable doing that.

Patricia verbalized similar feelings with her experience:

My first six months going into work was almost like you’re kind of nervous, like “Who are my patients going to be? What am I going to need to do? What if I don’t know how to do it?” I would say it took almost six months for me, from the time I got to the unit until six months later. For me to really start feeling comfortable. And it really just took practice every week ... after six months, that’s when I started being confident in what I knew.

Julie also felt scared as a new nurse, yet raved about her orientation experience as being a contribution to easing her feelings with the new role:

I came as a brand new nurse I had already done the orientation because I was an extern in there like a year before. So, I had already done a full orientation there as

a student and then I came and – their orientation was amazing ... I felt so confident by the end of it, which was kind of a false confidence, but I felt really good leaving my orientation and I think that was something I needed because as a new nurse I was so scared. It was just so terrifying you're on your own and you're responsible for all of this.

She spoke of a false confidence, which was interpreted as reaching an adequate level of self-confidence on orientation and then returning to feelings of self-doubt upon entering a new phase. Despite the immediate post-orientation period being a time of intimidation and uncertainty, it was an era of immense growth and realization of their own ability, skill, and self. There was not a particular duration equated with this phase as it was what the nurses experienced it as, described it as, and stated how long it was. Two participants sensed it to last approximately six months.

Characteristics of the immediate zone are “standing alone” and “you’re responsible for all of this.” Descriptors for the beginning of this zone are nervousness, scared, uncertainty, uncomfortable feeling, unable to recall, false confidence, terrified, and intimidated. The goal during this phase is to gain experience. Descriptors to explain the ending of this zone are confident, more comfortable, and thinking independently.

In summation, the immediate zone is the transition from standing alone and being frightened, scared, uncertain, and nervous to a state of increased confidence and comfort. Through the conditions of time and experience, self-confidence and comfort increase and the ability to think independently is also gained. Therefore, it is recognized as a parallel relationship between the increase of self-confidence and the increase in comfort.

Comfort zone. The post-orientation comfort zone was claimed to have been experienced as early as six months in a nurse’s career (Jessica) or more typically between 12 to 18 months as claimed by the majority of participants. The 12 to 18 month mark

was consistent with the nursing literature; it was known to be the timeframe in which nurses developed confidence, competence, and a comfort level with independent practice, which also equated to role fulfillment according to Pellico et al. (2009). The researcher was curious about what “comfort” really meant to the participants. She was able to talk with Becky during a member check and Becky expressed the definition of comfort:

I most relate comfort with “free from stress.” When I talk about being comfortable--it means that I had enough experience performing certain skills that I no longer second-guessed or questioned what I was doing. This could be applied to performing tasks, an examples is sedating a patient--it used to make me nervous but after I had done it a couple of times, I knew what to expect and what was expected of me; or clinical judgments, an example of this is when my patient is desating--what do I do? While as a new nurse I would have freaked out and become frazzled, now I am comfortable and remain calm and come up with a game plan for what to do. In general, right after orientation, I was nervous coming to work--I never knew what to expect and I was worried I would be faced with something unfamiliar or what if my patient started to go bad I wouldn't know what to do. As the months passed, this feeling of nervousness slowly went away as I became more comfortable in what I was doing--both experiencing more things multiple times, and knowing my patient population better and what I could expect.

Where these two sub-phases meet is a subjective point in time and could only be identified by the nurses themselves. It was when the nurse described a sense of comfort, accomplishment, or success in their role and that was synonymous with when they felt they had finally *become* a nurse. How comfortable or feeling comfortable was defined as what the nurse stated it to be. Lisa confirmed comfortable to mean “being used to someone or something so that you are no longer afraid or fearful of it. It’s when you settle into a groove and no longer have to be reminded or told what to do because you know what comes next.” Patricia believed she felt comfort but still was transitioning as she said:

I would say it still took me about six months until I really started feeling comfortable with everything but again that was just me feeling comfortable

And then transitioning into after that first year, I don't think I really realized it at looking back if those nerves went away. I went to work. This is what I had to do and you surprise yourself when you just know the answers.

Heather felt it took her more time to reach the comfort zone and commented:

I think that at the end of my first year, I can also remember a mentor saying "it takes people about a year to feel like a real nurse." I think it took me about a year and a half if not even just going into my second year. It just really takes experience.

Melissa valued the experience component and knew it was an essential element she must acquire: "I think right out of school, I knew I needed to be experienced. Experience couldn't be taught, I just had to get it." Ryan's comment put a perspective on the time element in relation to experience:

I felt comfortable in the RN role after about 1 year; however I felt much more comfortable after two years. Two years as a RN allows you to experience many more situations. Since every day is different, it takes many shifts to get the gist of what you are doing."

In the post-orientation phases, relationships could now be chosen by the nurse instead of prescribed by the unit management and leadership. These relationships were mentor-mentee relationships or friendship or merely acquaintances or co-worker relationships. Social relationships developed into a strong sense of family and camaraderie. Jessica stated she felt like she belonged to "a little family," which was not what she expected. In her nursing program, she was told to expect sabotage to her practice from "nurses eating their young" but that was not what she experienced. She commented on the "importance of support from each other and this camaraderie that we have gained" as a unit working together had been a positive experience in her own "special bubble of a unit." Tamara also contended, "We created a family and help each

other out to make sure one person isn't 'sinking' or struggling. We communicate well with each other and support each other's care."

In summary, there are two distinct phases of practice--supervised and unsupervised and they follow a pattern of dependent practice to independent practice. The majority of the participants were satisfied with their unit orientation. One voiced dissatisfaction with her hospital orientation--it was too long (two months) and was a review of anatomy and physiology. Orientation is a time when the connections to others are established; this includes the relationships the new nurse forms with preceptors, other RNs on the unit, other new nurses in the agency, unit leadership, physicians, patients, and families. The emotional experience during this time evolves from accounts of nervousness and discomfort to gradually feeling comfortable and confident. The element of time is a critical element, as demonstrated from the orientation and post-orientation phases, as this is specifically when and where working together occurs through connections to others.

With respect to the human ecological theory, the post-orientation phase is most centered within the microsystem and is basically concentrated on the advanced beginner nurse him/herself. The pattern that forms between the chronology of orientation phases and the systems within human ecological theory is one that began broadly at the beginning of the process and narrowed gradually as the process progressed with time. As time passes through each orientation stage, the scope of systems narrows from a larger community environment associated with many connections (exosystem) to a narrow system composed of just the new nurse (microsystem). To reflect on how this was visualized on the orientation timeline, refer back to Table 5.

Shaping

From the data and constant comparative analysis of GTM, shaping is identified as the first of four processes to occur in understanding how an advanced beginner nurse experiences the sense of becoming. The outcome for the process of shaping is “independent practice.” The context in which it is experienced is closely associated to the orientation phase--when a new nurse is placed in a preceptor-preceptee relationship with an experienced nurse specifically to orient the new nurse to the unit. The contextual condition for shaping is labeled working together. The consequence of the new RN engaged in the orientation process and working together with experienced nurses is the connection to others as the new RN prepares for the journey to independent practice. The connection to others is the property that defines shaping and gives it meaning.

Connection to others. Within the process of shaping, relationships appear as connection to others in many forms and is a multifaceted concept. The most obvious relationship is the preceptor-preceptee relationship. These relationships are prescribed as they are placed upon the new nurse as part of the orientation process. The relationship or connection between the new RN and his/her preceptors is the strongest and most crucial bond in all aspects of the orientation phase and the context of working together. The connection, albeit positive or negative, impacts other processes of knowing, growing, and advancing through subsequent concepts of self-confidence facilitators or barriers, strengthening or questioning of competence, and fostering or delaying empowerment.

Preceptor-preceptee relationships. Tamara had exceptional comments about her relationship with her preceptor during orientation: “My preceptor was my biggest cheerleader, she made me the nurse I am today, in which I am grateful. My preceptor

was such a huge role model for me; I wanted to follow in her footsteps because she was the ultimate nurse.” Tamara’s comments supported the dimensions of a positive relationship--support and respect. She also commented on feeling “accepted into the unit” culture and felt like “part of a family.”

Amy had a couple of preceptors during her orientation. She recalled a situation that started out with a neutral preceptor relationship and ended up being a barrier to increasing her confidence. But once she was placed back into a trusting, supportive relationship, the strategies debriefing proved to be a powerful learning experience:

This specific preceptor, she’s a little bit more hands off in her teaching approach but I had a particular patient that was kind of going downhill: wasn’t getting the treatment that she needed but I wasn’t in the know-how to advocate for what she needed. I felt like I wasn’t getting the support from my preceptor to do that. So everything ended up being fine with the patient but I lost my confidence with that. It was almost towards the end of my orientation, so it kind of kicked me in the butt a little. I actually worked the next day with a different preceptor and she was the one I worked with almost every day. So, when I talked to her, she was able to debrief about the situation with me and talk me through what should’ve been done and what we should have been advocating for. And we actually had the same patient back. So we were able to work with her [patient] and I could see what needed to be done and why we were doing certain things.

Becky found her relationships with preceptors positive and felt accepted as a new nurse: “I was a new grad and learning. I just feel lucky that everyone was so friendly and accepting of that because it made the whole transition a lot easier.” She commented on the use of feedback as an import dimension to her experience: “I had a couple preceptors tell me a few times, ‘It seems like you’re a little apprehensive doing.... changing a chest tube dressing. But I’ve seen you do it before and you know what you’re doing.’” She further commented on this: “You just kind of have to own that and start giving off that vibe like you know what you are doing. And it’s things like that that you really need to hear because you can be so unsure of everything.” This demonstrated the promotion and

strengthening of the attributes of accountability and building self-confidence within the shaping process.

Heather reflected on her orientation and appreciated multiple perspectives from different preceptors from which to incorporate different skills and methods into her own practice that supported the sharing of experience:

I had a primary preceptor, so it was the nurse that I worked with the most, but I mean for scheduling it's hard and with everyone doing 12-hour shifts you do get other preceptors. It's nice. I was glad that I was able to see or be able to work with other preceptors because then you get--it's a lot like when you're briefed during your orientation. You're starting to build your practice. So you see how this person does it and you're like "Oh I like that." Then you see how someone else does it and you might tweak it, change it a little bit and different perspectives along with your own build your own practice.

Jessica appreciated multiple practice styles as well and stated, "Having multiple preceptors also enabled me to see different aspects of nursing, like how they approach a situation in different ways. I could take away what I wanted from each situation and develop my own nursing style based upon that." She further commented on their support: "Both had a great approach to precepting, both there when I needed them, constant support, they would help me if I was getting overwhelmed, they would explain things."

Five nurses commented about experiencing a negative interaction with a preceptor, another nurse on the unit, or another member of the health care team. Patricia and Julie stated they experienced a negative interaction when a physician had yelled at them after they had called them on the telephone during their orientation time. Patricia said, "I did actually get yelled at a couple of times by doctors so it's practice makes perfect. I think everyone makes mistakes and we all learn from our mistakes." Julie commented,

I had the dad swearing at me and then the doctor yelling at me ... I remember just sobbing and the charge nurse was like, "It's fine. This is not a big deal. I know that right now it seems like this is a horrible thing, it's not a big deal." I just remember feeling so sick and I remember being so upset with the doctor. Who treats someone like that? So, that was a learning experience for me because I should have said, "You know what sir, I wasn't here when they rounded." I should have said something, but I didn't. So I've learned.

In addition to negative interactions with physicians and families, they also occurred with other nurses. Amy shared her story of a negative relationship with one preceptor whose style did not align with hers:

There was one preceptor I did have problems with. When I brought it up with my nurse educator, they were addressed immediately and I didn't have to work with her again. So we're fine now; we are really good coworkers but her teaching style didn't quite coincide with what I needed during orientation. When I was at that level, I really liked somebody to explain to me why we were doing this and being a little bit more hands-on with me than this preceptor wanted to be. She just wanted to let me go. But I was a new grad, so I needed a little bit more guidance than that. So we just really didn't see eye-to-eye there.

Julie told her experience with a preceptor in which their practice styles did not coincide and the incident perpetuated further negative interaction, specifically with unprofessional work behaviors. Her situation, while still on unit orientation, was evidenced in her statement:

I think that I had a very good relationship with everyone, but the preceptor that I had, the older woman, she like very hands-off, so another friend that I went through orientation with actually said something and complained about her to our supervisor and said, "Look I feel like I don't have the support. I feel like during my shift I don't know where she is. She's not supporting me like she should". So, our supervisor talked to that nurse, and then of course that nurse was angry that the younger nurse complained about her. So then she was complaining about her to me. I think seeing that, I was even more afraid to speak up.

When witnessing or being involved with a negative interaction, being afraid to speak up brings up another important concept for new nurses--the concept known as self-censorship. This is when employees do not feel safe to speak up or challenge tradition or

ways of doing thing. The reason employees fear speaking up is for self-preservation, which is a protective instinct that is powerful. Self-preservation practices inhibit employees from speaking their mind or reporting something of value due to uncertainty. People instinctively keep quiet in order to play it safe at work (Detert & Edmondson, 2007).

Jessica too had a negative experience with a preceptor while on orientation and commented:

My first negative encounter as a new nurse and my preceptor had left early so they swapped out a different preceptor. I had never worked with this particular person before and I just felt like I didn't have the support that I needed from that one preceptor. I was asking her for help, I ended up asking other individuals on the unit because I felt like she wasn't giving me the support that I needed and wanted to help this mother and to help this patient. So I did ask other people, but it was just a very negative experience and I felt like ultimately it was the patient that was suffering ... It was my, I think, second or third week on orientation and I just kind of felt like I was drowning a little bit. Even though in general she has more of a hands-off approach precepting and kind of with her nursing. She has like just a different attitude; more standoffish than most of the other nurses that I've worked with before.

The common theme among these three encounters involved a preceptor-preceptee relationship during the orientation phase in which the preceptor possessed a "hands-off teaching style" that was not favored among new nurses. This preceptor style was unanimously viewed as unsupportive by all three participants, especially in situations the new nurse deemed critical. Various single comments surfaced that indicated unprofessional behavior on the part of the experienced nurse was a barrier to shaping and growing for new nurses. These accounts exhibited direct barriers to fostering connections to others through the lack of support and not fostering a culture of mutual respect between each person involved.

Other relationships. Other relationships of value during the orientation phase were peer relationships, meaning those with other new nurses; this included other new RNs on the unit and/or from nursing school. This type of relationship also resulted in connections to others and involved the same dimensions. Gail was the only participant to share an experience that illustrated a positive relationship and support:

I actually started with a girl I went to nursing school with and having her be my person on the same level as me, starting on the same day, we should be on the same level. That was really, really beneficial because we feel there was an unsaid pact at the beginning. Like there are no stupid questions between us. Anything you need, “I’ve got your back.” I would say that has been really, really positive. Because at the end of the day, everybody I work with, everybody is at a different level. Everybody has their weaknesses, everyone has their strengths. Having someone who started with me, has been really nice because I feel like she has kind of like helped me through.

Two of the participants (Patricia and Thomas) told interesting stories of when they were in the post-orientation phase- immediate zone. They would purposefully get their work done early so they could help out other nurses they respected and looked up to spend time with them caring for the other nurse’s patients. They wanted to spend time with them to learn about their specific practices with patient care; they found that by “helping out” was a way to work side-by-side with them. Thomas stated, “These nurses were willing to share stuff with you.” However, since there was no time to do that, his motivation was to help them out with their patient care so he could learn from them. Patricia found this practice of finding other nurses to help out after she had cared for her patients was a way she learned about organization, clustering of care, and prioritization. She stated this “was how I learned and how I transitioned into it.”

Indirect relationships. An interesting dynamic was noted by the participants with regard to relationships between themselves and indirect others. These were relationships

that were observed by the advanced beginner nurses but did not directly involve them. Lisa stated, “I have heard horror stories of nurses yelling at each other but I have never experienced that.” Melissa, Ryan, Julie, and Gail also told stories involving an account with a friend or someone they knew from nursing school and included the friend’s experience in an encounter or situation as a new nurse with other nurses or physicians. These indirect accounts left impressions upon the new nurses even through their distance and indirectness.

Unprofessional behavior. Other interesting phenomena related to relationships were the cliques within units and nurses eating their young.

Cliques. Two participants talked about cliques--a group of nurses who gathered together and typically supported only one another. The behaviors exhibited within the cliques were described as a negative experience for the new nurse and left him/her feeling uncomfortable. Gail commented on her recognition of cliques and the negative image she was left with:

With that being said, my coworkers can also be a very big negative. I remember when I started, in being in such a big unit there is definitely cliques. People that like each other, people that don’t like each other. And trying to stay out of that drama, it feels like high school sometimes and I wish we could change it. But it is just kind of the way it is when you put that many people together, that many strong personalities, it’s kind of unavoidable. But I would say that was probably a big negative – the cliques. I feel like earlier I said I don’t know what it is, I don’t know if it is my personality, but I feel like some of the senior nurses have taken to me much more positively than they have to my fellow coworkers... My one coworker, she is like the expert. So she comes in to the room to help my friend. And [name of friend] had accidentally gotten rid of the one tube of blood that wasn’t quite enough to send off for labs and they retook it and got enough blood where they were going to add them together but she had already thrown one away. And the more senior nurse was like, “Are you serious? I just helped you and you just...” She made a mistake. It was totally unintentional. But a 6 o’clock in the morning brain, throwing away labs, not a big deal. But the next day, my friend wasn’t working the next day, and the next night the more senior nurse told me that, “I don’t know about her. She had a serious blonde moment

last night.” I was like, “Oh. Haha.” And she was like, “No but really, I don’t know about her.” And I was not just going to sit here and talk about this. And I am definitely not going to tell my friend because I know it is just going to hurt her. But it is just situations like that where I can just tell that.... I don’t know. It seemed cynical and innocent enough but being there and seeing it, there is like underlying more to it.

Melissa shared her perspective and accounts about cliques in her nursing unit as well:

You know, the people who were cliquish, there was a girl, she and I graduated the same year. She worked down in the ER too and she is very cliquish. And she blended in well. I did not blend in well with the cliques at all. And also it could be different where, because it’s smaller, where I’m at now ... Because down in the ER, people have been working together for 10 years plus. Sometimes it’s just hard to break in to a new group and become accepted or feel like you have to prove yourself. That you know what you are talking about or. You know? It’s kind of like “Mean Girls” too, I think. One of the gifts God has given me is I don’t really talk about people. I’m just kind of like a loner, I guess you would say. Or if I hang around with people, it’s around people who have a spiritual base or a spiritual bond. And you don’t have a whole lot of that down in the ER. It’s just like “Mean Girls,” really mean, catty. They’ll sit back and watch you run your butt off while they’re Face Booking on their phones. And then talk about you behind your back, like you suck or something.

From the two participants who talked about nursing cliques, the association with cliques was negative as it segregated the nursing staff into distinct groups and did not foster teamwork or communication. The presences of cliques made the new nurses feel uncomfortable whether they were part of one or not. They were also viewed as unprofessional from their perspective.

Nurses eating their young. Julie, Jessica and Gail mentioned the phenomenon of “nurses eating their young.” Jessica was alerted to this phenomenon in nursing school as others informed her that established nurses try to sabotage new nurses’ practice. Gail’s insight about positive and negative attitudes and behaviors involving others allowed her to summarize the following from her perspective, which addressed the codes of acceptance, respect, and trust:

Unfortunately there is still a culture of, I don't want to say they eat their young, but I feel like the majority of the older nurses, they will respect you but they won't have respect and confidence in you until they see what you can do. Whether that be, trusting you to take more difficult assignments, or trusting you to listen out for their patient while they go to the bathroom or take a break. I feel that, for some reason, that hasn't been shaken over the years-- that older nurses getting past welcoming us younger nurses.

Julie commented on her experience of nurses eating their young:

I know a lot of my friends who I've talked to have had a really hard time at other hospitals and stuff like that just because I think there is that mentality in nursing where the older people, they kind of eat their young. They are just miserable and mean and the new nurses have to somehow prove themselves to get the older nurses to like them.

Other negative relationships included two participants recalling incidents where they were "yelled at" or felt "fear of being yelled at" by physicians. Patricia said, "I did actually get yelled at a couple of times by doctors so it's practice makes perfect. I think everyone makes mistakes and we all learn from our mistakes." Melissa had never experienced being yelled at by a physician but spoke to the "fear of being yelled at." She said a nurse must learn "knowing when to call the doctor, when not to call the doctor and having to abandon the fear of getting yelled at." Many participants indicated that preceptors provided them with strategies and tips when it came to deciding when and why to call physicians.

In summarization of the process of shaping, connection with others was a multifaceted and significant component to the process of transitioning through the advanced beginner stage according to the participants interviewed. The preceptor-preceptee relationship was crucial as it was associated with support, trust, respect, and acceptance. Positive and negative relationships both impacted the new nurse's experience. Negative interactions or unprofessionalism were contingencies to connecting

with others and were barriers to this process. Engagement in relationships and the dimensions of trust, support, and respect were important in understanding how new nurses experienced progress toward independent practice.

Knowing

Knowing is understood as the progressive development of connoisseurship. Connoisseurship is a term very specific to the Benner (1984) Novice to Expert framework and one that fits well here as it is meant as knowledge and expertise. The consequence for knowing is competence. The dimensions of the process of knowing are knowledge base, application of theory to practice, and continued development. The context in which it is experienced is through conscious effort and concentration. Competence is present to some degree as the advanced beginner nurse presents as a new graduate. This empirical knowledge is gained in the didactic portion of the nursing program and the limited experience encountered during clinical practicums.

As described by the participants, situations and events encountered by new nurses prompted them to question their competence as well as provide strategies to build up their competence level. Strategies for self-educating, taking the initiative to seek out experienced nurses and offer to help them, or just watch and listen helped them absorb new knowledge.

Competence is known as a person's capacity to perform job responsibilities; whereas competency is "an individual's actual performance in a particular situation" (McConnell, 2001, p. 14). Competence is gained from learning through various domains—cognitive, affective, and psychomotor. Competence must be maintained and improved, which might be challenging in health care but must be continued as it is "an

essential ingredient in quality patient care outcomes. And although achieving and maintaining it is time-consuming and expensive, consider the cost of ignorance” (McConnell, 2001, p. 14).

The attributes to competence are having curiosity, readiness to know and willingness to ask questions, being open to seek help; knowledge, skill, and attitude; and becoming activity involvement. Experience in nursing, opportunities to link theory and practice, repetitive practice, confronting and engaging in challenging situations, nursing education, and clinical practice are elements that contribute to competence and competence development. The consequences of competence are self-satisfaction, respect, support, increased patient satisfaction, self-fulfillment, greater responsibility, performance improvement, and a greater sense of achievement (Ursuy, 2012).

To demonstrate how competence was experienced, Thomas provided this detailed example of making a conscious effort for a learning opportunity he experienced shortly after entering the post-orientation phase:

They [unit leadership] just assume that I’ve got this now, and it’s like “yeah maybe.” It’s interesting because that’s why I kind of like being able to help out the other nurses because we had a patient that was super sick, she was DNR [do not resuscitate] and she was going to pass pretty soon. Her kidneys were shot so she was leaking out of everywhere and I ended up jumping in with this senior nurse that was wrapping her and she had a triple [patient assignment] so I was helping her and just the 40 minutes or hour and a half that I was helping her with a couple of the patients I learned so much. Things like wrapping techniques and what to watch for, how to work the joints, and walked me through stuff and gave me helpful hints and I never would have gotten that exposure anymore, unless you help out these other nurses that are willing to share stuff with you. There’s a lot of technique stuff that you can try to figure out [through] your own method of doing something but having someone that can show you something that can save you time or save your back or help the patient better I feel like I’ve got to seek that out now.

Becky shared the same thoughts as did Thomas of strengthening her competence to learn from others:

You can learn from everyone. Every time you go to work, you learn something new or see something done by a different nurse in a different way that I wouldn't have thought of. Where you constantly have to be learning and knowing that there isn't one right way of doing everything. If you can see that, acknowledge it, and retain that, that is very beneficial in terms of shaping your own practice and how you go about things--just watching everyone.

Heather shared a similar experience:

You're starting to build your practice. So you see how this person does it and you're like "Oh I like that." Then you see how someone else does it and you might tweak it, change it a little bit and different perspectives along with your own build your own practice. I personally had several preceptors, but you're assigned to one main person that would be your go-to person if you really needed to find someone. They'd be your first call.

Patricia also took it upon herself as a new nurse just off orientation to learn from experienced nurses in real time:

I learned prioritization by watching my senior nurses. I was seeing what they would see as a priority over others. I used to always try to be a helping hand with others after I had taken care of my patient, I would always go and find the other nurses who were still in patient rooms and hadn't taken a lunch break yet, and I would go and help them and observe them--of how they took care of their patients.

Competence was also demonstrated as learning from your experiences with patients. Patricia claimed to learn something every day from her patients. Lisa commented on learning from experiencing the death of a patient:

We had an old patient that passed away, I felt really good about being there for this family, to offer the support and open your [my] heart to the family. It was an amazing experience both times I got to experience it, I felt privileged that I was allowed to share it with the family and I took something out of that, that I think positively impact my entire practice.

Gail associated competence as challenging her knowledge and self-confidence in her ability:

I feel like throughout my two years of experience, the greatest lesson I learned was knowing who my resources are and how to pick out the right resources and having that balance between having confidence in yourself but knowing when your competence isn't there and seeking the help you need to make it safest for everybody... On our floor we are allowed to pick our own assignments. We get a mini report and pick our assignments. So it was very much a learning curve as far as having the confidence and guts to seek out the challenges but having my coworkers push me in that direction too.

Gail had the support of her coworkers as they encouraged her to accept new challenges and opportunities for learning. At the same time, she was conscious about patient safety as she was aware of her competence and abilities in her independent practice.

Competence is noted to be deliberate actions and initiatives taken by the advanced beginner nurse. Enhancement competence is the new nurse seeking learning opportunities or any opportunity to learn something new, reinforce something, or refresh. These experiences are gained from a variety of sources--preceptors, mentors, coworkers, experienced nurses, and patients. Becky confirmed this, "I just knew that I needed to continue to go to work and get that experience, so that I could become more comfortable." This introduced the relationship between the processes of knowing and growing with a direct link of becoming more comfortable as the result of increased competence and self-confidence. New nurses commented on the relationship between competence and comfort. Heather stated:

Well, for me, my critical thinking just got better with time because of experience, just like anything else. I saw more things, I remembered I had seen this with that patient and this had happened. For me it's just been an accumulation of everything that I've been exposed to. Learning the disease process more, learning your nursing skills more, it just helps my critical thinking because I feel now that I'm kind of a step ahead. Not always, of course, but with some things and especially the types of patients that I've had a lot. But I definitely think that, and I hope, that my critical thinking will just get better throughout the years. And stronger.

Thomas further commented:

It's different when you're in clinical because you're kind of just watching and you've only got one patient or maybe two patients but it's not the whole shift. Even back in our first semester we would leave at 3pm and we would start at 7am at the beginning of the shift, you really didn't get to see that end of the shift and how that actually goes down. I think that part is always kind of funny, that last hour between 6pm and 7pm is when something always happens even if you're trying to be all ready--things getting out of hand still happens. No matter how organized and ready I think I am--something always blows off of someone's body or stuffs flying everywhere and I'm just like, "Oh, why does this always happen to me?"

Melissa addressed competence and the process of knowing in her statement:

That is still coming together [for me], I learn by experience. I need to go back to my memory and say, "I remember this and this is how we handled this before." Sometimes there is brand new stuff that comes up that I don't know how to do. I think intuition is something that develops and I think I am getting better at it but initially I wouldn't know where to start. Whenever I have a patient that is like a train wreck, which we may call it, it's like what to do first? That prioritization has gotten a lot better.

Her comments about this process still coming together demonstrated it was still a work in progress and it was not at a competent level for her yet. She talked about recall and association to prior experiences to try and make sense of the situation. She also recognized that sometimes new, unfamiliar situations come up still from which she has no prior knowledge to rely upon. As she spoke about prioritization, she questioned the order or priorities, which indicated a need to really concentrate on deliberate thinking.

Caroline stated,

Well, I was substitute teaching while my children were younger. I had a...my first degree was in French, so it's completely different from nursing. So, I have experience with kids in the school setting. So, I brought that experience with me and dealing with balancing lots of things at one time, prioritizing things, and also as a mom too. So, I knew the population as far as their developmental growth and all that, but not with sick kids. So, I brought that experience. You think maybe that helped a little bit too in my confidence. Yeah and competence.

I think competence goes hand in hand with having some confidence too. In knowing that you do know what you're doing (laughter) and that takes a while as a new nurse I think. Especially someone who has no experience before in nursing. I was never an aide, I didn't have any kind of experience at a hospital except for clinicals during nursing school. So, and with the pediatric population too, their status can change really quickly if they're going down and having something very scary happen. Just being able to evaluate and do your assessments and evaluate and feeling confident and being able to talk to the doctors, talk to the medical team about your assessment and how you think things are. Being able to advocate for your patient too and feeling confident that you are advocating for the right thing for them. I think that's ongoing, for me, it's still ongoing after two years. But I feel confident in my role and I feel like a good nurse. But I think it's an ongoing thing. I don't know. I think after two years – I'm not sure how other nurses, older nurses would feel.

In retrospect, Gail, who was comfortable in her role, was able to appreciate the stance of new, incoming advanced beginner nurses and spoke to the priorities of the brand new nurse in comparison to herself and level of connoisseurship at that present time:

In watching, especially the new nurses coming on now, and now that I have some experience under my belt, I feel that sometimes the hardest thing is getting [understanding] the critical thinking and remembering that is the first and foremost thing and forgetting about the tasky things. I feel like sometimes new nurses struggle with "Ok. I just want to keep up on my tasks. This is how I am going to time manage." But at the end of the day, if your kid doesn't have a blood pressure--THAT is the more important thing. You can back chart, you can give those antibiotics later, it is not a big deal. The most important thing is--where is your kid hemodynamically?

From the participants' comments, the experience of the process of knowing was closely linked to the process of growing and linked back to the process of shaping. The element of time was a factor with respect that experience occurred over time through the orientation and post-orientation phases--this was specifically when and where conscious effort and concentration occurred through competence. Knowledge base, application of theory to practice, and continued development were the means by which the process of knowing was experienced and resulted in the outcome of progressive development of connoisseurship. The barrier identified in the process of knowing was negative

interaction, which might delay development of connoisseurship. The process of knowing was demonstrated to be linked to patient safety and quality of care provided in the acute care setting.

Growing

The way that growing is understood is by the concept of refining awareness. This is experienced as the balancing of skills and ability with experience. Experience occurs through the element of time, which is a constant factor in the process. The consequence is self-confidence; it is dimensionalized as the ability to perform the role of the nurse and is impacted through external reinforcement and through the accomplishment of professional goals. Aside from the process of shaping, the process of growing is a highly significant process in the advanced beginning nurses' experience with the sense of becoming as evidenced by each participant discussing their level of self-confidence at some point during their interview.

Self-confidence in nursing has been conceptualized as being strong in clinical skill acquisition, clinical decision-making, collaboration, autonomy, and professional socialization (White, 2009). It is generally defined as "the belief in oneself and in one's powers and abilities" (Self-confidence, 2014). Precursors to self-confidence are support, knowledge, experience, "gearing up," which refers to preparing to approach the situation, and success (White, 2009, p. 110). Perry (2011) added perceived readiness, personal goals, situational role, emotions, and adaptation as antecedents to self-confidence in nursing. The nursing literature indicated education, some level of skill acquisition, exposure to situations, practice, involvement and interaction, positive self-talk, encouragement, and validation from experts must happen and be present for self-

confidence to build. Self-confidence is characterized by persistence, belief in positive achievements, and self-awareness (White, 2009). Positive attributes of self-confidence are emotional intelligence, confidence, attitude, trust, intuition, and resilience. Negative attributes are uncertainty, doubt, negativity, depression, and narcissism (Perry, 2011). If self-confidence is not fostered, then self-doubt might result (Perry, 2011; White, 2009).

Patricia talked about her experience on orientation and lacking self-confidence: “I didn’t have the confidence in what I considered good critical decision making skills. So I relied a lot on the seniors nurses, well the charge nurses.” She also stated she lacked self-confidence in communication with physicians. She reiterated several times in the interview how her lack of self-confidence “was a big, big gap to get through.”

Experience was a precursor to adequate to high self-confidence upon starting the new role. Caroline described the process:

I think actually, I’m not sure how long it takes, but I do feel confident. I feel like a confident nurse, but it took a while to get to that point and to have the confidence. I think competence goes hand in hand with having some confidence too. In knowing that you do know what you’re doing (laughter) and that takes a while as a new nurse I think. Especially someone who has no experience before in nursing. I was never an aide, I didn’t have any kind of experience at a hospital except for clinicals during nursing school. So, and with the pediatric population too, their status can change really quickly if they’re going down and having something very scary happen. Just being able to evaluate and do your assessments and evaluate and feeling confident and being able to talk to the doctors, talk to the medical team about your assessment and how you think things are.

In reflecting on her transition to independent practice, Becky commented that the experience was “just an overall increase in how confident I felt” relating to communication with others, her critical thinking ability, and prioritization of the care she provided to her patients. Julie said it was “time on the unit” and experience that helped develop her self-confidence. As a new nurse, Tamara found an increase in confidence in

communicating with parents through repetitive teaching opportunities in the emergency department setting. She said, “I feel that my greatest involvement in my practice has been my confidence. I was very nervous at first ... I now feel stronger, smarter, and can respond quickly to emergent situations.”

Jennifer commented on how collaboration with other nurses in a critical situation helped build her self-confidence: “I think that the support from the other nurses on the unit and just collaborating with them really helped not only build my confidence and build my skills, but to help a better end result for this particular patient.”

In the post-orientation immediate zone, Gail talked about self-assigning patients on her unit and building self-confidence in that period of time: “It was very much a learning curve as far as having the confidence and guts to seek out the challenges [patient] but having my coworkers push me in that direction too.” This demonstrated what the literature described as support from experts and gearing up.

With regard to challenges to development of independent practice, Becky introduced the notion of self-doubt with her comments:

I think still having that unsure feeling every once in a while. If you're faced with something, even just a lack of confidence with certain things still. You have to give yourself a little bit of credit, but if you start doubting yourself other people can see that and feed off of it. If you don't allow yourself to own it and move forward, you are putting up a wall without even realizing it.

Learning from mistakes also built self-confidence. Amy had an experience while on orientation with a “hands-off” style preceptor in which her self-confidence declined:

I had a particular patient that was kind of going downhill, wasn't getting the treatment that she needed but I wasn't in the know-how to advocate for what she needed. I felt like I wasn't getting the support from my preceptor to do that. So everything ended up being fine with the patient but I lost my confidence with that. It was almost towards the end of my orientation, so it kind of kicked me in the butt a little.

If new nurses were uncertain about skills, nursing judgments, or made mistakes, then debriefing with a trusted preceptor helped this become a learning experience and enhanced self-confidence (not going to make that mistake again). Self-confidence had grown and developed insidiously in the new nurse. As Heather described, “I went to work. This is what I had to do and you surprise yourself when you just know the answer. When before it was like ‘What’?”

Thomas’ self-confidence was impacted by uncertainty about how his performance was viewed from nursing administration: “So I don’t really know how I’m sitting with management so it’s hard to have any confidence.”

Jessica commented on the power of believing in one’s self as she stated:

The biggest thing is confidence. If you’re not confident in your decision-making skills, if you’re not confident in the way you’re expressing yourself, then I don’t think people are going to necessarily listen to you or take your opinion seriously if they don’t think that you believe in your own opinion or your own voice.

She continued, “The one thing that really helped promote my confidence was when I got my first compliment card” from a patient and family thanking her for her care and being the patient’s “favorite nurse.” This reinforced the need for support to develop self-confidence.

During the orientation and post-orientation phases, self-confidence is at a level that needs to be built up. Situations and associated outcomes could build it, neutralize it, or break it down. New, challenging encounters with patient conditions and events and the new nurse’s role and performance in those situations impacts self-confidence. Barriers to building self-confidence or instilling self-doubt might be through negative interactions or witnessing unprofessional behaviors.

In the post-orientation comfort zone, Julie found her confidence continued to build as “people start to look towards you as a resource or ask you opinion ... you feel like ‘oh they actually value what I think and they’re asking me’ and it makes you feel better and it helps you gain confidence with stuff like that.”

Gail told a story of a new nurse hired onto her unit who had struggled with confidence in her transition: “I feel like because it hasn’t been that long [for me], I can totally relate to that. I have just been trying to pump up her confidence.” Gail in turn was showing support for other another new nurse.

The experience of the process of growing was vividly demonstrated in the participants’ stories. The element of time continued to be a factor as the orientation and post-orientation phases were instrumental in facilitating opportunities for experience. The new nurse’s ability to perform the role, external reinforcement through the connection to others, and accomplishment of professional goals served as facilitators to the process of growing. This resulted in the outcome of refining awareness. Heather commented that you come to “be aware” pretty easily and quickly as to “who you can count on” to be supportive. Julie also mentioned that “you develop an awareness for other people” in case others need your help.

Advancing

Advancing is quite simply to reach for a higher potential. Advancing is the last of four processes to occur in understanding how an advanced beginner nurse experiences the sense of becoming. The context in which it is experienced is referred to as professional development. The consequence results in empowerment. Empowerment can mean different things to different disciplines and different populations. The most simplistic

definition is “to enable to act” (Chandler, 1992, p. 65). This is the transition from dependent to independent practitioner.

Empowerment is known in many ways to the nursing profession. There are different meanings depending upon the context and perspective of the source and use of it; nonetheless, it is a potent tool that influences nursing quality of care and patient safety (McCarthy & Holbrook, 2008). As the category of empowerment emerged, it was closely aligned with the work by Manojlovich (2007) as she researched the many types and theories of empowerment; empowerment is meant as a psychological experience and is described as a motivational construct and a personal attribute. Empowerment in this context was viewed as enabling and motivating through the enhancement of personal efficacy. Empowerment in this form linked the nurses’ beliefs, values, and behaviors to their job requirements; it was known as a process of interaction between the nurses’ work environment and the nurses’ personality characteristics (Manojlovich, 2007). The consequences to empowerment in nursing have been identified as higher career aspirations, increased risk taking, and achievement orientation; while a lack of empowerment results in frustration and feelings of failure (Rao, 2012). It is a strategy for increasing performance and job satisfaction in the nursing and general management literature. A strong relationship has been shown between empowerment and work satisfaction (Spence Laschinger, Wilk, Cho & Greco, 2009). In becoming empowered, it was realized by Gail who stated:

I remember on orientation, one instance, where my preceptor was very adamant about not being in agreement about what our one doctor was saying. And kind of advocating heavily for the patient and I remember looking at her and I was like, at what point am I allowed to contact the doctors the way you do? And she was like... It was kind of a half joking question, half serious. She’s like, “Gail, honestly, as soon as you want – go for it. This is what you are geared for.

Yesterday you should be.” And I remember it definitely was not something I was able to do for a while.

Over time, she was able to keep gaining experience; as time went on, she was able to build up to this level of empowerment and then put into action the skills and ability she had been trained to use. She concluded her story with a situation she experienced about six months after her orientation ended:

I had been following this patient for a couple of days and there were a couple of things definitely on my mind... I wanted to address in report during [physician] rounds. I remember rattling off this mini-list, it wasn't that many things, but I remember being like, “Oh, there are a couple things I am curious about or wanted to talk about.” And I remember one of the attendings, who is really well respected, she's probably one of my favorite doctors ever. I remember her looking at me and she was like, “Wow Gail, that's kind of... I think she used the word aggressive but not in a bad connotation.” She was like, “You're kind of aggressive this morning, I like it!” And she was like, “Welcome to the PICU” and walked away. And I was like [to myself], “Oh, Ok, that is how it is supposed to work. It took me a while, but I got there.” The attending then said, “I've never seen this side of you before.” I was like, “Do you know who my preceptors were?” And we just laughed about it because once I told her what nurses had precepted me, it all made sense [to her].

Becky shared a moving story of an encounter she had with a patient and described how she professionally developed from the experience:

I have been in a code before and it was my patient that coded while I was holding him. You think you know what you are doing and you get in your groove and then you have a curveball that is thrown at you that makes you take a couple steps back and acknowledge that I'm still learning and growing as a nurse. You are never going to know everything. You never know what your patients are going to do. So while you do have an increased confidence, you do feel more comfortable, I think it is important to remember that you should never feel too comfortable. While the code was a really stressful shift and stressful couple of hours, looking back on it, I am really glad that it happened.

The influence of mentors through support, belief, and challenge results in the new nurse empowering him/herself. Gail stated, “I feel as though some of the mentors I do have on the unit pushed me towards more challenging assignments.” She further

explained that “I feel sometimes they almost have more confidence in me” than she did herself. She highlighted a story that was meaningful to her when she realized that she had realized how empowered she had become:

I was taking care of a kid who was pretty sick and I just remember the charge nurse, the rapid response nurse, everybody kept checking in on me because they knew my kid was really sick and I was like, “Ok. If you want to help me you can. I was able to delegate to people. And it was one of those situations where the kid was kind of crashing but I was able to delegate and people were able to recognize that I had it under control and ultimately, it worked out to be ok. But I feel like the way they, the older nurses, were receptive to me, was I was like, “Wait a second, you’re going to take orders from me and you’re not going to try to take over this situation yourself. It was “You’re fine, you’re fine, just tell us where you want us to be.” And I feel like the person who had the best perspective on that was the patient’s mother. Who, a week or so later once he was doing better, she was telling me that, it was one of my coworkers who told me this, that she had been bragging about me all week saying that, “That little nurse was running around. I felt like she had it under control.” And, I don’t know, I feel like it was one of those situations where I was like, “Ok, I finally have made it.”

Heather commented, “For me, it was time, it was experience, and it was something that snuck up on you. Then you just realize that when you stop to think, ‘Wow, I feel like I’m a real nurse. I feel confident. I feel like I know what I’m doing’.” Her comment addressed each process; she addressed the element of time in relationship to the context of the advanced beginner stage and the progressive movement of moving through shaping and concluding with advancing. The insidious onset spoke to the process of growing as well as confidence. She also pointed out that she felt she knew what she was doing, which addressed the process of knowing.

In addition to feeling they had reached a level in their everyday clinical practice, the participants also shared accounts of beginning leadership activities in which they have participated. Heather and Becky shared they were very instrumental in the

implementation of a hospital-wide electronic medical record and that they were “super-users” for the program and resources for their units. Becky commented:

I remember one day charting; I ended up having one-on-one time with our most senior nurse on the whole unit. It was just the two of us and it was just funny that of all the people in this unit, the most senior nurse and I are sitting in this room. She has a ton of questions about the charting system and I knew that I would be able to help her with that. It makes you feel good knowing that you can help someone. Knowing that if we both went out working on the floor and I had a question about how to take care of a patient, she would be one of the first people I would go to and ask and she would be more than happy to help me.

In Becky’s reflection, the categories of respect, sharing of experiences, and support were brought forward through her account of this empowering interaction. Being involved with unit-based committees and hospital projects provided opportunities for professional development for the advanced beginner nurses within the meso- and exosystem levels.

Seven of the participants stated they were involved with mentoring activities on their unit for either high school student groups or nursing students in an ADN or BSN programs. None of the participants had yet precepted new nurses hired into their unit. Heather had also stated she had been trained for charge nurse responsibility through a one-week orientation to the role that occurred about a year and a half after starting on the unit.

The common theme among these experts was the accomplishment of finally realizing they had advanced to the higher potential they had been working toward since they started working on the unit. Finally, they had achieved a level of practice they had envisioned for themselves back in the pre-orientation phase. They had finally sensed they had developed and advanced to a higher level as evidenced through statements of “I finally made it” (Gail).

Participant Characteristics

This was a subjective assessment on behalf of the researcher; it emerged out of the interviewing process and common themes that became apparent. Through the interview process with 14 nurse participants, the researcher identified three distinct participant types: (a) participants who were passionate about their role as a nurse, (b) participants who were passionate about advancing their nursing career, and (c) participants who were content but still trying to find themselves and where and how they fit as a nurse.

The participants who were passionate about their role as a nurse shared the following qualities: they were very enthusiastic to be interviewed; demonstrated happiness in their voices when talking about their RN role and experiences; their demeanor was welcoming, positive, upbeat, and trusting; they voiced a love and thankfulness for their job; they provided vividly clear and detailed stories and spoke candidly and unrestrictedly about their role, patients, and fellow coworkers; and shared explicit examples and information without hesitation or reservation. The researcher subjectively determined that five participants belonged to this category based on their demeanor and characteristics, which clearly defined this category as a group who displayed true, genuine passion and enthusiasm for their nursing role and chosen career: Lisa, Becky, Gail, Tamara, and Melissa.

The next group of participants was passionate about their nursing career and their future trajectory. This group demonstrated enthusiasm, positivity, and passion as well but toward their own personal agenda for future plans and goals that included graduate school and advanced practice roles such as certified registered nurses anesthetist

(CRNA), family nurse practitioner (FNP), and acute care nurse practitioner (NP) as opposed to their current RN staff role. They demonstrated happiness in their voices, their demeanor was welcoming and positive, but not as trusting due to the fact that their stories and descriptions were not as detailed or clear. The researcher had to probe for more detail when discussing their experiences in their current role. This group tended to have shorter interview sessions as it was challenging for the researcher to abstract rich narratives from them as compared to the group previously described. The researcher felt the following five participants fit this description as a result of their interview demeanor, responses, and characteristics: Patricia, Heather, Jennifer, Amy, Jessica, and Ryan. These participants stated they had an agenda that took them beyond their BSN degree and current role as staff nurse. Each of these participants was accepted into a nursing graduate degree program with a fall start date or already enrolled in courses for the Master of Science in nursing nurse practitioner (NP) program or doctorate of nursing practice (DNP) with BSN entry program.

The third group of participants demonstrated contentment in their role. They neither voiced elements of passion about their nursing career, the nursing profession, their patients or unit, or their future trajectory. They spoke of stability with their role; yet, they were still searching for what and where they still fit in. They were neither happy nor discontented where they were now; they were not seeking a change at this time and wanted to maintain their present position. They were uncertain of the future as far as a personal, family, and professional life. The researcher categorized four participants into this group based on their interview responses, demeanor, and characteristics: Caroline, Julie, and Thomas. They were content in their current role but wanted

increased comfort with self and the RN role before entertaining notions of returning to school, role advancement, unit transfer, or increased responsibilities in their current role or within their unit.

In addition to participant types was the theme of personality. Several participants referred to the “type of person(ality)” they possessed. Jennifer directly stated, “I have a pretty strong personality” as she described how she became an ICU nurse. Lisa had wondered if her personality was a good fit for the unit while she was on orientation. Julie commented that she tends to gravitate toward others (nurses) with similar personality styles as hers: “I know three people standout in my head, who I idolize as a nurse ... They’re someone who I always turn to if I have questions.” She also stated that it is her nature to keep busy during work: “I had done my externship and I had worked as a tech all through college so I knew I didn’t like sitting down. I knew I liked when it was busy, I liked to be very proactive.” Jessica stated she had become more assertive since she started working as a RN and that the orientation helped bring that out in her personality. Gail also talked about her personality in reference to being accepted and “taken under the wing” of senior nurses as compared to her advanced beginner peers who were not “taken in.” The only types of personality characteristics that were verbalized were assertive, strong, and keep occupied. Participants did not state any other descriptors that were similar or contrasting. Personality types would be an area for further research among this population of nurses.

The working framework began with Benner’s (1984) stages in the top row parallel to the phases outlined in the findings of this research on the second row. The pre-orientation phase is equal to Benner’s Novice stage. The orientation and post-orientation

zones aligned with Benner's advanced beginner stage. Personal characteristics were placed below as they transcended through the elements of time and impacted each area. In the first column are characteristics of Benner's model. The researcher aligned these with the concepts that emerged from her research. The concept of relationships did not align directly with any of the characteristics of Benner's model; neither did the concept of empowerment or personal characteristics. Two of the three characteristics in Benner's model did align: safe practice/perceptual awareness to the concept of self-confidence and connoisseurship and knowledge to the concept of competence from the research. As the grid was populated, sub-concepts populated the grid for their respective concepts in relation to time. Personal characteristics was not a component researched in this study but was noted as an additional finding. It was included as an element that should be considered as it transected the stages and was present for all points in time.

Role satisfaction (including stress and support) was a precursor to the research. When reviewing participant characteristics, there was a link to what was observed and noted in their interview tone, body language, and attitude. The first group was observed to have high satisfaction, the second group had low satisfaction, and the third group was mixed at this point--content but did not know their true satisfaction status.

Professional socialization was learned here at the same time--the learning of norms, behaviors, roles, values, ethics, and status of cultures. This led to professional identity and was reinforced with Gail's statement of "do you know who my preceptors were?"

In following the pattern of the interview questions, the participants stated the attributes they most *wanted* in orientation of their new role were guidance, self-

confidence, experience, to understand (population and normal day), and feedback. The attributes the participants indicated they most *needed* in this phase were support, resources, and coaching. What the participants felt they *received* were relationships or connections to others, most importantly a preceptor-preceptee relationship--a connection to another RN and someone to “show them the ropes” or guide them in everyday practice. They also realized at some point in the advanced beginner stage they developed a greater sense of self-confidence and their competence level rose. Furthermore, the combination of relationships, self-confidence, and competence eventually led to empowerment. It was empowerment that launched the independent sense of practice and led to the comfort zone.

Selective Coding

The last step in the coding procedure was selective coding--the identification of a single category identified as the central phenomenon. It is this phenomenon, the essential core concept, in which a story is constructed around. This core concept has the power to elucidate many aspects of the situation at hand. Furthermore, it is the development of hypotheses or propositions in relation to the model, also referred to as the “process of integrating and refining the theory” (Strauss & Corbin, 1998, p. 143). Propositions are the links or glue that bind categories and properties of the model. These propositions interrelate the categories of the model. With this, the researcher was able to select and integrate the categories into a model and form a visual model (see Appendix E), which enabled the development of a narrative statement or storyline. It is the way in which the theory is explained (Creswell, 2007; Willig, 2013).

The selective coding process focused on just one core category as the new focus for analysis—advancing in a new professional role. The core category emerged from the coding process as the most saturated, relevant, and powerful variable because it connected the other categories together to form a whole.

Selective coding is at a more abstract and discriminate level of analysis and is described as the “process of integrating and refining the theory” (Strauss & Corbin, 1998, p. 143). This step integrated all of the interpretive work in the analysis. The purpose of this stage of coding was to explain the story line, which described the central phenomenon (Strauss & Corbin, 1998).

Recall the general meaning of what *becoming* is--a process of changing and starting to be something different. More aesthetically consistent is Aristotle’s belief that becoming means “any change from the lower level of potentiality to the higher level of actuality” (Becoming, 2014, p. 1). The sense of becoming was applied to Benner’s Novice to Expert (1984) framework, specifically to the advanced beginning nurse stage. Therefore, the first research question at hand was “How do advanced beginner nurse experience the sense of becoming?” To address this question, one must recognize that becoming is a process that spans over time. It does not specifically begin and end within a stage nor does it have a minimum or limit to the length of time it occurs.

The orientation stage starts with a new graduate nurse (waiting to write the NCLEX-RN exam) or a new registered nurse (passed NCLEX-RN exam) hired into an acute care hospital unit. This process initiates with a constructive connection to others, specifically between a new nurse (novice) and an experienced nurse; the connection between the two nurses is a major element in this structure. If it is amenable, there will

be positive outcomes for both parties. If there are any negative instances during this connection, then there may be barriers to growth. Upon establishment of the connection to others, the condition of working together is formed. Positive relationships exhibit the qualities of support, trust, respect, and acceptance. Support is experienced as responsibility, feedback, debriefing strategies, and being a resource to others. Each nurse involved in the process brings a degree of competence, self-confidence, trust, and factor of empowering to the assembly. Both share common goals--safe, high-quality patient care. The new nurse is seeking to gain knowledge and grow closer to an independent RN practice for him/herself. The new RN looks to the more experienced nurse to shape him/her into a strong, knowledgeable, new independent RN to work on the unit for staffing. The new nurse is focused on developing into the best nurse he or she can be and being an independent practitioner. As time passes, the advanced beginner nurse engages in more patient care on the unit; experiences more routine, varied, and diverse encounters; and becomes accustomed to the routine and flow of the unit. The process of growing and the application of knowing (in multiple ways) are occurring. There is an increase in ability and responsibility that perpetuates a refining awareness of self and promotes self-confidence in the activities of thinking and doing. There is evolution in the new nurse's trust of him/herself as time passes and the more he/she has seen and done. Over time, this experience leads to change in the new nurse and is exhibited as empowerment. Empowerment has been fostered through increasing competence, the building of self-confidence, and the employment of trust. It is gradually rendered as the new nurse engages in and accepts the transfer of power and responsibility to him/herself from his/her preceptor in the managing and delivering of care to patients. The outcome

of empowerment is to reach for a higher potential. The transition that has occurred over this orientation time period is a change in the new nurse from a state of dependence to a state of independence in a new professional role--patient care practice. More specifically, the new nurse has reached a point of being self-reliant and autonomous in his/her thinking and actions. He/she has progressed to a state of being where he/she comes to *own* his/her practice. When orientation is complete, the preceptor-preceptee relationship is dissolved. A mentor-mentee relationship might evolve, it might be the “go-to” person relationship, or it just might become a peer-to-peer coworker relationship.

Barriers to the processes are negative interactions and unprofessionalism, e.g. recognizing nursing cliques on the unit consisting of experienced nurses only, being yelled at by a physician or a family member, or having a preceptor with a “hands-off” precepting style that did not align with the new nurse’s wants and needs.

At this point, many new nurses do not appreciate a level of comfort in the RN role as he/she is still transitioning through the advanced beginner stage, i.e., he/she is still advancing but in an independent context versus dependent context and not under the direct supervision of an experienced nurse. The new nurses are humbled to know they do not know all there is to know and they have not experienced all there is to experience. They remain open to learning and gaining experience during this post-orientation phase: the immediate zone time period. Time, practice, and exposure are elements to advancement in this phase that is felt to last 12-18 months. As time, practice, and exposure occur, the nurse begins to realize his/her awareness is heightened, he/she realizes he/she knows more than he/she/did when he/she first started as a RN, and he/she is more confident in him/herself as a whole. Thus, the process of the change from the

lower level of potentiality to the higher level of actuality, the advancement in a new professional role, is quite simply the sense of becoming.

Theoretical Memoing

Writing about what was being observed in the data, keeping track of ideas, relationships between codes, and emergent concepts was the basic premise of memoing in GTM. There are no rules in memo writing; it is a free flowing of ideas, a purging of consciousness, and constant thoughts throughout analysis. It was also the reflection on one's role in the research process (Glaser, 1992; Strauss & Corbin, 1990).

The important task of memoing was accomplished through several techniques. For the first strategy, the researcher read through the data, listened to the participant talk, and coded the data line-by-line. To accomplish this, she underlined words and phrases in the hard copy interview and made notes or memos in the margin. This technique of memoing was a way of recording her initial ideas, posing questions, making connections within and between the interview data, and diagramming rough sketches. "The researcher uses memos to augment data with analytical ideas and as the primary record of data analysis" (Schreiber, 2001, p. 72). Memoing began after the first interview to capture ideas (Corbin & Strauss, 2008). After open coding an interview, the researcher went to her notebook journal and added an initial entry. This was the researcher's second entry and included her ideas, thoughts, and perceptions of the codes brought forth in data during the open coding. As the researcher entered the second-level open coding, this same process was followed and included more theoretical and conceptual ideas relating to the second-level codes.

A second strategy for memoing was used after several interviews were transcribed and coded; the researcher reflected on all she had heard, read, and memoed. The researcher drove a long distance in her car, turned on the tape recorder, and started talking aloud to herself about the patterns, comparisons, contrasts, and gaps she had noticed in the whole of the data at that point in time. She went by memory and reflected on all of the data. She felt when she did this that she was looking at the forest instead of an individual tree. She practiced this on a weekly or bi-weekly basis during the coding process. During this time, she reflected back to the literature review in Chapter II. The researcher felt when she was away of the data and not directly in her sight, she had a deeper theoretical appreciation for what she had already researched and knew about an element and how it might or might not relate to the data and what was emerging from it. It was then that the author could identify areas of strength and weakness. This was especially useful in knowing how to refine and structure the next interview.

Standards of Validation

Strauss and Corbin (1990) stated there were four primary requirements for judging GTM: (a) fit, (b) understanding, (c) generality, and (d) control. The validation of fit pertains to the phenomenon of advancing being carefully derived from the collected data and supporting the reality of the sense of becoming, ensuring the emerging theory of advancing in a new professional role could be understandable to others vested or not familiar with the transition experienced by new nurses. Generality includes the variation and abstraction of the phenomenon to be applied in a variety of contexts. Control, as a standard of validation, identifies the conditions for which the theory of advancing in a new professional role is applied and provides for a reasonable basis for action. Thus, in

the process of moving back and forth in the constant comparative method of analysis between the data and ongoing participant interviews, it was determined by the 14th interview that no new codes, concepts, or categories would be found. Three member checks were also performed to verify and validate the ongoing axial and selective coding processes.

Theoretical Saturation

Theoretical saturation was the term used to describe when enough data had been acquired to develop each category or theme to its fullest in terms of properties and dimensions as well as account for possible variations (negative case). There are no defined rules for this; however, when the categories did not yield any new information, were well developed, and redundancy occurred, saturation was achieved (Corbin & Strauss, 2008; Schreiber, 2001). Saturation also constituted the point when concepts and relationships between them had been verified, there was no need for any additional data, all aspects of the theory remained hypothetical, and the conceptual boundaries were marked (Morse, 2004). It has been said, and depending upon the topic, 8 to 24 interviews are the average number of accounts where most studies achieve a saturation point (Riley, 1996).

Challenges

Challenges for GTM were anticipated by the researcher--one being aware of her own personal bias. To work through this, the researcher used reflexivity throughout the entire research process. It was also important for the researcher to follow the systematic method of inquiry of Strauss and Corbin methodology (1990) to ensure proper steps of data analysis were followed. Any variation or deviation would have resulted in the

researcher committing theory slurring or blurring, thus contaminating a pure qualitative data analysis (Evans, 2013).

Other challenges anticipated were theoretical saturation and sufficient detail in the theory. Theoretical saturation was reached through 14 interviews as no new concepts or categories emerged with successive interviews and the theory that emerged held true for them (Creswell, 2007).

Chapter Summary

The three-step constant comparative analysis process of open coding, axial coding, and selective coding in Strauss and Corbin's (1998) grounded theory methodology yielded a story line that incorporated the four processes of shaping, knowing, growing, and advancing. These processes were supported from excerpts from the participant interviews. The 25 categories and the core concept of advancing in a new professional role emerged from the constant comparative analysis but the theory was constructed and built by the researcher from the analyzed data (Corbin & Strauss, 2008).

Shaping was defined through the connection to others, specifically relationships that supported working together to facilitate independent practice. The process of knowing was experienced as a conscious effort; concentration in thinking and judgments related to competence resulted in the progressive development of connoisseurship and advancement within the Benner (1984) framework. Growing was associated as self-confidence, which was increased through the new nurses' ability to perform his/her role in conjunction with external reinforcement and resulted in accomplishing professional goals. This transition of balancing skills and ability with experience produced a refined awareness of the new nurse. Finally, the process of advancing was defined through

empowerment, specifically by speaking up, doing, and improving in clinical practice. The process enabled the new nurse to reach for a higher potential. Transition through these four processes was how advanced beginner nurses experienced the sense of becoming.

The intervening conditions were categorized as facilitators or barriers as they explained the relationship between processes. Facilitators were positive relationships, trust, respect, acceptance, feedback, the strategy of debriefing, resources, and increasing assumption of responsibility. Barriers were instances of negative interaction and unprofessional behaviors directly or indirectly experienced by participants.

These findings were refined, interpreted, and integrated into the substantive-level theory, which presented the participants' stories expressing their experience on transitioning from a new nurse to an independent practicing professional nurse and how that was experienced by them at a particular point in time. The core category of advancing in a new professional role offered a plausible explanation about the experience of the sense of becoming for advanced beginner nurses.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Who you are is shaping your so-called reality. When you change—
the world changes with you. Bryant McGill

The premise of this work was to understand how the sense of becoming was experienced and influenced by advanced beginner nurses. The author's interest in the sense of becoming was to learn the processes or mechanisms for surviving and thriving among advanced beginner nurses in their first RN position in an acute care setting as they figured out "who I am" as a nurse and navigated through their expectations of the professional RN role.

It was believed by the researcher that the transition through the advanced beginner stage might have been a time of vulnerability and fragility for new nurses working in acute care settings. It was further believed to be a time when the most learning and growth occurred for nurses. Compounding this sensitive and critical period in a nurse's career, it was speculated this time was when new nurses felt the pressure of developing a positive personal and professional identity, building of confidence, and becoming socialized into the nursing profession, all while meeting the demands of providing high-quality, safe patient care. A better understanding of how the "sense of becoming" during the critical transition period in new nurses' careers might reveal evidence that could impact the retention rate of qualified and trained nurses in the hospital setting in order to

impact the high cost of RN turnover and ultimately contribute to higher quality and safer patient care practices.

The Substantive Theory of Advancing in a New Professional Role

This research produced a substantive theory of advancing in a new professional role. This is not a formal theory as formal theory is geared toward a broad, conceptual area in a discipline. Theories are “constructed to express a unique, unifying idea about a phenomenon that answers previously unanswered questions and provides new insights into the nature of the phenomenon” (Walker & Avant, 2011, p. 193). Substantive theory is developed for a specific area of social concern and its purpose to explain; in this case, it explained *how* advanced beginner nurses experienced the sense of becoming (Walker & Avant, 2011). The phenomenon of interest was becoming, meaning the “process” of becoming. The definition of choice by the researcher was Aristotle’s definition of “going from a level of lower potentiality to a higher level of actuality” (Becoming, 2014, p. 1). As this definition indicates, the movement is implied as a process. In keeping with this definition, becoming as it was experienced as a process was the premise of this social research.

The first question at hand was how advanced beginner nurses experienced the sense of becoming. To theorize *how* becoming was experienced, 14 qualitative interviews were completed and analyzed following the constant comparative method of grounded theory through Strauss and Corbin’s (1998) methodology. This research discovered that for the 14 BSN prepared nurses interviewed, how the sense of becoming was experienced was a process of shaping, knowing, growing, and advancing throughout

the new nurse transition. The substantive theory was embedded within the advanced beginner stage of Benner's (1984) Novice to Expert framework (see Figure 2).

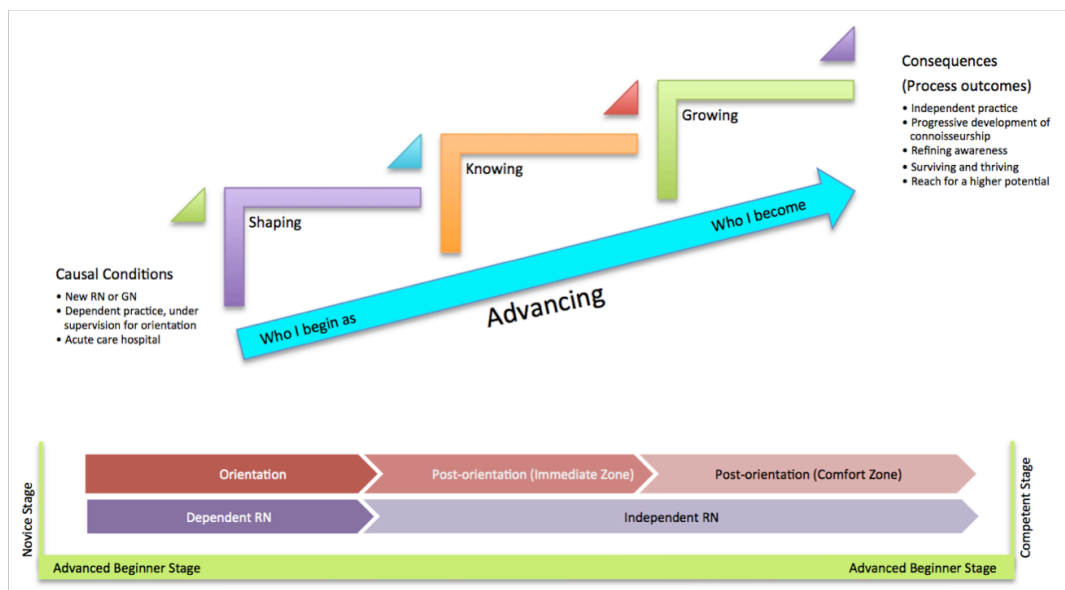


Figure 2. Advancing in a new professional role.

The substantive level theory of advancing in a new professional role emerged from the structured transition periods of orientation and post-orientation (immediate zone and comfort zone). The processes of advancing in a new professional role substantive theory reflected the sequence of the transition periods but in an upward and forward trend versus linear.

During the advanced beginner stage, there were structured and unstructured time periods of the new nurse's transition to independent practice—orientation (structured), post-orientation-immediate zone (unstructured), and post-orientation-comfort zone (unstructured). All new RNs interviewed experienced each of these phases sequentially with varying amounts of time. At the beginning of the advanced beginner stage, the new

nurse identified him/herself and who he/she was as a new graduate; this included noting what nursing program he/she had graduated from and where he/she had accepted employment. The program in which he/she graduated and the employer and type of unit in which he/she was now working set the tone and defined him/her as “who I begin as.” “Who I begin as” was labeled as his/her identity at the beginning of the advanced beginner phase.

During the transition of a new nurse, the new RNs encountered four interactions of the theory: shaping, knowing, growing, and advancing. “Who I begin as” was labeled as his/her identity at the beginning of the advanced beginner phase. Shaping was associated as the connection to others. Connecting to others through relationships that were prescribed or not was the significant component of shaping. This process prepared the new nurse for independent practice through the influences of support, trust, respect, acceptance, and gaining experience. What constituted support was responsibility, resources, and the strategies of providing feedback and debriefing.

The participants placed emphasis on relationships with their preceptors during orientation. The bonds created in the preceptor-preceptee relationships over time fostered mutual trust between the new nurse and his/her preceptors. The more time spent in this relationship allowed the preceptors to know the abilities and learning needs of the new nurse. The new nurse trusted the preceptor and took from the relationship the practice pearls that were helpful and beneficial to his/her practice. The new nurses need to feel support from the preceptor. They needed to know there was someone they could turn to at any point and ask questions, have them demonstrate unfamiliar procedures and interventions, and explain unfamiliar conditions and diagnosis. They needed the

preceptors to “show me” how or where. The new nurses also strongly desired feedback. They wanted to know how they were doing and what they could do to improve. Participants indicated they did not receive consistent or regular feedback other than from their primary preceptors. So if a new nurse had many preceptors, the feedback was not regular; whereas participants with “a couple preceptors” had regular feedback. New nurses also needed to debrief intense patient situations, events, and work days. The participants who shared experiences of critical situations such as code blue events or a rapidly declining patient, being yelled at by a physician or family, or reports of an extremely busy day indicated they needed to talk about the events, their role and responsibility, what was done or not done, and what should have been done with their preceptor. They indicated this was a significant learning opportunity even if it occurred the next workday. As the new nurse’s experience, competence, and self-confidence increased, increasing responsibility was gradually transferred to the preceptee from the preceptor. The new nurses needed to feel accepted and welcomed into their work environment as well. Several participants talked about their unit staff welcoming them and over time they began to feel like family; they supported this with indicating how much time they spent at work and the desire to get along well with their coworkers because of that.

Barriers to the shaping process were known as contingencies (unexpected events) and were identified as negative interaction and professionalism experienced or witnessed by the new RNs. Instances where a preceptor might have exhibited a “hands-off” teaching approach, meaning they were hard to find on the unit, were not consistently present to support the new nurse, refused to accompany the new nurse to the bedside, or

did not communicate to the new nurse's expectations were viewed as unprofessional and recognized as barriers to the shaping process. Participants knew they did not want to work with more experienced nurses who exhibited these qualities nor did they want to incorporate those types of behaviors into their practice. They also indicated they did not trust that particular nurse/preceptor, nor respect them. Other stories of unprofessional behavior were also noted: talking about others, specifically other new nurses; nurses yelling at each other on the unit over patient care responsibilities among shifts; and showing favoritism toward others resulting in only helping certain nurses when they needed help.

Another barrier the new nurses found challenging was nursing cliques. Several of the new nurses indicated their units had experienced nurses who were in a clique. The new nurses did not view this positively as they felt like they were not accepted. It was noted the new nurses believed they had to prove themselves to others on the unit to be accepted or liked. Interestingly, the nurses who indicated they felt welcomed and accepted in their unit did not mention nursing cliques. The new nurse had changed and could recognize this; they were now "who I become" as a result of advancing in a new professional role.

Knowing was characterized as competence or knowledge development. This was an extension of what was learned in nursing education and applied to practice. Progressive development of knowing resulted in progressive development of connoisseurship and thus increased expertise. Competence development and realization was synonymous with self-confidence, each an independent concept, but yet interwoven and dependent upon one another. Increasing competence was established with increasing

learning opportunities, reinforcement from preceptors, and making sense of the situation. Knowing was a progressing and continuous process that moved the new nurse along to the stage of feeling comfortable with his/her nursing practice.

Competence, whether progressive or realized, was associated with safety and quality of care delivered to the patients. This process was closely associated with the process of growing. They both occurred simultaneously and were relative to one another. When a new nurse described being successful or competent in a situation, then his/her self-confidence rose. If he/she made a mistake, forgot something, or did not realize something, then he/she associated that with not feeling competent and that translated to self-doubt in his/her thinking and abilities.

Growing was connected to self-confidence. Self-confidence was the inner strength and belief the new nurse had for them and their abilities. The new nurses described lacking self-confidence initially in the orientation phase but it built up and grew with time and experience. The action outcome for this process was refining awareness. As refining awareness is specific to the advanced beginner stage of the Benner (1984) model, it is meant as a heightened perceptual awareness and involves building confidence and an increasingly efficient and skillful practice. Self-confidence was reported to grow in the presence of support from preceptors, mutual respect, and trust. Support from preceptors in the form of feedback, debriefing, and progressive responsibility was noted as the main indicator of establishing self-confidence.

Barriers to establishing self-confidence or impacting it and resulting in self-doubt were claims of new nurses not receiving support from experienced nurses, either by not having help extended to them when needed or not being able to find a preceptor when a

patient was rapidly declining, not having questions answered, or by not receiving constructive feedback or being yelled at. The new nurses voiced that when they encountered a situation with which they were unfamiliar, they needed support to be shown what to do, know the experienced nurse was present to answer questions, and not let the new nurse make a mistake. If they received the support, then self-confidence, trust, and respect were fostered. If there was a breakdown resulting in a contingency to this process, then self-doubt developed. Self-confidence seemed to be a fluctuating concept since it could be built up and broken down based on events and personal assessment. If a new nurse had a negative encounter and his/her self-confidence dropped, there was opportunity for it to be repaired if certain facilitators were in place to strengthen it and build it back up. This was exemplified by Amy's experience of caring for a patient who was declining; she did not know how to care for the patient at that point and her temporary hands-off preceptor was "not helping." She indicated how this situation "kicked her in the butt" and she lost confidence over it. Through the strategy of debriefing with a trusted and respected preceptor, she was able to review the day and the case, thus providing successful care for the patient the following day. The debriefing and repetition of caring for the patient allowed her to see what needed to be done and to understand why.

The process of advancing was all encompassing and spanned the entire process, which pointed to why this emerged as the core concept. Advancing was characterized through empowerment as it was meant to mean "enable to act" (Chandler, 1992, p. 65). Empowerment in this context was a combination of the nurses' values, beliefs, and behaviors (Manojlovich, 2007). Through the realization of empowerment, the new

nurses professionally developed through the culmination of shaping, knowing, and growing to progress forward and “act” on their own. It was the gradual progression from a state of feeling and being dependent in their role to a state of being independent and functioning on their own--in their own practice, following their own values, beliefs, and behaviors that evolved over time. The processes of shaping, knowing, and growing could not adequately stand alone as a core category as they were interdependent and relative to one another. The core category of advancing was the one that stood out and was the result of the other three resolving into it.

The overall consequences of the interactions of shaping, knowing, growing, and advancing yielded connections to others, competence, self-confidence, and empowerment. Consequences experienced by the nurses were independent practice, progressive development of connoisseurship, refined awareness, and reach for a higher potential. The language of Benner’s theory was able to be carried through to the outcomes. Although understanding how advanced nurses experienced the sense of becoming was interesting, most enlightening from the findings of the research was the influential factors that contributed to how it was experienced and what made the greatest impact. The end result of the processes was each nurse ultimately advanced to the state of independent practice and achieved a level of comfort in his/her own professional RN practice.

Returning to the Literature

In all sectors of professional work, there exists an expectation-reality gap to some degree or aspect. Nursing is no exception and it was researched by Kramer (1974) and Duchscher (2008; 2009) but is known as reality shock and transition shock, respectively.

Ways in which the nursing profession attempts to balance expectation-reality gaps, reality shock, and transition shock are through professional role development of transition programs. Hoffart et al. (2011) compiled information on pre-graduation and post-graduation new nurse transition programs. Pre-graduation programs consisted of senior precepted clinical practica, summer externships, and cooperative learning programs. Post-graduation new nurse transition programs included the traditional orientation of new nurses by experienced staff as preceptors and nurse residency programs. In their findings, role concepts were more realistic through a six-month nurse residency program; however the literature was limited and scarce on all of these programs. Solid evidence did not exist to guide future practice (Hoffart et al., 2011).

Reality Shock

Forty years ago, Kramer (1974) introduced “reality shock” into the nursing literature, which contended there were disturbing discrepancies between what new graduates understood about nursing from an educational perspective and what they experienced in the real world of nursing. Kramer indicated the phases a new nurse progressed through in relation to a new professional role: the honeymoon phase, shock phase, recovery phase, and resolution phase. The honeymoon phase is the period of time when a new nurse is excited to have graduated, passed the NCLEX-RN, and is practicing in an acute care hospital in his/her first RN role. This time is when his/her world is viewed through “rose-colored glasses” and he/she has a positive view of everyone and everything in their environment. The shock phase is a dangerous period; this is when new nurses are overwhelmed with clinical responsibilities and perceive their work environment as being stressful including difficulty patients, regulatory burdens, lack of

resources, and stressed staff. Any negative interactions or witnessing of negative encounters or professionalism contribute to this shock phase. The recovery phase is when the new nurse becomes more acclimated to the environment and appreciates the positives and negatives. They are also more competent in their practice at that time. In the last phase, the resolution phase, the new nurses have reached a point of fitting into the environment through possibly adopting the values and belief of coworkers, albeit positive or negative professional behaviors and attitudes. The transition time between a new nurse's orientation and post-orientation phases is a make-or-break period; it is the most vulnerable time for a new nurse in that organization's culture (Kramer, 1974). Negative instances or unprofessionalism might overwhelm new nurses and can be a turning point for the new nurse to either acquiesce or seek other nursing opportunities at the earliest convenience.

Transition Shock

Duchscher (2009) researched the concept of professional development in nursing extensively. She explored Kramer's (1974) reality shock even deeper and created the transition shock model and the transition conceptual framework to complement Kramer's seminal work. Duchscher's transition conceptual framework contended that new nurses are confronted with physical, emotional, developmental, intellectual, and sociocultural changes during transition--the initial three to four months of a new nurse's role. During this transition shock timeframe, the new nurse must learn to make professional adjustments characterized by feelings of anxiety, inadequacy, insecurity, and instability. Her theory was based on a new graduate nurse's roles, responsibilities, relationships, and knowledge. The first 12 months of the transition process are labeled as the process of

becoming as the nurse evolves through the stages of doing, being, and knowing.

Duchscher's work proposed that education institutions and employers should focus on role transitioning for senior nursing students and facilitate clinical placements that are "dynamic, highly intense, and conflict-laden" (p. 1111). She further recommended that structured mentoring programs foster healthy partnerships between new nurses and seasoned nurses. Transition shock theory reinforces the need for role transition theory to be included at the senior level of nursing curricula to bridge undergraduate education to workplace expectations so new nursing professions successfully integrate into the highly dynamic and stressful world of professional nursing practice (Duchscher, 2009).

Duchscher (2009) has made it her life practice to put her research into action and created a national Canadian organization called "Nursing the Future." This organization was developed to support and guide new graduate nurses of Canada to "make a difference" in their profession. Select members of the organization formed a leadership team to groom young, new graduate members to prepare and mentor them for dealing with critical issues in nursing and moving healthcare forward. The organization hosts a national conference in Canada each year and hosts a website for members (Nursing the Future, 2010).

The findings from this research supported the assertions of Kramer (1974) and Duchscher (2009). Comparisons were made between this research and the work of Duchscher (2009); however, the responses from the participants of this study did not fit Duchscher's timeline of 12 months. There was a three-month difference in the progression to a state of comfort relating to role transition. The emotions expressed by the participants of this study were similar to those in Duchscher's work but the only

common word was anxiety. Participants in this study did not use the terms of inadequacy, insecurity, or instability. Terms used by the participants to describe their experience were feeling scared, nervous, and feeling sick driving into work, which expressed significant degrees of worry.

The most recent findings in the nursing literature regarding new nurses, career changes, and their work attitudes stemmed from extensive national research through New York University and the University of Buffalo supported by the Robert Wood Foundation (2009). Preliminary results from the 10-year study showed a shift in the traditional work pattern of new RNs--from beginning in a hospital-based setting, in special-care units, and being involved with direct patient care to now working as managers or continuing their education in formal BSN or NP programs. Many had experienced fewer local job opportunities and held a second job (Kovner, Brewer, Fatehi, & Katigbak, 2014). The research had preliminarily calculated that about 17.5% of new nurses left their first job within one year of starting it and 31% by their second year (Kovner, Brewer, Fatehi, & Jun, 2014). Turnover rates were related to verbal abuse in the workplace and to a lesser extent physical injury such as needle sticks. As Budin, Brewer, Chao and Kovner (2013) claimed, newer RNs who reported being exposed to moderate to high verbal abuse from nurse colleagues planned to leave their position within 12 months.

Personal characteristics the researcher noted about the participants supported the finding of *The RN Work Project* (Kovner & Brewer, 2009). Fifty percent of the participants interviewed in this research were enrolled in graduate school at the time of the interview; all had returned to school within a two-year time frame from graduating from their BSN program. This evidence supported Kovner, Brewer, Fatehi, and Jun's

(2014) claim of the shift from traditional work patterns to nurses continuing their education in a formal program.

Professional Development

Professional development was not initially explored but the findings from this research and the substantive theory suggested it be examined. The literature pertinent to professional role development in nursing was limited. What was known was the professional nursing role is equated with being assimilated with work experience and is primarily defined after graduation through experience in the workplace and through repetition, role modeling, and interaction with others of the same professional group. A clear, well-defined role is an essential building block for overall development (Olsson & Gullberg, 1991).

Incorporating professional role development into nursing curricula has been researched and early introduction of professional nursing socialization of students to the nursing profession was found to be beneficial. Tracy, Samarel, and DeYoung (1995) researched an innovative teaching methodology designed to introduce sophomore nursing students to the professional role of nurse early in their education. The results produced favorable results that included student enthusiasm, “zest to class,” support of interpersonal skill development outside of the classroom and non-clinical environments, and the ability for students to actualize their involvement in professional organizations and activities (Tracy et al., 1995, p. 182). Learning experiences were fostered through participation in activities in and out of the classroom including joining a professional nursing organization, attending a professional nursing organization meeting, participating in an activity sponsored by a professional nursing organization such as a professional

nursing conference, participating on a committee, or becoming involved with a professional nursing organization. Results showed the sophomore students become involved with their Student Nurses Association via meetings and a conference, involvement with a Sigma Theta Tau program, and other all-day or research conferences. It was noted that many students exceeded the minimum number of requirements for the course. This early engagement and curriculum requirement was successful for the researchers of that study and their program outcomes (Tracy et al., 1995). Early introduction and involvement with this type of professional socialization might have many more implications for professional development. However, more research is needed to determine if that is true and what the effects might be on new nurse transition and role development during the different stages of Benner's (1984) framework.

Professional socialization was explored in Chapter II and was noted to be closely related to the sense of becoming in that socialization is a lifelong process that develops self-concept. Socialization in nursing has been demonstrated to increase coping with the demands of nursing and prepare for adaptation to real world practice (Dinmohammadi et al., 2013; Lai & Lim, 2012). Self-concept is an interesting phenomenon that was associated with several other phenomena explored with this research. LeMone (1991) noted self-concept is comprised of body image, self-esteem, and personal identity. The historical definition LeMone followed was from the Random House Dictionary where self-concept was defined as "the idea or mental image one has of oneself and ones' strengths, weaknesses, status, etc." (p. 127). To know thy self is also a popular language phrase associated with self-concept. Self-concept is contrived as a "result of experience and is a determinant of behavior" and is more closely aligned with a modern definition by

nursing theorist, Sister Callista Roy (LeMone, 1991, p. 128). She contended that self-concept is self-defined of one's perceptions of others' reactions and directed by the persons' behavior. She believed self-concept is a result of social interactions and experiences (LeMone, 1991). The meaning and theoretical underpinnings of self-concept were closely associated to the shaping process in this research.

Employer Expectations

The most current and accessible information put forth by employers regarding hiring new nurses in the United States indicated most nursing executives do not believe new graduate nurses are fully prepared to deliver safe and effective practice. Research reported that low job satisfaction among nurses was due to heavy workloads and an inability to ensure patient safety (Twibell et al., 2012). New nurses specifically reported they were dissatisfied with relationships with peers, interprofessional colleagues, role transition including reality shock, management, not enough time with patients, negative organizational culture, and low salaries (Salt et al., 2008; Twibell et al., 2012). It was further noted that discontent initially peaked at four-six months in a new nurse's career and again at the end of year two. It is known that employers need to provide innovative orientation programs such as nurse residency programs to establish best fit practices between the new nurse and the new position and provide qualified preceptors to socialize the new nurse into his/her new role and workplace. Research has shown that practice needs to provide support to nursing by nurse managers and leadership to ensure success of their programs and to retain nurses. Workplace environments need to create environments that promote a smooth transition for new nurses from their nursing program into practice. Approaches to ensure this includes evidence-based strategies of residency

programs, strong preceptors and support for them, simulation for extended training, a healthy work environment, fostering of trusting relations, and making leadership visible (Twibell et al., 2012).

Impact of This Research

The findings from this research supported existing theories and frameworks in nursing, specifically the work by Duchscher (2008, 2009), spanning 10 years and four qualitative studies concentrating on new graduate transition built upon Kramer's (1974) reality shock; this research also concurred with suggested evidence-based strategies to enhance the new nurses transition to acute care practice.. The transition of new nurses is said to be an ordered process in which a new nurse passes through the stages of doing, being, and knowing and in those stages potentially experiences 11 different actions related to the main concepts. Although there appeared to be some overlap in the conditions for which transition occurred in the first year of nursing practice according to Duchscher's theory, the findings from this research somewhat paralleled her work but remained embedded within Benner's (1984) framework (advanced beginner stage), dimensionalized it, and deepened an understanding of this stage. The substantive-level theory of advancing in a new progression role was developed from the 14 nurses interviewed and the language for the theory was derived directly from the participants. As the steps of analyses ensued and the categories emerged, they were maximized to the participants' language and then related back to Benner's framework within the advanced beginner stage. What this produced was a substantive-level theory fully embedded within the Benner framework. Given what is known about Benner's framework, this

research involved one specific stage and was able to bring to light a greater depth and breadth to the inner mechanisms of this stage of Benner's framework.

The purpose of this research was not to evaluate the different experiences of the participants but was to discover how their transition was experienced. However, it was observed that one participant who participated in a nurse residency appeared to be extremely satisfied with her orientation. From this research, it was evident that whether a new nurse had prior experience or pre-graduation experience with a hospital unit, it did impact the comfort level initially on orientation as it provided a source for new nurses to recognize familiar staff, know the unit and population cared for, and understand the basic workflow of the unit. It was not voiced if pre-graduation experience impacted their post-orientation experience; however, facilitators of relationships, support, trust, respect, acceptance, and gaining experience influenced their transition to independent practice and establishment of a comfort level.

The human ecological theory postulated that a person interacts with their environment and their environment interacts with them. The researcher initially thought this perspective might help add to the understanding of how the sense of becoming was experienced with new nurses; however, the use of this lens did not provide any substantial or significant understanding of the phenomenon. Essentially, the researcher was only able to identify which HET system(s) were associated with specific processes of the advancing in a new professional role substantive theory. Therefore, the human ecological theory was not expounded upon as it did not contribute to the understanding of how the sense of becoming was experienced or the influences that impacted it.

Synthesis

In the overall analysis of this research and thinking about it as a whole, the researcher was drawn back to the demographic composite of the participants, specifically age, pre-transition factors such as second career BSN versus traditional, and prior unit familiarity with clinicals, senior immersion clinicals, nurse technician positions, and summer externships.

When considering those over 40 years of age (Thomas, Lisa, and Caroline), the key message was the desire for support from a preceptor on orientation, stability as they did not feel resilient as compared to younger peer nurses they observed, and wanting a designated “go-to” person post-orientation. They wanted the “buddy system.” Second career BSN new nurses indicated this as well (Heather, Caroline, Jessica, and Thomas). Among these two groups, communication with others was easy and comfortable. It was not deemed as a hurdle in comparison to the young traditional BSN grads who voiced feelings of being scared and nervous to talk to physicians, use their voice, advocate for patients, and “speak up.”

No differences were noted between male (Ryan and Thomas) and female nurses in any theme. The same concerns about wanting support, wanting to develop self-confidence and competence in the role, and becoming experienced were universal between genders.

There were no differences between the different types of unit familiarity, whether it was nurse technician experience, summer externships, nursing student clinicals, or senior immersion clinical experiences. There was diversity among age, gender, and unit familiarity in this specific analysis but no appreciable differences despite the diversity.

The only group this did not apply to was second career BSN new nurses as they did not indicate any familiarity with nursing student clinical experiences or senior clinical immersion experiences.

Six nurses (Patricia, Becky, Gail, Amy, Julie, and Melissa) directly spoke about critical incidents in detail as part of their sense of becoming experience. These incidents were considered significant because they were experiences of code blue events or a very near code blue event, a significant encounter involving a physician and patient/family, or patient and parent encounter. The most important thing that followed these events was the ability to debrief afterward between the new nurse and their preceptor or their “go-to” person. Patricia, Melissa, and Gail experienced their first critical events while in the orientation phase and Becky, Amy, and Julie had their experiences in the post-orientation phase.

Patricia worked an intermediate cardiac unit that experienced frequent code blue events. She indicated she felt lost and unprepared for these on orientation due to not knowing the cardiac medications and drips. She did not know what to do or how to interpret EKG’s and the responses to the medications. She indicated it took a year for her to become comfortable in these critical situations. Melissa worked in the adult emergency service setting and also experienced frequent critical situation of code blue and stroke code events. Her experiences resonated with those of Patricia--she did not feel prepared for RN responsibilities with the medications in response to these critical events initially and it took time to establish a comfort level with them. Gail’s first critical event encounter was a pediatric code blue in an intensive care setting. She was on orientation and was left with “a deer in the headlights” reaction in which she said she could not

function or be effective in any way. She was in disbelief that this actually was happening and she was actually witnessing this event. She recalled contemplating not returning to work after that because she was really unsure about everything at that point. She did return to work the next day and was able to debrief with her preceptor who sought her out to do so; that debriefing experience and “hashing it out and talking about the previous day” was what turned things around for her by “turning the worse experience possible into a positive one.”

Becky’s post-orientation encounter involved a pediatric patient who coded while she was holding him. It was her first code blue experience and she described it as “being thrown a curveball”; it was extremely stressful at the time and even for several hours afterward. Amy’s encounter involved a missing pediatric patient; the patient disappeared from the unit and she could not find her and had to call a missing persons code. Her event was described as “a very scary situation.” When the patient and her mother were found in another patient’s room, the mother’s attitude escalated and turned into an event that involved a confrontation with a parent when the nurse tried to teach the parent about the safety and security practices of the unit. Julie’s significant situation involved a parent (cognitively challenged and delayed) with a failure-to-thrive infant wherein she was educating the parent and attempting to feed the child. She indicated the parent started cursing at her, struck the bottle out of her hand, and yelled she was not allowed to care for the infant any longer. Julie indicated she should have called security immediately but she was so “shook up” about the situation she ran out of the room, horrified with the event she had just encountered and went to her charge nurse. The charge nurse diffused the situation, removed Julie from the assignment for that shift, and did not want Julie to

call security. She debriefed the situation the next day with her manager and learned that the proper action would have been to call security for that type of incident. Julie indicated she was left with confusion about proper protocol and advice from an experienced nurse. She wanted to call security and regretted she did not for the safety and advocacy of her patient, herself, and the unit.

The associated emotions with these events were regarded as highly stressful and for the first one an overall sense of panic and inability to be effective and function. These events do happen but they are not everyday occurrences for a nurse. They are the “curveballs” and not what new nurses are prepared for, most likely because they have never witnessed nor been exposed to an incident or encounter such as those. New nurses are not prepared to think that quickly on their feet or know the protocols to follow at the advanced beginner stage.

Nursing school and clinical experience do not prepare students for these events; an externship or nursing technician position might not prepare a new nurse for these types of events either. These critical incidents cannot be predicted; therefore, nursing educator cannot expose their students to them. The only way they can be experienced is being in the right place at the right time or created in a simulation. With so much general information, nursing curricula cannot prepare students for low frequent, high-risk events or situations; some things have to be learned on the job.

Even in units where critical events occur frequently, the new nurse does not feel prepared for them or how he/she is expected to function. Even in encounters where the new nurse has experienced conflict with a patient, a family member, or even another nurse or health care provider, they do not know how to react. They are not prepared how

to handle critical event situations; these situations are ones they will remember all of their lives and career. They are shaped by those events.

In thinking about the time factor with regard to the different variables of age, gender, BSN program type, familiarization with the unit, and orientation type at about the six-month mark, all participants were just starting to get used to their unit and population. At this point, they were all in the post-orientation immediate zone phase--even Tamara who had just completed a six-month nurse residency in a pediatric emergency center. One participant (Jessica) said she felt comfortable at this point but she did not have any accounts of the humbling “first critical incident” examples when asked. Jessica was a second career BSN student and had only been in practice for eight months at the time of her interview. In comparison to a counterpart with the same amount of nursing experience, just the opposite was voiced; Thomas did not yet feel comfortable in his independent role and still sought out the advice and help of experienced nurses even five months post-orientation. As for the other 12 nurses who were all in their second year of nursing practice, the majority of them indicated it took 12-18 months to become comfortable in their role and all voiced they learned something new every day. There were no accounts of over-confidence. Although 7 of the 14 participants had started a nursing graduate program, they were seeking higher education to fulfill their goals of advanced nursing practice through a NP, CRNA, or DNP degree. With half of the participants returning to school, this correlated with the literature about this trend of new graduates (Kovner, Brewer, Fatehi, & Katigbak, 2014).

No participants stated directly that they experienced reality shock or transition shock. The closest notation to an experience like this was Gail’s reaction about being

surprised there were no double checks of her work from her preceptors and she had to get used to the fact that she was “the one running the show.” Several participants were surprised about being hired on the spot and getting the unit of their choice. None of the participants had voiced any ideations about being unhappy or leaving their unit. It was not surprising the new nurses’ stories did not use the “reality shock” or “transition shock” language; however, their stories indicated they had experienced or sensed change within themselves in their new nurse transition.

The staging or structure of the process was an additional factor in how becoming was experienced by the nurses. The structure of the process included the orientation and post-orientation phases identified by the new nurses as they passed through at different paces. In the orientation phase, time was structured and prescribed depending on the type of orientation (traditional or nurse residency program). The traditional orientation was on average three months long and up to six months for a nurse residency program. Time allowed for the accumulation of experience in the clinical setting. The time following orientation was viewed as the most critical and vulnerable time known to advanced beginner nurses--the post-orientation: immediate zone. This was when new nurses were no longer under the supervision of an experienced nurse. They were independent in their practice and they did not feel as though they might not have the level of competence, skills, or ability needed to care for patients in the safe way they desired. This was a time of uncertainty and stress as new nurses voiced feelings of being scared, nervous, and lacking confidence in themselves. This correlated with the literature in Kramer’s (1974) work on reality shock. This period of time lasted between 9-15 months post-orientation for most nurses; the average length of time for this stage was 12-18 months from the start

of their first day on the unit until they felt comfortable in their independent RN practice role. Exiting this zone was when the nurses described feeling comfortable and more self-confident in their role.

During this stage, the post-orientation: comfort zone, the nurses were comfortable in the independent practice role in caring for patients they were assigned to and started to increase and broaden their responsibilities on the unit and pursue advanced practice nursing education goals. Seven of the 14 nurses were enrolled in advanced practice nursing programs for NP, DNP, or CRNA; four had indicated they mentored undergraduate nursing students, one mentored a high school student who shadowed her, two were trained for the role of charge nurse on their unit, four nurses indicated they were members of unit based committees (social committee, workload committee and continuing education committee), and two were involved in a hospital-wide initiative of implementing a new electronic medical record system (EMR) in which they were “superusers” and a resource for their unit and the hospital. Engagement in additional responsibilities and returning to school only occurred during the post-orientation comfort zone for the group; as Becky stated, “Orientation can be overwhelming and the first couple months after orientation, it’s enough to go in and take care of patients and then go home.” Assuming additional responsibilities or participation in additional hospital or unit would be too much for a new nurse to handle until he/she is comfortable in his/her role. As demonstrated, once comfort and independence is achieved in the RN role, then he/she is motivated and willing to continue to advance in his/her RN role and assume more professional responsibility and engagement.

In summary, the findings of this research supported theoretical and current research related to new nurse transition and evidence-based programs to enhance this process. The findings did not capture all of the aspects noted in the literature but did mirror many of the same key points such as promoting a good fit between preceptor and preceptee relationships for orientation; establishing new nurse support beyond the orientation period; a positive, welcoming workplace environment; opportunities and supports in place to allow for growth of knowledge; and fostering self-confidence in a busy, fast-paced environment all the while providing safe, high-quality patient care.

Implications

The key findings from this research revealed that preceptor-preceptee relationships, support, and gaining experience were the most critical elements in order to develop self-confidence and competence by this homogenous group of new BSN nurses. They sensed and knew they needed self-confidence as they indicated this was low upon starting as a new nurse. They also knew they needed experience. The only way to move forward was to engage in a professional clinical RN role and all participants experienced the traditional orientation and post-orientation transition programs into professional practice in an acute care setting. The end goal was independent practice wherein they would provide safe nursing care and feel comfortable doing so. To obtain this goal, they knew they needed support as they were not confident in their knowledge base at this point. Therefore, they had low self-confidence levels in their knowledge and ability. This was a common theme shared among all participants. They knew the only way to reach their goal would be through experience in the clinical setting. It was at this time of starting out in their first professional RN role that they were constructing their

professional identity in nursing as they were becoming socialized to their new employer and nursing unit. This was the beginning of the shaping process as they started in the advanced beginner stage of Benner's (1984) model. It was a time for them to identify "who I begin as" in the professional role of the RN.

As time progressed with their orientation, what they wanted, what they needed, and what they received varied by each participant. Even though they were all on the same path toward independent practice, each participant experienced the same process but with individual encounters with different degrees and intensities of facilitators and barriers as they progressed. As their 18-24 months of professional nursing practice unfolded, they shared meaningful moments that impacted the shaping of their practice. They discussed what built their self-confidence, what did not, what strengthened their competence, and what made them doubt it. They all achieved a level of independent nursing practice between three and six months post starting with their unit but continued to experience learning and growth in their practice. They had reached a level of comfort about 12-18 months after starting with the unit (with the exception of two participants who had only been employed for eight months). After listening to their stories, their responsibilities, their level of comfort, their future goals, and the steps they were taking to achieve those goals, many were transitioning into Benner's (1984) next stage of competence; yet some were still working in the advanced beginner stage. Everyone had their own pace, comfort zone, and goals.

With the knowledge learned from this research, we have the power to take this information and to enhance or improve the transition process for advanced beginner nurses working in the acute care setting. Applying what we know might possibly

enhance and benefit the transition experience of new nurses, thus increasing the retention rate of nurses in the acute care setting.

Relationships

Connection to others is relationships between people. Specifically in this research, the relationship between the new nurse and his/her preceptor(s) was most significant. To a lesser account, relationships between the new nurse and other new nurses, other experienced RNs on the unit, patients and families, other health care professionals, and nursing administration were important but not to the magnitude of the preceptor-preceptee relationship.

Preceptors. Based upon the findings from this grounded theory research, the relationships between a preceptor and a preceptee, fostered through support and the element of time, were considered critical factors in the shaping of new nursing practice in the acute care setting. This finding mirrored the literature and affirmed the role of the preceptor in practice is vital to the new nurse's transition experience. Preceptors are experienced nurses whose nursing role has been expanded to teach, supervise, and evaluate the new nurse as he/she transitions to the role of RN; it is viewed as an altruistic responsibility to promote the nursing profession (Richards, 2010). While few people possess the natural ability to be an effective teacher, many others do not; they need to be trained and learn the art of teaching others. This is where professional development through education and training could be beneficial for experienced nurses who are interested in or are in the preceptor role. Preceptor development programs are a good investment in the human capital of a hospital. This type of training program could be solely hospital based or structured as a collaborative venture between hospital systems

and/or local nursing programs. Preceptor-developed programs are designed to educate and support experienced nursing staff to improve their skills in coaching, mentoring, teaching strategies, leadership, communications, and evaluation (Meng & Conti, 1995). Because the preceptor role has been associated with the disadvantages of being time-consuming, an increased workload, a source of stress, and a loss of patient contact, it might be challenging for a nursing unit to find willing volunteers to step up and precept new nurses. Despite the challenges associated with being a preceptor, experienced nurses are needed to facilitate the transition of new nurses into practice, thus promoting altruism for the profession. They are needed to teach and guide the new nurse in terms of socialization to the professional role and help the new nurse discover his/her professional identity. Research has demonstrated the benefits of preceptor development are satisfaction from knowledge sharing and expertise, stimulation of personal growth, honor and recognition within one's employing agency, and satisfaction from observing the preceptee grow. Granted the preceptor role produces intrinsic rewards, nurses who precept desire formal recognition, financial rewards, feedback from preceptee, guidance for the preceptor role, and time with the preceptee away from the patient unit (Stevenson, Doorley, Moddeman, & Benson-Landau, 1995).

As the literature supported, preceptors need to be given strategies to use when precepting new nurses in the patient care setting, specifically when identifying the strategies of debriefing and feedback. These were practices the participants wanted and needed during their orientation in order to shape and advance successfully to independent practice. Since these strategies are not inherent to all people by nature, training and education on the methods for preceptors could be introduced through professional

development and practiced through role-modeling and simulation exercises. Knowing these strategies and being trained on how to properly execute feedback and facilitate debriefing sessions might elevate the nurse's preceptor style to a new level and result in a high degree of satisfaction from the preceptee and the overall preceptor-preceptee relationship.

In considering styles of preceptors, the participants spoke of a "hands-off" precepting style. This style was not favored among the three participants who identified and experienced it. Ryan had an optimistic perspective and specifically indicated that the "hands-on" style was a positive condition of his experience. Nursing administration should be cognizant of their employees' teaching style and approach to patient care; if a nurse exhibits a "hands-off" style, they might not be suited for preceptor responsibilities with a new nurse. As part of preceptor development, teaching and learning inventories could be conducted to identify a preceptor's teaching style and the preceptee's learning style. This might create a learning opportunity for preceptors to learn about themselves as well as identify their preferred teaching methods so they can be paired to a preceptee with receptive learning preferences.

Support from the preceptor-preceptee relationship was found to be the transfer of responsibility of time from the preceptor to the preceptee. Support was also recognized as the sharing of experiences and information so information was handed down from the preceptor to the preceptee in the form of helpful tips, tricks, and ideas. Support was identified as an extension from the orientation phase to the post-orientation phase and was labeled as the "go-to" person for the newly independent nurse. The "go-to" nurse was discussed and described by 9 of the 14 participants. Having this resource available

after the new nurse was “on their own” was a significant element in how the new nurse experienced becoming. Knowing that a preceptor might be regarded as a “go-to” person after orienting a new nurse would be good information for the experienced nurse so he/she can expect questions from the new nurse beyond his/her time as preceptor. A balance must be reached between what is needed—experienced, willing, and effective preceptors and what can be done to lessen the disadvantages of the role—training, support, recognition, and consideration of incentives.

Extended relationships were also found to be desired by new nurses as several participants sought out opportunities to help experienced nurses with their patient care assignments in order to seize learning opportunities and glean practice pearls. Formal coaching or mentor programs should be considered for new nurses for approximately a year.

Development of community. Beyond the training and education in academia, it is proposed to initiate a development of a community of nursing students, new nurses, and preceptors. Preparing experienced nurses, in Benner’s (1984) competent and proficient stages, with preceptor development and support programs could be a first step. However, hospitals should consider incentive and recognition programs for preceptors. Nursing programs should include theoretical content and practicum experience that immerses the senior BSN student nurse in a “real world” environment for an expanded period of time, emulating the true nursing role. This lived experience should introduce the student nurse to real life nursing and help prepare them for “reality shock” and “transition shock” when they begin their first RN job. Educators have a responsibility to prepare students for real life nursing, not to ignore the real world issues and let them

become confused and conflicted in their first several months of practice. The goal would be to expose and immerse the student in a high-stress, demanding role, being directly supervised by an RN clinical teaching associate, while teaching them strategies and giving them tools to survive and thrive in a “real world” nursing environment. Nurse educators should be equipping nursing students with a tool kit full of resources to use for various situations they are likely to encounter in real world nursing practice. They should be practicing using these tools through simulation and standardized patient encounters.

Lastly, nurses from academia and practice could follow the lead of our Canadian neighbor nurses and develop a support community for new nurses and those who precept. This organization could be a sub-organization or an extension of an already existing nursing organization such as a state-based or national level American Nurses Association (ANA) or comparable professional organization. The extension would be specific to and concentrate on the transition process for senior students and new nurses. This community could be virtually based in a website with an online community including blog topics and forums. An annual conference could educate, support, integrate, and network new nurses and preceptors. Purposes include celebrating the successes of nurse graduates and honoring those experienced nurses who are investing in the integrity of the profession by precepting and building future leaders in nursing. Conference activities might include a keynote speaker; concurrent training sessions that would focus on topics of interest to these groups, round table discussions, panel discussions, poster presentations, and an exhibitors and vendor area.

Support

Support is known as helping, giving assistance, giving confidence or comfort, keeping something stable, or pertaining to sustainability (Agnes, 2002). Support is needed from multiple sources and directed toward all persons involved in the new nurse transition process. Support must be provided to the new nurse from the preceptor and the nursing unit. Support must be provided to the preceptor so they can adequately and effectively fulfill their role as guide and coach. Support for this process and persons involved traditionally stem from nursing academia (preparing the new nurse/preceptee) and nursing practice (preparing the preceptor).

Nursing leadership. Preceptor-preceptee relationships are essential as they establish mutual trust and respect between the new nurse and the experienced nurse. The supportive element of this relationship is built through feedback, debriefing, and the transference of responsibility for patient care during the element of time known as the orientation phase. With this information, nursing administrations can utilize this knowledge in preparing and planning the orientation of future new nurses. They can take measures to establish the best possible match between the experienced nurse and the new nurse. Considerations to be noted, as found from the participant interviews, are generational and recognized as the older new nurses being over age 40 and the younger new nurses in their 20s and 30s. Younger nurses alluded to increased satisfaction with their preceptor-preceptee matching outcome when they were paired with a nurse closer to their generation and level. It was evident from three participants that when paired with nurses who were significantly older than them, positive outcomes did not occur and they took action to ensure they would not be paired with that nurse on a regular basis for their

orientation. The literature supported that nurses in the competent and proficient levels of Benner's (1984) framework made the better preceptors for new nurses. The expert nurse works from intuition and might have a difficult time explaining, expressing, or relating to the new nurse. Whereas nurses in the competent stage are more likely to relate to the nurse as they reflect upon their own transition experience and become less frustrated with the new nurse's lack of speed (Meng & Conti, 1995). Nursing administrations should consider nurses in the competent stage and who are closer to the new nurse's generation when planning the orientation for new hires.

Older new nurses indicated a desire to be nurtured but did not voice a bias toward age of the experienced preceptor. Male new nurses did not indicate a desire toward any particular generation but it was noted that one male nurse did appreciate a nurse with 41 years of experience as "a great wealth of knowledge and kind of an old school nursing coach" who provided him with a "hands-on approach" to patient care. He also appreciated an experienced nurse as a preceptor who had 15 years experience as "she was able to give good insights on how to manage" the team better and was "a wealth of knowledge." It must also be taken into account that this male nurse had prior knowledge of the unit and staff from the perspective of a student and an extern. Only one female participant, Becky, was able to appreciate an older nurse on her unit; she described her as "the most senior nurse" and through building a connection with her regarding electronic medical record training, she was able to establish a connection with her that mutually benefitted both of them. Becky indicated she could teach the senior nurse what she wanted to know and, in turn, the senior nurse would answer her questions and be a resource should she need to ask her a question in the future regarding patient care. Becky

stated, “You learn anyone can become a resource.” Becky did not have prior knowledge of her unit in any capacity prior to starting on the unit as an RN.

Another important factor to consider is if the new nurse has any prior experience with the unit and the staff. If they have been a student there or held an externship or nursing technician position, then the new nurse is familiar with the culture and the RNs on the unit. It is suggested for nurse managers that communication occur between them and the new nurse regarding prior experience, expectations, and preferences for orientation. If the nurse manager elicits background information, it might be beneficial and assist in the planning of the new nurse’s orientation.

Nursing administrations might consider maximizing the new nurse’s orientation experience and have the new nurse orient and train on the shift where they will be working for a larger percentage of the time during his/her orientation. Only one participant voiced this concern but keeping this in mind when planning orientation could avoid any barriers to the nurse’s transition.

Nursing educators. As anyone entering a new role in a profession, there is an expectation-reality gap. Once nursing students graduate and leave academia, the angle of influence is transferred to practice. The real world of nursing is “what it is.” There are positives and negatives as in any profession. The challenges that face nursing today are complex and cannot be immediately solved. New graduates will enter the workforce and face challenges on many levels such as national concerns (exosystem level) for safe staffing levels, safety on the job, and mandatory overtime. They might also encounter immediate (mesosystem level) events related to the barriers found from this research--unprofessionalism and negative encounters with coworkers and other members of the

healthcare team. New nurses will also experience unexpected events related to clinical situations when they must respond with their limited knowledge, skill, and experience such as a code blue, a rapidly deteriorating patient, an angry patient or family, having to call a physician and get yelled at, or the death of a patient. Regardless of the magnitude of the event, nursing students need to be prepared for current issues that impact the profession and for events that occur in the workplace.

Introducing nursing students to the realities of the nursing profession and ensuring they are adequately prepared for reality shock and transition shock falls in the responsibility of academia before the student graduates. Prior to graduation and entering the workforce is the only logical time for it to occur. Nursing students need to be prepared for their transition from student to practice and they deserve to know what possible situations to expect. More so, they need to be as educated as much as possible on how to handle the events and situations they might face. They need to be given strategies and tools that are useful in dealing with others in the face of conflict and then practice with standardized patients. They need to practice rare clinical events in a controlled, safe simulation environment to exercise their clinical reasoning, nursing judgment skills, communication, and emergent response skills. Nursing students don't know what they don't know or what they are not told. Preparing for the worst and hoping for the best is a popular philosophy; this approach to training and educating nursing students might be the type needed to prepare them for reality shock so when they do encounter it, it might not be as intense or stress provoking. The goal of this type of course, or training within a course, would be to fully inform students about the realities of real world nursing practice. This type of approach would be best delivered through

academia with collaboration with practice partnerships, especially newer nurses, unit leadership, and preceptors. Natalie, a key informant, said about her transition experience: “Once I got through the first critical event on my own, I was fine after that. But it was just working through that first one—then I knew I could do it.”

Nursing educators could also be proactive and incorporate learning activities into their courses that assess learning styles, personality types, and strength assessments. Assignments could be designed where students complete assessments such as the Kolb Learning Styles Inventory, the Meyers Briggs Type Indicator Tool, Transition Theory, Strengths Finder, and Authentic Happiness. When students learn and are aware of what their preferences and affinities are, they can communicate them to future employers. That information could be useful for nurse managers planning their orientation as well as for preceptors who will be working closely with them for three to six months.

Other ideas to foster positive relationship with new nurses would be for the hospital unit to consider a formal onboarding strategic plan. Onboarding is known in the human resource world and business management discipline as a strategic process of bringing a new employee to the organization and providing information, training, mentoring, and coaching throughout the transition (University of North Carolina, 2008). This process initiates at the time an employment offer is accepted through the first 6 to 12 months of employment. The first day or weeks on a new job can be stressful; making the new nurse feel welcome, orientating them to their new position, and familiarizing them with the hospital and the culture of the nursing unit can promote feelings of acceptance and support while lessening uncertainty and emotions of nervousness and feeling scared.

Although hospitals might be anxious to rapidly onboard new nurses to get them to a status of productivity sooner, this practice should be used with caution as with the experiences of Patricia and Melissa whose orientations were cut short due to staffing needs. Rapidly onboarding a new nurse carries safety and quality implications that negate patient safety practices.

Based upon the results of this research and the literature, it is recommended that academia and practice promote multiple methods in which nursing students can become familiar with practice and an agency. In addition to nursing clinicals, pre-transition methods such as employment as a nurse technician, a nursing assistant, or a summer externship could be considered and pursued by students. Incorporating immersion type experiences during students' senior year is also a strategy found beneficial to students. These options all require planning and support from academia and practice, financial support, and human resource capital. Opportunities for learning in clinical areas must also be present and exist for these types of programs to be viable and sustainable.

In the post-orientation phase, support from coworkers, nursing units, staff development, or nursing education departments are immediate sources for new nurses and are all related to the agency. Options of building an online community support program would be an innovative project as a holistic approach to support new nurses and preceptors. It could also serve as an opportunity to build nursing leaders within a region and support nursing professional organizations.

Recommendations

This research was just a small step in the theoretical development of advancing in a new professional role, which supported previous theoretical research in this area.

Grounded theory captured the experiences of a select, homogenous group of nurses during a specific point in time. Their stories were just a representative sample of the thousands of nurses who enter the workforce each year. Extensive work lies ahead to fully exploit and test the theory. Analysis of the theory is a recommended first step for the researcher post-dissertation. Analysis would be a systematic and objective process in examining the content and structure of the theory by examining its “origins, meaning, logical adequacy, usefulness, generalizability/ parsimony, and testability” (Walker & Avant, 2011, p. 206).

Once analysis is completed, the next process would be theory evaluation. Evaluation of the theory would assess its potential contribution to scientific nursing knowledge. This is important because it determines the theory’s worth upon which decisions and actions might be based (Walker & Avant, 2011). This complex process would use a set of criteria that judge the merits of the theory and reflect the theory’s epistemic, cognitive, moral, or social values (Reed & Shearer, 2011).

The third step would be theory testing. Theory testing would include conducting quantitative research based on the theory and generating hypotheses to test following the theoretical model (Walker & Avant, 2011). Publications related to this research and any future research that stems from this are essential in the engagement of scholarly activity.

In addition to extending the evaluative work of the substantive theory of advancing in a new professional role, additional recommendations include promoting the findings of this research as further support of already existing theories and research relating to new nurse transition. As affirmation of the literature, this research should be used to inspire innovative partnerships between education and practice to enhance

nursing education in order to better prepare BSN nursing students for the acute care practice environments. It also extends a call to practice to examine individual hospital and unit practices for onboarding new nurses and structuring their orientation to provide continuity and stability for both the preceptor and preceptee. Research is encouraged for all new pioneering strategies and programs involved in new nurse transition.

Limitations

The qualitative research approach included 14 BSN participants working in acute care hospitals in four different states of the United States. It was specifically aimed at advanced beginning nurses only. The scope of this research following GTM yielded a micro-level theory, meaning the theory applied to a specific phenomenon within a limited population for a certain point in time. Further research is necessary to comprehensively develop and understand how the phenomenon of the sense of becoming is experienced, especially to all stages in Benner's (1984) Novice to Expert framework and in the different contexts of nursing practice. This research examined just one stage of a five-stage model and it only took into account the stories of the nurses involved. It did not include any other factors or persons such as nursing education programs or experienced preceptors. A significant limitation to the research was it did not capture the stories of any nurses who had left nursing practice within the first three years, unemployed nurses who were unsuccessful in securing a nursing position, or nurses who had switched or transferred positions in that time frame.

Conclusion

From this study, the researcher found the sense of becoming as it emerged within the Benner (1984) model's advanced beginner stage. How the sense of becoming was

experienced was outlined through the substantive-level theory of shaping, knowing, growing, and advancing. Influential factors to this process were relationships, support, trust, respect, acceptance, and gaining experience. Barriers that delayed this process were negative interaction and unprofessionalism.

Implications for this research included providing support and professional development for preceptors, providing nursing administrations with assessment strategies for facilitating and designing a strong and solid new nurses orientation, and prompting nurse educators to examine their curriculum and ensure their students are adequately prepared to meet the demands of 21st century acute care nursing. For preceptors, their role is vital to the sustainability of the profession as they assume a leadership role within their unit in guiding, coaching, teaching, and supporting new nurses. They support the new nurse and they, in turn, need to be supported as this might be a new experience for them as well. Hospitals need to recognize their service and reward them. Nurse managers are encouraged to get to know and research new hires and nurses from the competent level of Benner's (1984) framework in order to determine the best match between preceptor and preceptee.

Nursing educators can assume a greater responsibility for professional role development, socialization, and professional identity in the education and training of nursing students. Incorporating innovative teaching strategies or creating activities to address those high-stress, low volume occurrences in nursing for which students are not prepared when they graduate might be viable options to explore to promote professional role development in nursing students so they are better equipped to meet the demands and face the challenges associated with a new professional nursing role in an acute care

setting. Innovative partnerships between education and practice are encouraged to promote a smoother and seamless transition for newly prepared BSN nurses.

This study was just a beginning step in the researcher's discovery trajectory. As a result of this process, she is inspired to continue her work in grounded theory methodology. Upon completing this research, the next step is to develop a science program that establishes theoretical nurse pathways such as continuing to research innovative strategies to advance the knowledge of nursing education and bridge it to practice so it can further support and smoothly transition nursing graduates into well-shaped, independent, highly competent, confident RN practitioners. As this study has concluded, dissemination of the results to nurse educators, hospital-based nursing leadership and middle management, to preceptors, advanced practice nurses, and future generations of nurses will be the researcher's priority through presentation and publication.

REFERENCES

- Advance Healthcare Network. (2010). *One-third of RNs plan to leave job in next 3 years, survey finds*. Retrieved from <http://nursing.advanceweb.com/News/National-News/One-third-of-RNs-Plan-to-Leave-Job-in-Next-3-Years-Survey-Finds.aspx>
- Agency for Healthcare Research and Quality (AHRQ). (2004). Hospital nurse staffing and quality of care. *Research in Action*, 14.
- Agnes, M. (Ed.). (2002). *Webster's new world college dictionary* (4th ed.). Cleveland, OH: Wiley Publishing, Inc.
- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M. & Silber, J. H., (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of American Medical Association*, 290(12), 1617-1623.
- American Nurses Association. (2006). Nursing quality. Retrieved from www.nursingworld.org
- American Nurses Association. (2014). *Turn quality data for your hospital into solutions you can use*. Retrieved from <http://www.nursingquality.org/about-NDNQI/Quality-Data-Solutions#intro>
- American Association of Colleges of Nursing (AACN). (2014). *The impact of education on nursing practice* [Fact sheet]. Retrieved from <http://www.aacn.nche.edu/media-relations/fact-sheets/impact-of-education>

- Anderson, G., Hair, C., & Toder, C. (2012). Nurse residency programs: An evidence-based review of theory, process, and outcomes. *Journal of Professional Nursing*, 28(4), 203-212.
- Become. (2012). Retrieved from www.macmillanenglish.com
- Becoming. (2014). Retrieved from www.dictionary.reference.com
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice-Hall.
- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. Stanford, CA: The Carnegie Foundation for the Advancement of Teaching.
- Bhanji, S. M. (2013). Welcoming future nurses: Preparing undergraduate nursing students for role transition. *i-manager's Journal on Nursing*, 3(1).
- Birks, M., Chapman, Y., & Francis, K. (2010). Becoming professional by degrees – A grounded theory study of nurses in Malaysian Borneo. *Singapore Nursing Journal*, 31-42.
- Bowles, C., & Candela, L. (2005). First job experiences of recent RN graduates: Improving the work environment. *Journal of Nursing Administration*, 35, 130-137.
- Boyle, D. K., Popkes-Vawter, S., & Tauton, R.L. (1996). Socialization of new graduate nurses in critical care. *Heart and Lung*, 25(2), 141-154.

- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development* (pp. 197-249). Greenwich, CT: JAI Press.
- Budin, W. C., Brewer, C. S., Chao, Y. Y., & Kovner, C. (2013). Verbal abuse from nurse colleagues and work environment of early career registered nurses. *Journal of Nursing Scholarship*, 45(3), 308-316. doi:10.1111/jnu.12033
- Buerhaus, P. I., Auerbach, D. I., & Douglas O. Staiger, D. O. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs*, 28(4), 657-668.
- Bureau of Labor Statistics. (2014). *Occupational Employment and Wages, May 2013*. Retrieved from www.bls.gov/oes/current/oes291141.htm
- Buteyn, P. N. (2010). *Hospital educators' expectations of entry level graduate nurses* (Unpublished doctoral dissertation). University of Wisconsin, Oshkosh.
- Chandler, G. (1992). The source and process of empowerment. *Nursing Administration Quarterly*, 16, 65-71.
- Cook, T. H., Gilmer, M. J., & Bess, C. J. (2003). Beginning students' definitions of nursing: An inductive framework of professional identity. *Journal of Nursing Education*, 42(7), 311-317.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Grounded theory procedures and techniques* (3rd ed.). Newbury Park, CA: Sage.
- Creswell, J. W. (2007). *Qualitative inquiry and research design. Choosing among five approaches*. (2nd ed.). Thousand Oaks, CA: Sage Publications.

- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St. Leonards, Australia: Sage.
- Denzin, N. K., & Lincoln, Y. S. (2005). *Handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Detert, J. R., & Edmondson, A. C. (2007). *Why employees are afraid to speak*. Retrieved from <https://hbr.org/2007/05/why-employees-are-afraid-to-speak>
- Dillon, J. (2000). The question of being. In J. Brunschwig & G. E. R. Lloyd (Eds.), *Greek thought: A guide to classical knowledge* (pp. 51-71). Cambridge: The Belknap Press of Harvard University Press.
- Dinmohammadi, M., Peyrovi, H., & Mehrdad, N. (2013). Concept analysis of professional socialization in nursing. *Nursing Forum*, 48(1), 26-34.
- Dotson, M. J., Dave, D. S., Cazier, J. Z, & Spaulding, T. J. (2014). An empirical analysis of nurse retention: What keeps RNs in nursing? *Journal of Nursing Administration*, 44(2), 111-116.
- Dreyfus, S. E., & Dreyfus, H. L. (1980). *A five-stage model of the mental activities involved in directed skill acquisition*. Unpublished report supported by the Air Force Office of Scientific Research (AFSC). Berkeley: University of California.
- Drury, V., Francis, K., & Chapman, Y. (2008). Letting go and moving on: A grounded theory analysis of disengaging from university and becoming a registered nurse. *Nurse Education Today*, 28, 783-789.
- Duchscher, J. B. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *Journal of Continuing Education in Nursing*, 39(10), 441-450.

- Duchscher, J. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing*, 65(5), 1103-1113.
- Ellerton, M. L., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *Journal of Continuing Education in Nursing*, 34(3), 103-107.
- Evans, G. L. (2013). *A novice researcher's first walk through the maze of grounded theory: Rationalization for classical grounded theory*. Retrieved from <http://groundedtheoryreview.com/2013/06/22/a-novice-researchers-first-walk-through-the-maze-of-grounded-theory-rationalization-for-classical-grounded-theory/>
- Fernandez, N., Dory, V., Ste-Marie, L. G., Chaput, M., Charlin, B., & Boucher, A. (2012). Vary conceptions of competence: An analysis of how health sciences educators define competence. *Medical Education*, 46, 357-365.
- Fiester, L. (2013). *The RN work project: A national study to track career changes among newly licensed registered nurses*. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/11/the-rn-work-project.html>
- Franklin, B. (2015). *Moveme quotes*. Retrieved from <http://www.movemequotes.com/tag/benjamin-franklin/>
- Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing*, 32(2), 473-480.
- Glaser, B. (1992). *Basics of grounded theory analysis: Emergence versus forcing*. Mill Valley, CA: Sociology Press.

- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Greene, M. A. (2010). Paying for nursing orientation. *Journal for Nurses in Staff Development*, 26(6), E3-E7. doi:10.1097/NND.0b013e3181fc0459
- Harwood, M. (2011). Transition shock--Hitting the ground running. *Nuritinga:Electronic Journal of Nursing*. Retrieved from http://www.utas.edu.au/__data/assets/pdf_file/0007/156661/M_Harwood.pdf
- Hershey, J. (2007). The lived experience of becoming a professional nurse for associate degree nursing graduates: A phenomenological study. (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses @ CIC Institutions. (3284936).
- Hinson, T. D., & Spatz, D. L. (2011). Improving nurse retention in a tertiary acute-care hospital. *Journal of Nursing Administration*, 41(3), 103-108.
- Hoffart, N., Waddell, A., & Young, M. B. (2011). A model of new nurse transition. *Journal of Professional Nursing*, 27(6), 334-343.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.
- Institute of Medicine (IOM). (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press. Retrieved from <http://www.iom.edu/Reports/2010/The-future-of-nursing-leading-change-advancing-health.aspx>
- Institute of Medicine. 2011. *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press.

- Jewell, A. (2013). Supporting the novice nurse to fly: A literature review. *Nurse Education in Practice*, 13, 323-327.
- Jones, M., & Alony, I. (2011). Guiding the use of grounded theory in doctoral studies – An example from the Australian film industry. *International Journal of Doctoral Studies*, 6, 95-114.
- Journey. (2014). In *Dictionary.com*. Retrieved from www.dictionary.reference.com
- Jung, C. G. (2015). *Quotes*. Retrieved from <http://www.goodreads.com/quotes/50795-i-am-not-what-happened-to-me-i-am-what>
- Kelly, B. (1996). Hospital nursing: 'It's a battle?' A follow-up study of English graduate nurses. *Journal of Advanced Nursing*, 24(2), 1063-1069.
- Kohn, L. T., Corrigan, J. M., & Molla, S., Donaldson, M. S. (Eds.). (1999). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Konecki, K. (1997). Time in the recruiting search process by headhunting companies. In A. Strauss & J. Corbin (Eds.), *Grounded theory in practice* (pp. 131-146). Thousand Oaks, CA: Sage.
- Kovner, C., & Brewer, C. (2009). *The RN work project: A study of newly-licensed registered nurses*. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/09/the-rn-work-project.html>
- Kovner, C. T., Brewer, C. S., Fatehi, G., & Katigbak, C. (2014). Changing trends in newly licensed RNs. *American Journal of Nursing*, 114(2), 26-34.
doi:10.1097/01.NAJ.0000443767.20011.7f

- Kovner, C. T., Brewer, C. S., Fatehi, G., & Jun, J. (2014). What does nurse turnover rate mean and what is the rate? *Policy, Politics, & Nursing Practice*, 0(0), 1-8.
doi:10.1177/1527154414547953
- Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St. Louis, MO: C. V. Mosby.
- Lai, P. K., & Lim, P. H. (2012). Concept of professional socialization in nursing. *International e-Journal of Science, Medicine & Education*, 6(1), 31-35.
- LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage and Family*, 67, 837-857.
- LeMone, P. (1991). Analysis of a human phenomenon: Self-concept. *Nursing Diagnosis*, 2(3), 126-130.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- MacIntosh, J. (2003). Reworking professional nursing identity. *Western Journal of Nursing Research*, 25(6), 725-741.
- MacLellan, D., Lordly, D., & Gingras, J. (2011). Professional socialization in dietetics: A review of the literature. *Canadian Journal of Dietetic Practice and Research*, 72(1), 37-39.
- McCarthy, V., & Holbrook, L. (2008). A multidisciplinary concept analysis of empowerment: Implications for nursing. *Journal of Theory Construction and Testing*, 12(2), 68-74.
- McConnell, E. A. (2001). Competence vs. competency. *Nursing Management*, 32(5), 14.

- McGill, B. (2014). *Quote*. Retrieved from <http://bryantmcgill.com/excerpts/who-shaping-called-change-world-changes.html>
- McHugh, M. D., & Lake, E. T. (2010). Understanding clinical expertise: Nurse education, experience, and the hospital context. *Research in Nursing and Health*, 33(4), 276-287.
- Meng, A., & Conti, A. (1995). An opportunity to stimulate critical thinking. *Journal of Nursing Staff Development*, 11(2), 71-76.
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.
- Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Online Journal of Issues in Nursing*, 12(1), Manuscript 1. doi:10.3912/OJIN.Vol12No01Man01
- Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1), 1-10.
- Miskelly, P., & Duncan, L. (2014). 'I'm actually being the grown-up now': Leadership, maturity and professional identity development. *Journal of Nursing Management*, 22, 38-48.
- Mitchell, P. H. (2008). Defining patient safety and quality care. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses* (pp. 1-2). Rockville, MD: Agency for Healthcare Research and Quality./
- Morrow, S. (2009). New graduate transitions: Leaving the nest, joining the flight. *Journal of Nursing Management*, 17, 278-287.

- Morse, J. M. (2004). Theoretical saturation. In M. S. Lewis-Beck, A. Bryman, & T. F. Liao (Eds.), *The SAGE encyclopedia of social science research methods* (pp. 1122-1123). Thousand Oaks, CA: Sage.
doi: <http://dx.doi.org/10.4135/9781412950589>.
- National Center for Nursing Quality. (1998). *Nursing quality*. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx
- National Council of State Boards of Nursing. (2009). *Tri-council support for IOM report*. Retrieved from <http://www.aacn.nche.edu/media-relations/news-releases/2010/Tri-Council-Support-IOM-Report.pdf>
- National League for Nursing. (2013). Headlines. *Nursing Education Perspectives*, 34(2), 138. doi:<http://dx.doi.org/10.5480/1536-5026-34.2.138>
- Newton, J. M., & McKenna, L. (2007). The transitional journey through the graduate year: A focus group study. *International Journal of Nursing Studies*, 44, 1231-1237.
- Nieswiadomy, R. M. (2012). *Foundations of nursing research* (6th ed.). Boston, MA: Pearson.
- Nursing the Future. (2010). *About*. Retrieved from www.nursingthefuture.ca/about
- Öhlén, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing*, 28(4), 720-727.
- Olsson, H. M., & Gullberg, M. T. (1991). Nursing education and definition of the professional nurse role: Expectations and knowledge of the nurse role. *Nurse Education Today*, 11(1), 30-36.

- Parse, R. R. (1992). Human becoming: Parse's theory of nursing. *Nursing Science Quarterly*, 5(35), 35-42.
- Pellico, L. H., Brewer, C. S., & Kovner, C. T. (2009). What newly licensed registered nurses have to say about their first experiences. *Nursing Outlook*, 57(4), 194-203.
- Perry, P. (2011). Concept analysis: Confidence/self-confidence. *Nursing Forum*, 46(4), 218-230.
- Phillips, C., Kenny, A., Esterman, A., & Smith, A. (2014). A secondary data analysis examining the needs of graduate nurses in their transition to a new role. *Nurse Education in Practice*, 14, 106-111.
- Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Wolters Kluwer Health/Lippincott, Williams & Wilkins.
- Preceptee. (2014). Retrieved from www.medica-dictionary.thefreedictionary.com/preceptee
- Price, S. L. (2008). Becoming a nurse: A meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, 65(1), 11-19.
- Rao, A. (2012). The contemporary construction of nurse empowerment. *Journal of Nursing Scholarship*, 44(4), 396-402.
- Reed, P. G., & Shearer, N. B. (2011). *Nursing knowledge and theory innovation: Advancing the science of practice*. New York: Springer.
- Richards, J. (2010). The meaning of being a primary nurse preceptor for newly graduated nurses (Doctoral dissertation, University of Nevada, Las Vegas). Retrieved from ProQuest Information & Learning. (AAI3372137).

- Riley, R. (1996). Revealing socially constructed knowledge through quasi-structured interviews and grounded theory analysis. *Journal of Travel and Tourism Marketing, 15*(2), 21-40.
- Rilke, R. (2015). *Rainer Maria Rilke quotes*. Retrieved from <http://www.brainyquote.com/quotes/quotes/r/rainermari147758.html>
- Robert Wood Foundation. (2009). *Retaining experienced nurses research initiative: Final report*. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/01/evaluation-of-the-robert-wood-johnson-wisdom-at-work.html>
- Roberts, B. J., Jones, C., & Lynn, M. (2004). Job satisfaction of new baccalaureate nurses. *Journal of Nursing Administration, 34*(9), 428-435.
- Rush, K. L., Adamack, M., Gordon, J., Lilly, M., & Janke, R. (2013). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies, 50*, 345-356.
- Salt, J., Cummings, G. G., & Profetto-McGrath, J. (2008). Increasing retention of new graduate nurses: A systematic review of interventions by healthcare organizations. *Journal of Nursing Administration, 38*(6), 287-296.
- Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York: Springer.
- Scott, K. W., & Howell, D. (2008). Clarifying analysis and interpretation in grounded theory: Using a conditional relationship guide and reflective coding matrix. *International Journal of Qualitative Methods, 7*(2).

Self-confidence (2014). Retrieved from <http://www.merriam-webster.com/dictionary/self-confidence>

Serra, M. N. (2008). Learning to be a nurse. Professional identity in nursing students. *Educational Sciences Journal*, 5, 65-76.

Spence Laschinger, H. K., Wilk, P., Cho, J., & Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: Does experience matter? *Journal of Nursing Management*, 17, 636-646.

Spurgeon, D. (2000). Canada faces nurse shortage. *British Journal of Medicine*, 320(7241), 1030.

Stevenson, B., Doorley, J., Moddeman, G., & Benson-Landau, M. (1995). A qualitative study of perceptions of nurse preceptors regarding the preceptor role. *Journal of Nursing Staff Development*, 11(3), 160-165.

Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Newbury Park, CA: Sage.

Suresh, P., Matthews, A., & Coyne, I. (2012). Stress and stressors in the clinical environment: A comparative study of fourth-year student nurses and newly qualified general nurses in Ireland. *Journal of Clinical Nursing*, 22, 770-779. doi: 10.1111/j.1365-2702.2012.04145.x

Tabari-Khomeiran, R., Kiger, A., Parsa-Yekta, A., & Ahmadi, F. (2007). Competence development among nurses: The process of constant interaction. *Journal of Continuing Education in Nursing*, 38(5), 211-218.

- Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 45(6), 204-211.
- Ten Hoeve, Y., Jansen, G. & Roodbol, P. (2014). The nursing profession: Public image, self-concept and professional identity. *Journal of Advanced Nursing*, 70(2), 295-309.
- Texas Center for Nursing. (2012). *Workforce studies*. Retrieved from www.dshs.state.tx.us/chs/cnws
- The Joint Commission (TJC). (2014). *2014 national patient safety goals*. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx
- Thrysoe, L., Hounsgaard, L., Dohn, N. B., & Wagner, L. (2011). Expectations of becoming a nurse and experiences on being a nurse, *Nursing Science*, 101(31), 15-19.
- Tilley, D. B. (2008). Competency in nursing: A concept analysis. *Journal for Continuing Education in Nursing*, 39(2), 58-64.
- Tracy, J., Samarel, N., & DeYoung, S. (1995). Professional role development in baccalaureate nursing education. *Educational Innovations*, 34(4), 180-182.
- Twibell, R., St. Pierre, J., Johnson, D., Barton, D., Davis, C., Kidd, M., & Rook, G. (2012). Tripping over the welcome mat: Why new nurses don't stay and what the evidence says we can do about it. *American Nurse Today*, 7(6), 3.
- University of North Carolina. (2008). *Onboarding*. Retrieved from http://hr.uncc.edu/sites/hr.uncc.edu/files/onboarding_ppt.pdf
- Ursuy, P. A. (2012). *Exploring the concept of competence*. Unpublished manuscript, University of Northern Colorado, Greeley, Colorado.

- Valdez, A. M. (2008). Transitioning from novice to competent: What can we learn from the literature about graduate nurses in the emergency setting? *Journal of Emergency Nursing*, 34(5), 435-440.
- Wagensteen, S., Johansson, I. S., & Nordstrom, G. (2008). The first year as a graduate nurse: An experience of growth and development. *Journal of Clinical Nursing*, 17, 1877-1885.
- Walker, L. O., & Avant, K. C. (2011). *Strategies for theory construction in nursing* (5th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
- Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research*, 16(4), 547-559.
- White, K. A. (2009) Self-confidence: A concept analysis. *Nursing Forum*, 44(2), 103-114.
- Whitehead, B., & Holmes, D. (2011). Are newly qualified nurses prepared for practice? *Nursing Times*, 107, 20-23.
- Willig, C. (2013). Grounded theory methodology. In *Introducing qualitative research in psychology* (3rd ed., pp. 69-82). London: Open University Press.
- World Health Organization. (n.d.). *What is patient safety?* Retrieved from www.who.int/patientsafety/education/curriculum/who_mc_topic-1.pdf
- World Health Organization. (2014). *Global experts' consultation for the development of the leaders' guide*. Retrieved from <http://www.who.int/servicedeliverysafety/areas/leaders-guide/en/>
- Zinsmeister, L. B., & Schafer, D. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development*, 25(1), 28-34.

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of
NORTHERN COLORADO



Institutional Review Board

DATE: June 17, 2014

TO: Peggy Ursuy, MSN
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [611978-1] The Journey Within: Discovering the Sense of Becoming
SUBMISSION TYPE: New Project

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS
DECISION DATE: June 17, 2014

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Thank you for a clear and thorough IRB application for an interesting dissertation research project.

Best wishes with your research and please don't hesitate to contact me with any IRB-related questions or concerns.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX B

CONSENT FOR HUMAN PARTICIPANTS IN RESEARCH



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH UNIVERSITY OF NORTHERN COLORADO

Project Title: The Journey Within: Discovering the Sense of Becoming
 Researcher: Peggy Ursuy MSN, MA, RN, PhD student, School of Nursing
 Phone: (989) 295-2448 E-mail: brun2534@bears.unco.edu
 Faculty: Faye Hummel, PhD, RN, CTP
 Phone: (970) 351-1697 E-mail: faye.hummel@unco.edu

Purpose and Description: The primary purpose of this research study is to explore the new nurse's experience of the "sense of becoming." The research study is examining the gap between new nurse expectations and acute care employer expectations of new nurses. It is the author's hope that information gathered regarding these experiences will emerge concepts that will construct meaning through the grounded theory methodology on the sense of becoming from a new nurse's perspective and transition from the novice to advanced beginner stage of nursing proficiency.

As a participant in this research study, you will be asked to participate in a one-on-one, face-to-face audiotaped interview with the researcher. The interview will take approximately 60 minutes of your time. Should you decide to participate, every precaution will be taken in order to protect your confidentiality. The data for this project will be kept confidential and all information that refers to you, or can be identified with you will be kept confidential to the maximum extent allowable by law. If you choose to sign this consent form, you are also giving consent to have the interview audiotaped, so the researcher will have complete and correct information from the interview. You may request at any time to have the taping stopped and you can refuse to be taped at all. The audio- recordings are transcribed (written word for word); all identifying information will be deleted (i.e., names of people or places) so that your information cannot be identified. The audiotaped interview data will be transcribed using transcription software and analyzed with computer-assisted qualitative data analysis software. Typed transcripts of your interview will be kept as password protected files, and access to the information will be limited to only the researcher. Additionally, you will be assigned a pseudonym name. Only the researcher will know the pseudonym name. The data collected in the interview will be used for a doctoral dissertation that will be published. When I report the data the pseudonym name will be used; your real name, nursing school, and employer will not be used. All of the data collected and analyzed from the interview and the demographic questionnaire will be kept in a locked cabinet in the researchers office, which is only

accessible by the researcher for three years. Then it will be destroyed. I would be happy to share the results of the study with you when it is complete upon your request. Potential risks in this research study are minimal. You may feel anxious or nervous about being interviewed, but I am trying to minimize these feelings because the results will have no bearing on you or your employment. The benefits to you include contributing to the understating of the transition process for new nurses, gaining practice in interviewing, communication skills, and the opportunity to reflect on your nursing education and practice. In addition, if you become too uncomfortable with the interview, you may choose to leave the interview at any time and be dismissed.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. You will not receive any compensation, gifts, or extra credit for participating in the research study. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research study. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, University of Northern Colorado, Suite #25, Kepner Hall, Greeley, CO 80639; (970) 351-1907.

Participant's Signature Date

Researcher's Signature Date

APPENDIX C

SEMI-STRUCTURED INTERVIEW GUIDE

SEMI-STRUCTURED INTERVIEW GUIDE

Introduction:

I would like to thank you for agreeing to talk to me today. I really appreciate your taking the time to participate in this interview. The title of my research is “The Journey Within: Discovering the Sense of Becoming.” I would like to learn more about how new nurse graduates transition from the role of the student to professional nurse and experience the “sense of becoming.” During this interview, there are no right or wrong answers to any of the following questions and you are free to decline answering any of the questions as well. Therefore, speaking from your personal experiences are truly the best answers. I would also like to remind you that at any time you may choose to not answer a question, take a break during the interview, end the interview, withdraw participation, ask questions, or provide feedback about the questions at any point during our time together.

Interview

I am interested in your experience, your journey if you will, from graduating as a baccalaureate nursing student to becoming a professional, independent, practicing nurse.

1. Describe who you are today as a nurse.
2. Describe who you were at the time of your nursing graduation.
3. Along this road from graduation till now, you have encountered many experiences. Tell me what stands out to you and why.
 - a. Orientation
 - b. Positive aspects
 - c. Negative aspects
 - d. Supports
 - e. Challenges
4. Is there anything we haven’t discussed today that you would like to mention?

Thank you for your time and participation. If you have any questions or comments for me after our meeting, please contact me at (989) 295-2448 or brun2534@bears.unco.edu.

Sincerely,

Peggy Ursuy MSN, MA, RN

APPENDIX D

CONDITIONAL RELATIONSHIP GUIDE

Conditional Relationship Guide (Axial Coding)

	Category	What	When	Where	Why	How	Consequence(s)
1	Relationships	"I wanted to be just like my preceptor. She made people feel secure, well informed, and safe. She taught me how to juggle time, manage patients, and how to navigate a fast paced environment."	During orientation and/or post-orientation (immediate & comfort zones)	In a dyad, between 2 people (preceptor/preceptee) Association with other health care professionals Interaction with patients	Because new nurses need to learn the ropes from seasoned nurses Need to feel connected	By mutual reciprocation Role modeling Encouragement Support	Connection Engagement Empowerment Growth Vision Being shaped Socialized Professional identity Role satisfaction
2	Negative interactions	"Hands off personality" "Not good"	During orientation and/or post-orientation (immediate & comfort zones)	Between 2 or more people (preceptor/preceptee, other RN on unit, physician, patient/family)	Because of unfamiliarity with each other Possible generational gap Difference in teaching/learning styles Tradition Situational circumstances	Lack of communication Lack of collaboration Difference in expectations	Lack of engagement Discomfort Decrease in self-confidence level Conflict Stress Self-censorship Barrier to learning
3	Self-confidence	"Giving off vibe of knowing what you are doing" "I knew I could handle it"	During late orientation and post-orientation (immediate & comfort zones)	In patient care situations In hand-offs/report In delegation to others	Because it is a quality that is built up over time	By repetition and exposure to stimuli and situations Reinforcement from others Successful completion of a task Accomplishment of a goal	Reinforces/builds competence Lessens self-doubt Reduces anxiety Reassuring to others Comfort in role

	Category	What	When	Where	Why	How	Consequence(s)
							Empowering
4	Adaptation	"Nervous and scared at first [with role], but comfort increased with time"	During orientation and/or post-orientation (immediate zone)	In patient care situations In intra- and interprofessional relationships	Because of newness of the situation No prior or only limited experience	By repetition and exposure to new encounters/situations	Comfort in role Reinforces/builds self-confidence
5	Debriefing	"Recapped day (event/situation) with mentor"	At end of the day or the next shift	In the patient care setting/on the unit	Because the new nurse has questions There is uncertainty about the situation/incident Unresolved emotions/feelings	By communication between 2 or more people (experienced RN and new RN)	Understanding of new experience Demonstration of support Provides reassurance
6	Feedback	"Received constructive criticism from mentor and it was helpful"	During a shift, or at some point(s) of orientation	In the patient care setting/on the unit or virtual	Needs for direction Guidance	By communication between 2 or more people (experienced RN/unit administration and new RN)	Identification of strengths and areas for improvement Respect for others
7	Trust in others	Allowed self to learn and accepted what was told without suspicion (etic)	During orientation and/or post-orientation (immediate & comfort zones)	In intra- and interprofessional relationships	To establish guidance	By watching their practice and observing the outcomes By fostering positive relationships	Teamwork Respect for others Connection
8	Self-trust	"I know my decisions are right" "Ownership and accountability, project confidence to others"	During late orientation and post-orientation (immediate & comfort zones)	Within self (microsystem)	Allows for learning and growing	Adaptation Learning by "getting it right"	In building self-confidence Competence
9	Reliance	"I leave work thinking that I've really made a difference and	During post-orientation (immediate	In patient care situations In intra- and	Because of need to be valued To do the right thing	By repetition and exposure to situations	Teamwork Respect for others

	Category	What	When	Where	Why	How	Consequence(s)
		touch someone's life or done something better"	& comfort zones)	interprofessional relationships			Trust Connection
10	Acceptance	"Taken under wing" "Prove yourself and you're your ability"	During orientation and/or post-orientation (immediate & comfort zones)	In intra- and interprofessional relationships	Because of need to fit in	By demonstrating competence	Builds self-confidence Belonging Professional identity Nurse retention
11	Unprofessional behaviors	"Older nurses complaining (or talking) about younger nurses" "Getting yelled at by a physician" "Hear stories of nurses eating their young" "Butting heads with senior nurses"	During orientation and/or post-orientation (immediate & comfort zones)	In intra- and interprofessional relationships	Because of individual differences Personal intolerances Lack of interprofessional skills Poor work ethic Power struggles Feelings of threat	By intentional or unintentional means Noncompliance for boundaries	Barrier to increasing self-confidence and/or competence Stress Lack of respect for others Negative unit culture Unprofessionalism Self-censorship
12	Self-respect	"I am no longer the student, I'm now the one running the show" "Self management" "I've finally made it"	During late orientation and post-orientation (immediate & comfort zones)	Within self (microsystem)	Because of morals Desire to do the right thing	By maintaining integrity	Personal identity Professional identity Commitment
13	Respect for others	"Value them [senior nurses] for their experience"	During orientation and post-orientation (immediate & comfort zones)	In intra- and interprofessional relationships	Because of recognition of their knowledge and skill	By watching them Emulating their practice Valuing knowledge Learning from others	Connection Fostering relationships Trust in others

	Category	What	When	Where	Why	How	Consequence(s)
14	Resources	"My manager, my supervisor, the doctors"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations	Because of need to refresh Need for learning	By consulting with others Collaboration	Connections Learning Increased competence
15	Competence	"I wasn't aware of what I didn't know, but knew I didn't know everything" "Tasks and skills" "Organization of myself ... prioritize myself on the job"	During orientation and post-orientation (immediate & comfort zones)	In caring for patients In demonstration of tasks and skills In demonstration of knowledge of situation or condition	Because it is a quality that is built up over time	By repetition and exposure to stimuli and situations Opportunities to practice	Safety in practice Quality patient care Reinforces or builds self-confidence Establishes trust Establishes acceptance
16	Decision-making/Judgments	"How to critically think" "Better manage situations"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations	Because of need to prioritize Need to question abnormalities	By inductive/deductive reasoning Clinical reasoning Critical thinking	Competence Safety in practice Quality patient care
17	Communication	"Advocating for the patient" "Talk intelligently"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations In intra- and interprofessional relationships	Because of need for health care professionals to collaborate with one another Need to connect with patients/families	By written, verbal or non-verbal means	Safety in practice Quality patient care Barrier to safe practice Sharing of ideas
18	Organization (behavior)	"Time management and prioritization"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations	Because it maintains order Lessens room for error	By understanding processes Efficiency	Efficiency Reliance Trust
19	Prioritization	The task of prioritizing and making decisions based on need	During orientation and post-orientation	In patient care situations	Because work assignments and acuity of patients determine schedule	By repetition and exposure to situations	Establishes order of needs

	Category	What (etic)	When (immediate & comfort zones)	Where	Why	How	Consequence(s)
20	Responsibility	"Owning the situation"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations	Because it maintains structure Ensures work will be done correctly	By acceptance of challenges Success in doing the right thing	Competence Feel valued Empowerment
21	Learning Style	"Watching other people work" "Mentor gave further explanation" "Listening to the stories of others"	During orientation and post-orientation (immediate & comfort zones)	In patient care situations	Because it broadens knowledge	By observation, listening, and doing	Awareness Competence
22	Unit milieu	Welcoming "Establish friendships" "Family" "Camaraderie"	During orientation	In the nursing unit	Because there are many people working together	By unit leadership Agency policies	Culture of nursing unit Nurse recruitment/retention
23	Personal assets	"Picture of who you want to be" "My personality" "Learning style" "Motivation level"	During orientation and post-orientation (immediate & comfort zones)	Within self (microsystem)	Because every one has their own goals Individualized	By personal knowing Knowing thy self	Self-concept Competence
24	Empowerment	"Finding my voice" "Letting me do more" "Progressively taking over" "Speaking up" "Advocate for self or others"	During orientation and post-orientation (immediate & comfort zones)	In patient care situation In unit responsibilities	Because patient/nurse safety improves care, outcomes, and reduces errors Sometimes someone has to take charge	By being pushed/challenged/encouraged by preceptor Apply self to goal/task Do not let kindness be perceived as weakness	Safety in practice Quality patient care Becoming more assertive Doing the right thing Reinforces/builds self-confidence Response/responding

	Category	What	When	Where	Why	How	Consequence(s)
25	Practice pearls	Advice, hints, tips, suggestions, impromptu teaching/learning opportunities (etc)	During orientation	In patient care situations	Supplemental learning Verification/validation	By sharing knowledge, information, and experience Passing along vital information	Knowledge enhancement Strengthens competence Trust in others Communication

Grid adopted from Scott & Howell (2008)

APPENDIX E
VISUAL MODEL

